**San Joaquin County**
**Behavioral Health Services**

# Mental Health Services Act (MHSA)

**Annual Update to the**
**Three-Year Program and Expenditure Plan**
**FY 2018/19**

# SAN JOAQUIN COUNTY

# MHSA FISCAL ACCOUNTABILITY CERTIFICATION

County/City: SAN JOAQUIN COUNTY

☐ Three-Year Program and Expenditure Plan

X Annual Update

☐ Annual Revenue and Expenditure Report

| Local Mental Health Director | | County Auditor-Controller / City Financial Officer | |
|---|---|---|---|
| Name: | Tony Vartan | Name: | Jay Wilverding |
| Telephone Number: | 209-468-8750 | Telephone Number: | 209-468-3925 |
| E-mail: | tvartan@sjcbhs.org | E-mail: | jwilverding@sjgov.org |

Local Mental Health Mailing Address:

1212 N. California St. Stockton CA 95202

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

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

Tony Vartan, _____ _____
Mental Health Director Signature Date

I hereby certify that for the fiscal year ended June 30, 2016, 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, 2016 . I further certify that for the fiscal year ended June 30, 2016, 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 Signature Date

# SAN JOAQUIN COUNTY
# MHSA COMPLIANCE CERTIFICATION

County/City: SAN JOAQUIN COUNTY

☐ Three-Year Program and Expenditure Plan

X Annual Update


Local Mental Health Director

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Program Lead

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

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

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

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

Tony Vartan, _____ _____

Mental Health Director Signature Date

# Contents

# I. Introduction

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

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

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

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

All MHSA component plans must address the needs of children and transitional age youth (TAY) with serious emotional disturbances or mental illnesses and adults and older adults with serious mental illnesses, as well as address specific needs related to cultural competency and in serving the needs of those previously unserved or underserved.

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

A Three-Year Program and Expenditure Plan for the period of FY 17/18, FY 18/19, and FY 19/20 was developed and approved by San Joaquin County Board of Supervisors in June 2017.

This Annual Update for FY 2018/19 represents the continuation of prior MHSA programs and strategies; with the inclusion of several new projects expected to start in 2018/19. The Annual Update also incorporates the two INN Plans, reviewed by the Board of Supervisors in November 2018 and approved by the Mental Health Services Oversight and Accountability Commission in January 2018.

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

# II. Community Program Planning and Stakeholder Process

## A. Community Program Planning Process

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

**Quantitative Analysis:**

- BHS Program Service Assessment: December – March
  - Prevention, Early Intervention, Outpatient and Crisis Services Utilization Analysis
  - Penetration and Retention Reports
  - Timeliness Reports
  - Client Satisfaction Report
  - Cost per Person Analysis
- Annual Evaluation of Prevention and Early Intervention Programs for 2016/17

**Community Discussions:**

- Behavioral Health Board:
  - October Meeting at the Public Library in Lodi
  - February Meeting at BHS in Stockton
  - March Meeting at the Public Library in Tracy
- General Public Forums
  - February 26th at the Public Health Department
  - February 27th at the Robert J. Cabral Agriculture Center
  - March 8th at the Dorothy L. Jones Cuff Center

**Key Informant Interviews**

- San Joaquin County
  - Monica Nino, County Administrator
  - Supervisor Tom Patti
  - Supervisor Miguel Villapudua
- Community Partners
  - Meetings and program tours with both partner and non-partner community-based organizations throughout San Joaquin County.
- BHS Staff, Deputy Directors, and Clinical Program Managers

**Targeted Discussion Groups**

- Consumer Focus Groups
  - Wellness Center
  - Martin Gipson Socialization Center
- Potential Partner Discussion Groups
  - Justice Partners (Probation, Local Law Enforcement, Courts, District Attorney, etc.)
  - Schools (San Joaquin County Office of Education and Local School Districts)
  - Child Welfare Services

## B. Program Service Assessment

San Joaquin County Behavioral Health Services (BHS) provides behavioral health services, including mental health and substance use disorder treatments to over 15,900 consumers annually. Approximately 12,000 individuals are served through MHSA programs. In general program access is reflective of the diverse population of San Joaquin County; with a roughly even division of male and female clients. A snapshot in time analysis of services provided in March 2018, provides a general overview of program participation.

**Mental Health Services provided March 2018**

| Services provided by Age | Number | % of Total |
|---|---|---|
| Children | 1243 | 22.6 |
| Transitional Age Youth | 996 | 18.1 |
| Adults | 2634 | 47.8 |
| Older Adults | 634 | 11.5 |
| **Total** | **5507** | **100%** |

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

| Services provided by Race/Ethnicity | Number | % of Total |
|---|---|---|
| White | 2085 | 37.9 |
| Latino | 1325 | 24.1 |
| African American | 1039 | 18.9 |
| Asian | 558 | 10.1 |
| Other | 258 | 4.7 |
| Native American | 224 | 4.1 |
| Pacific Islander | 18 | 0.3 |
| **Total** | **5507** | **100%** |

Diversity of participants is similar to the distribution in prior years. African Americans are disproportionately represented amongst consumers compared to their proportion of the general population (19% of participants, though comprising 7% of the population of the County). Latinos are enrolled as lower rates compared to their proportion of the general population (24% of participants while comprising 41% of the population) – though this rate is up slightly from prior years.

Participation amongst children and youth is more reflective of the racial demographics of the overall population, with over a third of services provided to young Latinos (35%), suggesting that while stigma, language or cultural barriers, or access to health care services continue to impeded access for Latino adults with behavioral health needs more services are reaching the younger populations.

| Services provided by City/Community | Number | % of Total |
|---|---|---|
| Stockton | 3851 | 69.9 |
| Lodi | 512 | 9.3 |
| Tracy | 379 | 6.9 |
| Manteca | 365 | 6.6 |
| Other | 171 | 3.1 |
| French Camp | 142 | 2.6 |
| Lathrop | 87 | 1.6 |
| **Total** | **5507** | **100%** |

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

| Diagnosis | Number | % of Total |
|---|---|---|
| Mood Disorder | 1976 | 35.9 |
| Schizophrenia | 1493 | 27.1 |
| Anxiety Disorder | 732 | 13.3 |
| Adjustment Disorder | 493 | 9.0 |
| Other Disorder | 441 | 8.0 |
| Behavioral Disorder | 368 | 6.7 |
| Personality Disorder | 4 | 0.0 |
| **Total** | **5507** | **100%** |

Mood disorders and those on the spectrum of schizophrenia disorders are present amongst the majority of clients served. No significant differences are noticeable with regards to how illnesses are distributed by race/ethnicity, though a slightly greater proportion of the individuals diagnosed with schizophrenia are African American (24% of all individuals diagnosed with schizophrenia) likely reflecting the overall overrepresentation of African Americans in treatment services. More men are diagnosed with schizophrenia disorders than women and women are more likely to be diagnosed with mood disorders.

## C. Community and Program Discussions

### Findings from Consumer Focus Groups

Consumer focus groups were convened at the following locations:

- Martin Gipson Socialization Center, operated by the University of the Pacific Community Re-Entry Project
- Peer Recovery Services, a consumer operated wellness center

Nearly all consumers participating in the focus group self-identified as having co-occurring mental health and substance use disorders.

The discussions focused on responses to the following questions:

- What aspects of BHS program services are working well for you and supporting you on your recovery journey?
- Are there barriers or challenges that make it difficult for you to meet your recovery goals?
- What was your experience when you first started seeking assistance? Do you have any recommendations on how we can improve access to services?
- Do you have any other recommendations on how BHS can improve services or otherwise support your recovery process?

Overall, consumers who participated in the focus groups reported a strong appreciation of their clinicians and case management who provided services to them on a daily basis. They reported that case planning and one-on-one time with case managers was one of the most beneficial aspects of services and that being able to participate in groups and individual counseling sessions remained among their highest service priorities.

Housing, and the ability to maintain and secure safe and affordable housing, continues to top the list of major consumer concerns. While most of the consumers participating in groups reported having a place to live many were worried about increasing rents. Others (currently or recently homeless) shared troubling stories about their inability to find housing. Rising rents, scarcity of housing, and more stringent application processes seem to be fueling the housing crisis for consumers. Several consumers reported being homeless one or more day in the past six months.

Transportation was also a major concern in both discussion groups; one group reported that bus routes had recently changed impacting access to services. The second group discussed the need for a cross walk between BHS and the bus stop on the adjacent side of the street.

In prior years, consumers reported long wait times to see a psychiatrist. This year there were fewer concerns about wait times for routine psychiatric visits. This is likely reflective of the impact made by the hiring of several new psychiatrist in 2017. However many reported that they have a hard time

scheduling next-day appointments when they are feeling unwell. Several recommended being told that they should go to crisis because they couldn't get an appointment for a relatively non-urgent concern within a timely period. In particular consumers report having had trouble understanding how to get the help they feel that they need. Often during the discussion, one consumer would provide a recommendation to another consumer about who to call, what to say, and how to get appropriate services in a timely manner. Not surprisingly, consumers reported a need for more peer navigation services. This recommendation has been included in this Annual Update as a new CSS program.

Finally, consumers reported wanting more in the ways of recreation, socialization, and life skills such as healthy meal preparation and employment training. Consumers also reported concern about accessing primary health care services, including dentistry.

### Findings from Potential Partner Focus Groups

Meetings were held with stakeholders and community partners to determine new opportunities to expand and enhance services for individuals with mental illnesses, per San Joaquin County Board of Supervisors directives to expand and enhance collaborative efforts across government and community based partners (Three Year Strategic Priorities). The BHS planning team also met individually and in focus group discussions with community based partners, school personnel, child welfare services, and law enforcement and justice partners. The results from the planning discussions with law enforcement and justice partners, pertaining to non-serious and nonviolent offenders with behavioral health concerns and /or homeless individuals are reported in the section below as an update to the 17/18 planning process. In additional the following key findings and recommendations were determined.

- There remain critical system gaps for children and youth within the dependency system (child welfare and/or juvenile justice system). San Joaquin County does not have enough licensed short term residential therapeutic programs (STRTPs) to meet the local demand for services. As a result children within the child welfare system stay longer than indicated in the emergency children's shelter and, without appropriate level of care interventions, some youth have escalating behaviors that result in a juvenile justice contact.
    - Next Steps for 2018/19: BHS and the San Joaquin County Human Services Agency (HSA) will continue to develop collaborative strategies to address system gap. For the short-term BHS will increase clinical resources to the FSP program serving dependency youth and to the Mary Graham emergency shelter for children. BHS and HSA are also entering into exploratory dialogue regarding to potential to develop a crisis residential treatment program for children and youth.

- School base mental health services are insufficient to meet demand and are implemented with few oversights and varying levels of effectiveness at different schools. The biggest concern was the use of a "pool" of clinicians to work with schools. School personnel reviewed the importance of having dedicated clinical staff working within the school milieu and the importance of services beyond individual counseling for children and youth including life skills and rehabilitation groups to address impulse control, positive peer relationships. Other areas of service support recommended include more participation in student support teams and working

collaboratively with school staff to address behavioral concerns that escalate beyond the disciplinary / code of conduct rules and procedures for schools.

- Next Steps for 2018/19: BHS is ending the Trauma Services for Children and Youth program and creating a new and strengthened PEI program for School-based Interventions for children and youth that will provide early intervention services to elementary, middle, and high school age youth to address a range of behavioral health concerns. School-based Intervention services will be targeted to schools in which a large number of students have a higher than average risk of developing a mental illness. Extreme poverty, and adverse childhood experiences including poverty, are identified in the California Code of Regulations (§3720) as a risk factor for mental illness. School-based Intervention services will prioritize schools in which a substantial majority of students are eligible to participate in the free or reduced price meal program.

- Prevention and Early Intervention Services are primarily directed to children and youth. In prior years, more than 75% of all PEI programming was directed to children and youth. Community stakeholders suggested that more PEI services be directed towards Transition Age Youth (TAY), Adult, and Older Adult populations.
  - Next Steps for 2018/19: BHS will allocate over $3million in PEI funds for early intervention programs for TAY, Adult, and Older Adult populations in FY 2018/19. Services include funding for a new diversion support program; enhanced funding for a clinician to work with adults that have been victims of human trafficking; and a new program that will provide funding to one or more community based partners to provide trauma response services to TAY, Adult, and Older Adults in San Joaquin County. BHS will seek partners that can offer an array of culturally competent services using evidence based practices.

## Findings from Discussions with Staff and Partners

Meetings were held with Deputy Directors and clinical program managers from all areas of the BHS service delivery system in January and February of 2018, in order to gain input from clinicians regarding their thoughts on the greatest gaps and challenges in the mental health service delivery system.

Major Concern #1: Inpatient and Residential Services

Inpatient and Residential services are available for consumers with the most acute and chronic care needs. Utilization of inpatient and crisis residential services is high. Bed spaces are typically full in local crisis residential and psychiatric health facilities, sometimes requiring transport out of the county for necessary treatment services.

One challenge is that crisis personnel report having poor discharge options for individuals to step down to less restrictive levels of care because (1) programs are full – there are insufficient care homes to meet demand; or (2) programs feel that client acuity may be too high for the placement. The following have been identified as immediate needs:

- Adult residential facility, for individuals that are eligible to leave crisis residential treatment but do not have a safe and stable place in which to continue their recovery efforts.

- High-risk transition team, for individuals that have had one or more failed transitions from acute care services to routine outpatient services. The Transition Team will provide wrap-around case management while clients are staying in an inpatient hospital, crisis residential facility, or other licensed residential program in order to help facilitate the transition to routine treatment. A project goal is to reduce the number of emergency responses to residential facilities.

BHS also recognizes that some clients with high acuity require a long period of structured recovery. BHS is exploring options to develop a short term acute rehabilitation program. BHS will allocate a portion of CSS funds to the Capital Facilities funds in order to support crisis and acute care expansion project needs. (Pursuant to Welfare and Institutions Code §5892(b) Counties may allocate up to 20% of the total average amount of funds allocated to the County for the previous five years. Funds are distributed between WET, CFTN, and the Prudent Reserve.)

Major concern # 2: FSP Engagement and Service Utilization

Service utilization amongst engaged clients is lower than targeted. Individuals enrolled in FSP programs receive, on average, less than six hours of service utilization each month. Target expectations for FSP program clients is for significantly more contact with clinical and case management staff. BHS continues to review opportunities to strengthen service delivery. Program staff members indicate that some clients require very, very extensive services, reducing time available to spend with clients that have reached more of their recovery goals. As a result, BHS will be making significant changes over the next two years to the full service partnership delivery system.

This Annual Update describes two new programs to support FSP clients that require very intensive services. These shall be developed with contracted Organizational Providers that are identified through a public procurement process. Notice has also been given to existing partners providing FSP Engagement services that current contracts will end June 2019. Community partners are invited to submit applications in response to forthcoming Requests for Proposals or Qualifications (RFPs or RFQs). Most new programs developed through this Annual Update licensed and certified Organizational Providers. Community partners that are not Organizational Providers can contact CA Community Care Licensing Division for more information on the licensing and certification process.

## Updates from 2017/18 Recommendations:

Several findings were made during the prior year's MHSA community program planning process. The section below re-iterates those findings and recommendations and provides an update on the program services or actions that have been taken to address recommendations.

- There are insufficient affordable housing units available to ensure that all mental health consumers have safe and secure housing options.
    - Recommendation: Create new affordable housing solutions, blending funding from multiple sources.

  - Update: BHS created a project based housing fund and is working in partnership with the Housing Authority of San Joaquin County to develop new permanent housing units for people with serious mental illness that have, or are eligible for voucher-based housing (formerly Section 8 housing). Over the next two years BHS and the Housing Authority hope to construct up to 35 new units for people with serious mental illnesses.
  - Update: BHS received approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) in January of 2018, for the implementation of the Progressive Housing Innovation Program. Progressive housing is a shared housing program for formerly homeless individuals with serious mental illness and co-occurring disorders. Progressive Housing offers a tiered approach to housing and recovery services that is designed to support individuals at different stages of the recovery process with the goal of "graduating" participants into independent living programs.

- There are insufficient outreach and engagement staff members conducting "field outreach" with individuals whose symptomology indicates a possible mental health disorder.
  - Recommendation: Reconsider outreach and engagement with a multi-agency approach. Include law enforcement in discussions to enhance local capacity to divert individuals with mental health conditions from the local jail.
  - Update: BHS has been engaged in a planning process with law enforcement and other partners to address diversion opportunities for individuals with mild, moderate, and serious mental illnesses and co-occurring disorders. A collaborative project with joint BHS, District Attorney and Law Enforcement commitments is currently in the planning stages with pilot implementation planned for fall 2018. PEI resources will be allocated to this collaborative endeavor.
  - Update: BHS will also expand Mobile Crisis Support Teams. Two new mobile crisis support teams will join the existing fleet within the next fiscal year. The new teams will be stationed outside of Stockton in the North and South portions of the County.

- The population of homeless individuals with serious mental illness may be higher than anticipated. In the 2017 unsheltered homelessness count, 30% of homeless individuals self-reported a mental health concern.
  - Recommendation: Linkages to mental health services should be developed in tandem with any efforts to increase homeless outreach and engagement. More opportunities should be made available to meet individuals where they are during the assessment process.
  - Update: Given the homeless crisis that is currently being experienced BHS is committing more resources and effort to working collaboratively with a range of programs and services. BHS understands that homelessness is a major concern of the community and is shifting the local priorities for FSP enrollment so that experiences of homelessness are of major consideration for FSP enrollment. San Joaquin County has also recently appointed an individual to lead county-wide efforts to address homelessness.

- Individuals with serious mental illnesses continue to have high rates of co-morbid conditions, including co-occurring substance use disorders, high blood pressure, and diabetes. Smoking rates are very high amongst consumers and continue to lead to chronic health conditions.
    - Recommendation: Strengthen partnerships with primary health care services. Create joint training opportunities for psychiatrists and primary care physicians.
    - Update: BHS received approval from the MHSOAC for the creation of the Assessment and Respite Center in partnership with Community Medical Centers (CMC). CMC will operate a drop in facility for individuals with behavioral health concerns to receive assessment and intervention services: respite services, withdrawal management, triage, assessment, and referral to care services. On site staff include medical personnel, clinicians, substance use counselors, case managers, and peer partners. Through the CMC partnership clients will be linked to any needed health, mental health, or substance use disorder treatment services. CMC also offers dentistry, reproductive health, and other specialty health care services.

## D. Public Review

### 1. Dates of the 30 day Review

The document was posted for review and circulation on the San Joaquin County Behavioral Health Services website on April 16, 2018. The public review closes on May 16, 2018.

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 their public program areas that the draft plan was available for review. The plan was posted for review on the San Joaquin MHSA website at:

www.sjcbhs.org/mhsa/mhsaplan

### 3. Public Hearing

**May 16, 2018**
**6:00pm – 8:00pm**
**1212 N. California St.**
**Conference Rooms B & C**
**Stockton, CA 95202**

### 4. Substantive Comments

# III. Summary of MHSA Program Priorities

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

**Mission Statement**

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

**Vision Statement**

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

**BHS Planning Priorities**


MHSA Program Summaries and Implementation Updates follow.

## A. Summary of Changes from 2017/18

This Annual Update represents a substantial increase in program scope and allocations over that projected in the 2017/18 MHSA Three-Year Program and Expenditure Plan, approved by the Board of Supervisors in June 2017. In addition to the changes described here and elsewhere in the Plan, BHS will add a sum of $500,000 to the Prudent Reserve.

### Justification

The justification for the expansion is:

- MHSA allocations are sporadic, making long term spending projections challenging. However next year (FY 2019/20) the MHSA allocation is expected to be higher than prior years.

| MHSA Funds received by San Joaquin County FY 2013-14 through FY 2017-18 (year to date) | | | | |
|---|---|---|---|---|
| **2013-14** | **2014-15** | **2015-16** | **2016-17** | **2017-18 (3/31/18)** |
| $20,875,792 | $29,221,318 | $23,766,877 | $31,285,641 | $24,749,084 |

- Medi-Cal revenue continues add more than $10 million annually to program funds available for services. During the 2017/18 planning process there were grave concerns that the Affordable Care Act would be repealed, substantially reducing Medi-Cal related revenue for services. Congressional pushes to repeal the Affordable Care Act have stalled, so this revenue source is anticipated to continue for the foreseeable future.

- Between MHSA statewide disbursements and Medi-Cal fees for services, BHS is currently approximately $40 million in revenue annually for program services. The 2017-18 Three Year Program and Expenditure plan considered some $43 million in MHSA related program costs. However, BHS has experienced cast savings from past years when revenues were substantially higher than anticipated. This has led to a build-up of excess unspent funds.

- Through this Plan Update, BHS plans to allocate an additional $14 million in revenue annually, an increase of 33%. This spending plan will judiciously spend down the balance that has built up over time from the extreme fluctuations in revenue. BHS recognizes that this expenditure plan may not sustainable over the long term. Over the next three to five years BHS will carefully examine programming. Only programs that demonstrate considerable success will be retained in future years.

## Substantial Changes to Community Services and Supports (CSS) Programming

BHS anticipates a modest 16 increase in CSS program allocations. Increases in program allocations are related to the following substantial changes:

- Children and Youth and Transition Age Youth FSP programs will be expanded with new clinical staff.
- Mobile Crisis Support Team program will be expanded by two additional teams. One each to be stationed in the north and south portions of the county.
- The Whole Person Care Team will be shifted to PEI programs to enable the WPC teams to also serve those with emerging mental health concerns as well as serious mental illnesses.
- BHS will create a Housing Coordination Services and Supports program to manage housing referrals and placements; provide on-site case management to dedicated SMI housing programs; and to provide emergency housing funds, tied to a specific need of an individual, in order to stabilize and support recovery efforts.
- BHS will release the following RFPs, initially planned for in the 2017/18 Three-Year Plan:
    - Intensive FSP Services (Adults)
    - Intensive FSP Services (Justice Involved Adults)
- BHS will release three new RFPs to provide enhanced services and supports
    - High-risk Transition Team: Providing 90-120 day wraparound services for consumers exiting an inpatient or crisis facility and entering a lower level acute care treatment program, such as an enhanced board and care facility or a crisis residential treatment program. Brief, intensive services will be used to stabilize individuals and transition into routine outpatient care.
    - Peer Navigation: Providing 90-120 navigation support services for consumers following a crisis visit to help understand consumers learn about the treatment continuum, understand the importance of treatment compliance, and to successfully navigate through post-crisis appointments as they transition into ongoing outpatient services.
    - Adult Residential Facility (ARF): Providing 6 -18 month transitional housing for individuals stepping down from an acute care treatment program or to avoid hospitalization. The purpose of the ARF is to have a long-term transitional residential program as some individuals require a longer period to stabilize and meet recovery goals prior to joining a supported living program such as a board and care facility.
- BHS will investigate and procure technical assistance to improve digital information and access to services. Potential projects include enhancing website interface and creating new smart device applications. BHS will leverage early innovations of other Counties in these endeavors; one project under exploration is Tech Suite developed by Los Angeles Department of Mental Health.

## Substantial Changes to Prevention and Early Intervention (PEI) Programming

BHS anticipates a substantial increase in PEI program expenditures, with an increase in MHSA Program allocations from $9.5 million to $17 million, nearly doubling the amount of planned PEI allocations. Changes are as follows:

- No substantial changes to the three prevention programs: *Skill Building for Parents and Guardians; Family Therapy for Children and Youth;* and *Mentoring for Transitional Age Youth*. Budget changes are reflective of personnel changes, contracted program cost of living increases, and program completion by one contracted partner.

- Substantial changes are present in Early Intervention Programs. Changes include substantial funding changes and a re-organization of several programs. These include:

    1) BHS operated Trauma Services Programs are combined and *renamed Prevention and Early Intervention Transition Services (PEITS)* to more accurately reflect the work that is occurring. These programs exclusively serve children and youth in the dependency system – either juvenile justice involved youth or child welfare engaged children and youth. Early intervention services are available for all youth in juvenile detention; or are removed from their homes. Many of these children and youth are found eligible for FSP programs. Those that do not meet criteria for specialty mental health services at the moment, are presumed to be a heightened risk for a mental illness and are provided with early intervention services. Former projects, *Juvenile Justice Center* (*JJC) Access and Linkage to Treatment* and *Trauma Interventions – collaboration with Child Welfare Services* are combined in the PEITS program. Budget allocations for these programs are also enhanced to support increased demand and improved coordination of services with County program partners.

    2) The *Trauma Services for Children and Youth* program will be discontinued as of June 2018. This program will be replaced by the new *School-Based Interventions for Children and Youth*. The new program will include the competitive selection of one or more Organizational Providers to provide dedicated clinicians on elementary, middle, and high schools campuses throughout San Joaquin County. Partner qualifications and eligibility are described in the program summaries included in Section IV.

    3) BHS will introduce a new Early Intervention program that will work with Transition Age Youth (TAY), Adult, and Older Adults. *PEI Trauma Services* will provide short term clinical interventions (primarily rehabilitative groups and case management) to help individuals recover from traumatic life events such as family conflict, violence, or other severe trauma in order to prevent the negative outcomes that may result from untreated mental illness such as loss of employment or housing, incarceration or removal of children from the home. Multiple community partners are anticipated through an RFP process.

4) BHS will also introduce two new programs to work with law enforcement and justice partners: *Recovery Services for Nonviolent Offenders with Behavioral Health Concerns* (a diversion program in partnership with Stockton Police and the District Attorney); and *Forensic Access and Engagement for Repeat Offenders* (which will work with the San Joaquin County Collaborative Courts to get participants into rehabilitative groups and treatment programs). These programs will better support individuals with behavioral health concerns, which do not meet medical necessity, transition into appropriate behavioral health treatment and recovery programs for mild-to-moderate mental health concerns and/or substance use treatment. The purpose of these programs is to reduce the risk for negative outcomes of untreated mental illness such as incarceration, homelessness, and/or prolonged suffering by addressing underlying mental health concerns associated with behaviors.

- Substantial Changes to Other PEI Program Components

5) The *Whole Person Care Outreach and Engagement* program is shifted from CSS to PEI. This will enable the team to work more broadly with individuals at risk of a mental illness and help them understand their behavioral health needs and access appropriate services within the treatment continuum – including services for people with SMI through BHS and services for people with mild to moderate mental health concerns through other community-based mental health services. Ultimately it is anticipated that the Whole Person Care Outreach team will make referrals to both BHS and the Assessment and Respite Center (currently in development).

6) Other Substantial Changes: The *Community Trainings* project is split to more accurately reflect the trainings intended for potential responders to recognize the early signs of mental illness and other trainings for consumers, family, and schools to reduce stigma, denial and discrimination towards people with mental illnesses.

## Substantial Changes to Innovation (INN) Programming

The 2017-18 Three Year Program and Expenditure Plan identified three potential Innovation Programs. These programs were in the planning stage as the time the Three Year Plan was approved. Since that time BHS completed plans for two new Innovation programs. The third potential program – a transitional housing facility was deemed a better fit for CSS funding and is funded in this plan as the Adult Residential Facility. The two INN projects were approved by the MHSOAC on January 25, 2018.

- Assessment and Respite Center
- Progressive Housing

The two projects represent $17 million in project expenditures over the next five years.

## Substantial Updates to Workforce Education and Training Programming

Project funding for WET activities will end in June 2018 – ten years following receipt of the initial WET allocation. BHS has elected to refund WET programming in 2018-19 through a transfer of funds from CSS. $215,000 will be allocated to WET funds.

## Substantial Updates to Capital Facilities and Technology Needs Programming

Project funding for WET Activities will end in June 2018 – ten years following receipt of the initial CFTN allocation. BHS has elected to refund CFTN programming in 2018-19 through a transfer of funds from CSS. $3,430,000 will be assigned.

## Substantial Reallocation of Funds

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

BHS will transfer $4,142,786 from CSS to WET, CFTN, and the Prudent Reserve. Funds will be allocated in the following manner:

- Workforce Education and Training: $ 215,000
- Capital Facilities and Technology Needs: $ 3,427,786
- Prudent Reserve:

## B. Per Person Cost Analysis for CSS Programs

| For FY 2016/17 | Unique Participants | Actual Expenditures | Per Person Investment |
|---|---|---|---|
| **Full Service Partnership Programs** | | | |
| Children and Youth FSP | 121 | $1,236,275 | $10,217 |
| Transitional Age Youth FSP | 82 | $395,179 | $4,819 |
| Adult FSP | 1,313 | $8,279,596 | $6,306 |
| Older Adult FSP | 118 | $1,304,129 | $11,052 |
| Community Corrections FSP | 161 | $793,624 | $4,929 |
| InSPIRE FSP Program | 19 | $335,220 | $17,643 |

| For FY 2016/17 | Unique Participants | Actual Expenditures | Per Person Investment |
|---|---|---|---|
| **Consumer Support Services** | | | |
| Wellness Center | 822 | $416,791 | $507 |
| Mobile Crisis Support Team | 451 | $425,993 | $787 |
| Employment Recovery Services | 60 | $170,806 | $2,847 |
| Community Behavioral Intervention Services | 91 | $584,142 | $6,419 |
| **Crisis Response Services** | | | |
| Crisis Service | 955 | $4,818,557 | $5,046 |

## C. Mental Health Services Act Program Budgets

Program Budgets for FY 18/19 follow.

# FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan

## Funding Summary

County: San Joaquin Date: 4/14/18

| | | 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 FY2018/19 Funding** | | | | | | | |
| 1. Estimated Unspent Funds from Prior Fiscal Years | | $ 51,820,165 | $14,731,394 | $7,287,799 | $ - | $ - | |
| 2. Estimated New FY2018/19 Funding | | $ 23,721,800 | $ 5,931,300 | $1,560,600 | | | |
| 3. Transfer in FY2018/19a/ | | $ (4,144,786) | | | $ 215,000 | $ 3,429,786 | $ 500,000 |
| 4. Access Local Prudent Reserve in FY2018/19 | | | | | | | |
| 5. Estimated Available Funding for FY2018/19 | | $ 71,397,179 | $20,662,694 | $8,848,399 | $ 215,000 | $ 3,429,786 | $ 500,000 |
| **B. Estimated FY2018/19 Expenditures** | | $ 33,007,329 | $17,017,881 | $3,348,803 | $ 215,000 | $ 3,429,786 | |
| **C. Estimated FY2018/19 Unspent Fund Balance** | | $ 38,389,850 | $ 3,644,813 | $5,499,596 | $ - | $ - | |

| **D. Estimated Local Prudent Reserve Balance** | |
|---|---|
| 1. Estimated Local Prudent Reserve Balance on June 30, 2019 | $11,878,503 |
| 2. Contributions to the Local Prudent Reserve in FY 2018/19 | $ 500,000 |
| 3. Distributions from the Local Prudent Reserve in FY 2018/19 | |
| 4.Estimated Local Prudent Reserve Balance on June 30, 2019 | $12,378,503 |

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

**FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan**
**Community Services and Supports (CSS) Component Worksheet**

County: San Joaquin Date: 4/14/18

| | | Fiscal Year 2018/19 | | | | | |
|---|---|---|---|---|---|---|---|
| | | A | B | C | D | E | F |
| | | Estimated Total Mental Health Expenditures | Estimated CSS Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **FSP Programs** | | | | | | | |
| 1. | Children and Youth FSP | $ 4,650,011 | $ 2,817,403 | $ 1,013,147 | $ - | $ 818,501 | $ 960 |
| 2. | Transition Age Yourth FSP | $ 591,775 | $ 333,945 | $ 257,830 | $ - | $ - | $ - |
| 3. | Adult FSP | $ 11,160,635 | $ 6,675,353 | $ 4,458,582 | $ - | $ - | $ 26,700 |
| 4. | Older Adult FSP | $ 1,627,403 | $ 1,362,536 | $ 259,617 | $ - | $ - | $ 5,250 |
| 5. | Community Corrections: Forensic FSP | $ 1,689,667 | $ 1,305,101 | $ 357,725 | $ - | $ - | $ 26,841 |
| 6. | Intensive FSP-Inspire | $ 491,624 | $ 399,854 | $ 91,770 | $ - | $ - | $ - |
| 7. | Intensive FSP-Adult | $ 1,000,000 | $ 1,000,000 | $ - | $ - | $ - | $ - |
| 8. | Intensive FSP-Justice | $ 1,000,000 | $ 1,000,000 | $ - | $ - | $ - | $ - |
| 9. | FSP Engagement | $ 1,039,266 | $ 1,039,266 | $ - | $ - | $ - | $ - |
| 10. | Housing Empowerment Services | $ 544,069 | $ 544,069 | $ - | $ - | $ - | $ - |
| 11. | High-Risk Transition Team | $ 720,000 | $ 720,000 | $ - | $ - | $ - | $ - |
| 12. | Adult Residential Facility | $ 1,000,000 | $ 1,000,000 | $ - | $ - | $ - | $ - |
| **Outreach and Engagement Programs** | | | | | | | |
| 13. | Mental Health Outreach & Engagement | $ 652,488 | $ 652,488 | $ - | $ - | $ - | $ - |
| 14. | Mobile Crisis Support Team | $ 1,462,955 | $ 834,128 | $ 311,173 | $ - | $ - | $ 317,654 |
| 15. | Peer Navigation | $ 300,000 | $ 300,000 | $ - | $ - | $ - | $ - |
| | | | | | | | |
| | | | | | | | |
| *CSS Page 1 of 2* | | | | | | | |

**FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan**
**Community Services and Supports (CSS) Component Worksheet**

County: San Joaquin Date: 4/14/18

| | | Fiscal Year 2018/19 | | | | | |
|---|---|---|---|---|---|---|---|
| | | 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 |
| **System Development Programs** | | | | | | | |
| 16. | Wellness Center | $ 490,436 | $ 490,436 | $ - | $ - | $ - | $ - |
| 17. | Project Based Housing Program-Housing Authority | $ 4,000,000 | $ 4,000,000 | $ - | $ - | $ - | $ - |
| 18. | Employment Recovery Services | $ 191,623 | $ 191,623 | $ - | $ - | $ - | $ - |
| 19. | Community Behavioral Intervention Services | $ 733,095 | $ 398,391 | $ 333,104 | $ - | $ - | $ 1,600 |
| 20. | Housing Coordination Services and Supports | $ 2,816,442 | $ 2,737,442 | $ - | $ - | $ - | $ 79,000 |
| 21. | Crisis Services | $ 4,138,612 | $ 1,072,049 | $ 3,008,563 | $ - | $ - | $ 58,000 |
| 22. | System Development Expansion | $ 1,750,628 | $ 1,750,628 | $ - | $ - | $ - | $ - |
| 23. | | | | | | | |
| 24. | | | | | | | |
| 25. | | | | | | | |
| **CSS Administration** | | $ 3,076,194 | $ 2,382,617 | $ 693,577 | $ - | $ - | $ - |
| **CSS MHSA Housing Program Assigned Funds** | | $ - | $ - | $ - | $ - | $ - | $ - |
| **Total CSS Program Estimated Expenditures** | | $ 45,126,923 | $ 33,007,329 | $ 10,785,088 | $ - | $ 818,501 | $ 559,209 |
| **FSP Programs as Percent of Total** | | 55.1% | | | | | |

*CSS Page 2 of 2*

**FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan**
**Prevention and Early Intervention (PEI) Component Worksheet**

County: San Joaquin Date: 4/14/18

| | Fiscal Year 2018/19 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated PEI Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **Prevention** | | | | | | |
| 1. Skill Building for Parents | $ 520,422 | $ 520,422 | $ - | $ - | $ - | $ - |
| 2. Family Therapy for Children and Youth | $ 1,999,818 | $ 1,999,818 | $ - | $ - | $ - | $ - |
| 3. Mentoring for Transition Age Youth | $ 979,852 | $ 979,852 | $ - | $ - | $ - | $ - |
| **Early Intervention** | | | | | | |
| 4. PEI Transition Services | $ 3,539,315 | $ 2,842,310 | $ 690,239 | $ - | $ 1,266 | $ 5,500 |
| 5. School Based Interventions for Children & Youth | $ 2,914,259 | $ 2,914,259 | $ - | $ - | $ - | $ - |
| 6. Early Interventions in the Treatment of Psychosis | $ 996,771 | $ 577,700 | $ 419,071 | $ - | $ - | $ - |
| 7. PEI Trauma Services for TAY, Adults, & Older Adults | $ 1,200,000 | $ 1,200,000 | $ - | $ - | $ - | $ - |
| 8. Recovery Services for Victims of Human Trafficking | $ 706,106 | $ 706,106 | $ - | $ - | $ - | $ - |
| 9. Recovery Services for Nonviolent Offenders | $ 800,000 | $ 800,000 | $ - | $ - | $ - | $ - |
| 10. Forensic Access and Engagement | $ 600,000 | $ 600,000 | $ - | $ - | $ - | $ - |
| **Access and Linkage to Treatment** | | | | | | |
| 11. Whole Person Care Outreach and Engagement | $ 1,310,214 | $ 799,087 | $ - | $ - | $ - | $ 511,127 |
| **Outreach for Increasing Recognition** | | | | | | |
| 12. Community Trainings for Potential Responders | $ 25,000 | $ 25,000 | $ - | $ - | $ - | $ - |
| **Stigma and Discrimination Reduction Program** | | | | | | |
| 13. Community Education to Reduce Stigma | $ 25,000 | $ 25,000 | $ - | $ - | $ - | $ - |
| **Suicide Prevention** | | | | | | |
| 14. Suicide Prevention in Schools | $ 615,086 | $ 615,086 | $ - | $ - | $ - | $ - |
| **PEI Administration** | $ 2,195,700 | $ 2,195,700 | $ - | $ - | $ - | $ - |
| **PEI Assigned Funds** | | | | | | |
| Funds assigned to CalMHSA | $ 217,541 | $ 217,541 | $ - | $ - | $ - | $ - |
| **Total PEI Program Estimated Expenditures** | $ 18,645,084 | $ 17,017,881 | $ 1,109,310 | $ - | $ 1,266 | $ 516,627 |

**FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan**

**Innovations (INN) Component Worksheet**

County: San Joaquin Date: 4/14/18

| | Fiscal Year 2018/19 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Fiscal Year 2018/19 | Estimated INN Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **INN Programs** | | | | | | |
| 1. Assessment and Respite Center | $ 2,234,455 | $ 2,234,455 | $ - | $ - | $ - | $ - |
| 2. Progressive Housing | $ 916,348 | $ 916,348 | $ - | $ - | $ - | $ - |
| 3. Evaluation | $ 198,000 | $ 198,000 | $ - | $ - | $ - | $ - |
| 4. | | | | | | |
| **INN Administration** | $ - | $ - | $ - | $ - | $ - | $ - |
| **Total INN Program Estimated Expenditures** | $ 3,348,803 | $ 3,348,803 | $ - | $ - | $ - | $ - |

# FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan
# Workforce Education and Training (WET) Component Worksheet

County: San Joaquin Date: 4/14/18

| | Fiscal Year 2018/19 | | | | | |
|---|---|---|---|---|---|---|
| | 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 | $ 215,000 | $ 215,000 | $ - | $ - | $ - | $ - |
| **WET Administration** | | | | | | |
| **Total WET Program Estimated Expenditures** | $ 215,000 | $ 215,000 | $ - | $ - | $ - | $ - |

# FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan
# Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Joaquin Date: 4/14/18

| | Fiscal Year 2018/19 | | | | | |
|---|---|---|---|---|---|---|
| | 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. Crisis and Acute Care Services Expansion | $ 2,114,786 | $ 2,114,786 | $ - | $ - | $ - | $ - |
| 2. Planning and Development for CRT for Children and Youth | $ 150,000 | $ 150,000 | $ - | $ - | $ - | $ - |
| 3. Facility Upgrades | $ 1,065,000 | $ 1,065,000 | $ - | $ - | $ - | $ - |
| **CFTN Programs - Technological Needs Projects** | | | | | | |
| 4. Digital Health Management Solutions | $ 100,000 | $ 100,000 | $ - | $ - | $ - | $ - |
| **CFTN Administration** | | | | | | |
| **Total CFTN Program Estimated Expenditures** | $ 3,429,786 | $ 3,429,786 | $ - | $ - | $ - | $ - |

# IV. MHSA Funded Project List

1. **Community Services and Supports Projects**

**Full Service Partnership**

1 Children and Youth FSP

2 Transition Age Youth FSP

3 Adult FSP

4 Older Adult FSP

5 Community Corrections: Forensic FSP

6 Intensive FSP-Inspire

7 Intensive FSP-Adult

8 Intensive FSP-Justice

9 FSP Engagement

10 Housing Empowerment Services

11 High-Risk Transition Team

12 Adult Residential Facility

**Outreach & Engagement**

13 Mental Health Outreach & Engagement

14 Mobile Crisis Support Team

15 Peer Navigation

**General System Development**

16 Wellness Center

17 Project Based Housing Program-Housing Authority

18 Employment Recovery Services

19 Community Behavioral Intervention Services

20 Housing Coordination Services and Supports

21 Crisis Services

22 System Development Expansion

**2. Prevention and Early Intervention Projects**

**Prevention Programs**

1 Skill Building for Parents

2 Family Therapy for Children and Youth

3 Mentoring for Transition Age Youth

**Early Intervention Programs for Children & Youth**

4 Prevention and Early Intervention Transition Services

5 School Based Interventions for Children & Youth

6 Early Interventions in the Treatment of Psychosis

**Early Intervention Programs for Adults and Older Adults**

7 PEI Trauma Services for TAYs, ADULTS and Older Adults

8 Recovery Services for Victims of Human Trafficking

9 Recovery Services for Nonviolent Offenders with Behavioral Health Concerns

10 Forensic Access and Engagement for Repeat Court Offenders

**Access and Linkage to Treatment Program**

11 Whole Person Care Outreach and Engagement

**Outreach for Increasing Recognition of the Early Signs of Mental Illness**

12 Community Trainings for Potential Responders

**Stigma and Discrimination Reduction Program**

13 Community Education to Reduce Stigma

**Suicide Prevention Program**

14 Suicide Prevention in Schools

**3. Innovation Projects**

1 Assessment and Respite Center

2 Progressive Housing

3 Evaluation/Planning

**4. Workforce Education and Training Projects**

1 Training and Technical Assistance Category

**5. Capital Facilities and Technological Needs**

**Capital Facilities**

1 Crisis and Acute Care Services Expansion

2 Planning and Development for CRT for Children and Youth

3 Facility Upgrades

**Technology Needs**

4 Digital Health Management Solutions

# V. 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.

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.

## D. 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*

The summary of the FSP eligibility criteria and FSP component services are described below.

### 5. 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<br>• As a result, has substantial impairment, *and*<br>o Is at risk of removal from the home, *or*<br>o The mental disorder has been present for more than 6 months and is likely to continue for more than a year if untreated.<br><br>OR<br><br>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.<br>• Mental disorder, diagnosed and as identified in Diagnostic and Statistical Manual of Mental Disorders.<br>• As a result of the mental disorder, the person has substantial functional impairments<br>• 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.<br><br>OR<br>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:<br>• Homeless or at risk of being homeless.<br>• Aging out of the child and youth mental health system.<br>• Aging out of the child welfare systems<br>• Aging out of the juvenile justice system.<br>• Involved in the criminal justice system.<br>• At risk of involuntary hospitalization or institutionalization.<br>Have experienced a first episode of serious mental illness. | (1) Adults are unserved and one of the following:<br>• Homeless or at risk of becoming homeless.<br>• Involved in the criminal justice system.<br>• Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.<br><br>OR<br><br>(2) Adults are underserved and at risk of one of the following:<br>• Homelessness.<br>• Involvement in the criminal justice system.<br>• Institutionalization. | Older Adults are unserved experiencing, or underserved and at risk of, one of the following:<br>• Homelessness.<br>• Institutionalization.<br>• Nursing home or out-of-home care.<br>• Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.<br>• Involvement in the criminal justice system. |

## Criteria 4: San Joaquin County Priority Service Needs

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

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

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

## 6. 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:* 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.

***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 to make recommendations for treatment and service interventions which are outlined in the *Client Treatment Plan*.
- *(Adult) Client Treatment Plan*: Plans describe the treatment modalities and services recommended to support recovery. Planning may occur in one or more sessions and will be completed within 60 days of enrollment. Plans include a *Strength Assessment* that highlights the interests, activities and natural supports available to the consumer and the core areas of life, or domains, (e.g. housing or personal relationships) they wish to focus on through treatment. Clients will be evaluated by a psychiatrist to review and discuss medications as a component of the treatment plans. Client Treatment Plans will be updated at least every twelve months.
- *(Children and Youth) Service Support Plan*: For youth in treatment in a FSP, service support plans describe the treatment modalities and services recommended to support recovery. Planning may occur in one or more sessions. Plans include a *Strength Assessment* that highlights the interests, activities and natural supports available to the consumer and the core areas of life, or domains, (e.g. housing or personal relationships) they wish to focus on through treatment. 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 have intensive home or community-based case management. The frequency of contact will be directed by consumer needs and level of care.
- *Community Case Management:* Some FSP consumers may be assigned a specially trained community-based case manager from a partner agency that works jointly with BHS. Partner agencies have deep ties to various underrepresented communities and the formal and informal support networks within those communities. Community Case Management services include:
    - Treatment planning
    - Individualized services and supports
    - Group services and supports
    - Case management and referral services

  All Community Case Management services align with the vision and scope outlined here.

- *Individual interventions:* FSP consumers receive individualized interventions from a clinician. BHS clinicians are trained in several modalities. Consumers work with clinicians that have training in the modality that best meets their treatment needs. Individual therapeutic approaches to support consumers may include:
    - Cognitive Behavioral Therapies, including for psychosis
    - Trauma Focused Cognitive Behavioral Therapy
    - Parent Child Interactive Therapy
    - 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 any children or youth who meet Specialty Mental Health Services, and who would benefit from those 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, and include:
    - Wellness Centers
    - Mobile Crisis Support Team
    - Housing Empowerment Programming
    - Employment Recovery 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*: 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.

## 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: (1) juvenile justice involved, or (2) engaged with the Child Welfare System or (3) diagnosed with a serious mental illness or severe emotional disturbance that necessitates service interventions beyond the scope of traditional specialty mental health care.

**Project 1: CYS FSP**

This project serves children and youth that have a severe emotional disorder and /or a diagnosed serious mental illness that require a full spectrum of services and supports to meet recovery goals. In additional to clinical treatment services, the FSP program activities are designed to support the social, emotional, and basic living needs of children and their families to ensure ongoing participation in treatment services and stabilization in the recovery process.

Community based program partners may be contracted as parent partners or recovery coaches to support clinical interventions and case management activities. Case Managers are responsible for linking children and families to necessary resources and program supports within the community. Recovery Coaches/Peer partners conduct initial outreach work to link and engage clients within the first 90 days. Recovery Coaches assist families during their transition from MHSA into lower levels of care.

**Project 2: Dependency FSP**

Serves children and youth that are in the dependency system: either through Child Welfare Services, the Juvenile Probation system, or both. Children and youth that meet the Katie A subclass requirements are also eligible for FSP services.

BHS and community based program partners provide clinical case planning and therapeutic treatment services, services are provided by mental health clinicians, specialists, and outreach workers..

Services may be provided to youth within the Mary Graham Children's Shelter.

The Children and Youth FSP programs will be expanded during FY 2018/19. New services are incorporated into FSP program capacity to meet AB 403 regulatory requirements include:

- Enhanced capacity for residential treatment services for children and youth.
- EPSDT Medi-Cal Specialty Mental Health services to children/youth who are dependents/wards living in a Short Term Residential Therapeutic Programs (STRTP).
- Child Family Team meetings, meeting facilitation, and case management.
- Expanded clinical presence at Mary Graham Children's Shelter.

## 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/or co-occurring substance use disorders. Services include a high-focus on doing "whatever-it takes" to stabilize and engage individuals into treatment services, including 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, the 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. 53*):
    - 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*
- *Middle Eastern Consumers*
- *Native American consumers*
- *Southeast Asian consumers*

## CSS Project 4: Older Adult FSP

### Project Description

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

***Target Population:***

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

## CSS Project 5: Community Corrections: Forensic 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, but not limited to:
    - Adult Mental Health Court
    - High Violence Court
    - AB109 Reentry Court
    - Felony Drug Court
    - Parolee Reentry Court
    - Veterans Court

***Project Components***

**Forensic Full Service Partnership**

The Forensic FSP team provides intensive clinical supports and case management services to offenders that are participating in one of the problem-solving collaborative court programs, and have serious mental illnesses. The Forensic FSP team, established with MHSA funds in 2006, has provided a needed service to prevent SMI offenders with non-violent crimes an opportunity to participate in treatment services in lieu of incarceration and deepening engagement in the criminal justice system.

## CSS Project 6: Intensive Adult: InSPIRE FSP

### Project Description

This Intensive Adult FSP began as 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.

***Target Population***

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

***Project Components***

**InSPIRE Full Service Partnership**

The Innovative Support Program in Recovery and Engagement ( InSPIRE) program serves individuals between the ages of 18-59 who are hesitant or resistant to engaging in mental health treatment. A key element of InSPIRE is *Enthusiastic Engagement*.

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

InSPIRE strives to find additional pathways to mental health services for hesitant or reluctant clients to improve individual well-being and create a safer community. BHS seeks to expand the model created through the InSPIRE project and in 2018/19 will seek one or more Organizational Providers to provide additional intensive FSP services. (see CSS projects 7 and 8, below)

## CSS Project 7: Intensive Adult: Care FSP to Prevent Institutionalization

This Intensive Adult FSP will work with adult consumers, aged 18 and older, with serious and persistent mental illnesses that have co-occurring substance use disorders.

The project will provide wrap around services,; consistent cognitive behavioral interventions, and intensive, trauma-informed supportive services. The intensive FSP must offer "whatever it takes" to engage seriously mentally ill (SMI) adults in a partnership to achieve their individual wellness and recovery goals, using alternative models of care which offer greater benefits to them increasing the likelihood that they will experience positive outcomes.

***Target population***

The target population for the program is consumers who are at risk of acute or long term locked facility placement and/or have had multiple failed transitions from locked facilities to lower level of care.

A minimum ongoing caseload of 16 consumers will be served at any one time.

***Program Components***

Through a competitive procurement process BHS will identify an Organizational Provider to provide:

Assertive Community Treatment Model: The program should follow the Assertive Community Treatment Model (ACT) concept which uses team based services that produce positive outcome and reduce the number of hospitalizations and costs.

FSP Treatment and Support Team: Individuals enrolled in an FSP program will have an enhanced treatment team that includes a psychiatrist, clinician, nursing or medical staff, case manager(personal service coordinator) and a peer or family member with lived experience in recovery

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.

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. Case managers contact clients 3-5 times / week. Case managers will link consumers to resources pertaining to physiological needs (food banks, clothing pantries, medical services, etc.)

Housing: Housing is an integral part of recovery and the housing first model is an evidence base practice successfully implemented in a variety of settings. The acquisition of safe housing needs to be a priority and parallel process with engagement in mental health treatment. Partners are expected to work with the BHS Housing Coordination Team to identify appropriate housing options.

Rehabilitation and Socialization Skills: FSP consumers will receive a range of rehabilitation, stabilization and socialization activities, as appropriate to the level of recovery. Services will include:

- Guidance and practice on the activities of daily living
- Mental health and medication management education
- Self-care and Crisis Management (e.g. WRAP Plans)
- Linkages to recreation and socialization programs

Substance Use Disorder Services: Substance Use recovery is an integral component of behavioral health. Clients with a co-occurring disorder may require withdrawal management, medication assisted treatment, outpatient treatment, or residential treatment programs to address substance use disorders. The clinical case management team should expect to work with County Substance Abuse Services (SAS) to facilitate enrollment into substance use disorder treatment programs as indicated by the client treatment plan and the ASAM criteria.

Cognitive Behavioral and Skill Building Groups: FSP consumers will receive individualized interventions from a clinician. Contractor 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

Transition Planning: Following stabilization into services the case management team will begin decreasing the number and frequency of contacts and transition consumers to less intensive treatment services.

## CSS Project 8: Intensive Justice Response FSP

This Intensive Adult FSP will work with adult consumers, aged 18 and older, with serious and persistent mental illnesses that have co-occurring substance use disorders.

The project will provide wrap around services,; consistent cognitive behavioral interventions, and intensive, trauma-informed supportive services. The intensive FSP must offer "whatever it takes" to engage seriously mentally ill (SMI) adults in a partnership to achieve their individual wellness and recovery goals, using alternative models of care which offer greater benefits to them increasing the likelihood that they will experience positive outcomes.

***Target population***

The target population for this project is adults, between the ages of 18-59 (some exceptions) who have a serious mental illness; may pose a serious risk to themselves or others; have a history of reluctance to engage in traditional mental health treatment services; and have a history of repeated contact with law enforcement.

A minimum ongoing caseload of 16 consumers will be served at any one time.

***Program Components***

Through a competitive procurement process BHS will identify an Organizational Provider to provide:

Assertive Community Treatment Model: The program should follow the Assertive Community Treatment Model (ACT) concept which uses team based services that produce positive outcome and reduce the number of hospitalizations and costs.

FSP Treatment and Support Team: Individuals enrolled in an FSP program will have an enhanced treatment team that includes a psychiatrist, clinician, nursing or medical staff, case manager(personal service coordinator) and a peer or family member with lived experience in recovery

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.

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. Case managers contact clients 3-5 times / week. Case managers will link consumers to resources pertaining to physiological needs (food banks, clothing pantries, medical services, etc.)

Housing: Housing is an integral part of recovery and the housing first model is an evidence base practice successfully implemented in a variety of settings. The acquisition of safe housing needs to be a priority and parallel process with engagement in mental health treatment. Partners are expected to work with the BHS Housing Coordination Team to identify appropriate housing options.

Rehabilitation and Socialization Skills: FSP consumers will receive a range of rehabilitation, stabilization and socialization activities, as appropriate to the level of recovery. Services will include:

- Guidance and practice on the activities of daily living
- Mental health and medication management education
- Self-care and Crisis Management (e.g. WRAP Plans)
- Linkages to recreation and socialization programs

Substance Use Disorder Services: Substance Use recovery is an integral component of behavioral health. Clients with a co-occurring disorder may require withdrawal management, medication assisted treatment, outpatient treatment, or residential treatment programs to address substance use disorders. The clinical case management team should expect to work with County Substance Abuse Services (SAS) to facilitate enrollment into substance use disorder treatment programs as indicated by the client treatment plan and the ASAM criteria.

Cognitive Behavioral and Skill Building Groups: FSP consumers will receive individualized interventions from a clinician. Contractor 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

Transition Planning: Following stabilization into services the case management team will begin decreasing the number and frequency of contacts and transition consumers to less intensive treatment services.

## CSS Project 9: 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 is conducted by mental health outreach workers and recovery coaches; they 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 and provide recovery supportive services throughout treatment. Mental health outreach workers and recovery coaches are individuals who self-identify as a consumer, family member, or community member with experience in the recovery process. The FSP Engagement 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.

Mental health outreach workers and recovery coaches 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. Mental health outreach workers and recovery coaches 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

- *Consumer and Family Engagement*
  - Encourage and support consumers to attend behavioral health appointments and participate in all aspects of their recovery plan.
  - Educate consumers on resources available at BHS or in the community.
  - Engage family members and caregivers, as appropriate, to support the recovery process.

- *Navigation Assistance*
  - Assist the consumer in the navigation of the mental health system of care at BHS.
  - Assist the consumer with accessing substance use treatment.
  - Assist the consumer with accessing mental health crisis services.

  - Provide assistance with transitioning to specialty or community-based mental health services upon discharge from an FSP.

- *Provide FSP Ongoing and 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.
  - 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.
  - Provide weekly in-person or telephone follow-up support services for a period of up to six months following FSP discharge, or until stabilized in treatment (as determined by regular participation in scheduled appointments and recovery oriented activities) and satisfaction with new treatment services.

- *Mental Health Screening*: Individuals that walk-in or self-refer themselves to clinics must be provided with a mental health screening. Screenings are intended to determine the urgency for a full mental health assessment and the likeliness of requiring specialty mental health care treatments services. Individuals screened with likely mild to moderate symptoms may be referred to their primary health care provider or other community resource for follow-up.
  - Conduct initial mental health screening to determine need for mental health related services.
  - Create an assessment appointment with a clinician for individuals that have a positive mental health screening.
  - Refer all other individuals to other community resources for ongoing services and supports.

- *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)

**This project will be discontinued as of June 30, 2019.**

## CSS Project 10: FSP Housing Empowerment Services

### Project Description

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

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

The project is intended to result in:

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

### Target Population

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

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

### Project Component 1:

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:

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

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

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

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

3. Housing Coalition: Establish and facilitate a coalition of housing experts that meets at least four times per year, 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. Provide consumers with lists of current vacancies in these housing opportunities. Encourage and enlist other landlords and property managers to accept mental health consumers as tenants, especially those at risk for homelessness.

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

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

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

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

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

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

Housing Standards: Housing for each consumer will be decent, affordable and safe. Contractor will conduct property inspections prior to providing housing assistance. Determination of Housing Quality Standards will be based on standardized forms used by the federal Department of Housing and Urban Development (HUD). All housing options will also meet federal and local codes for safety and habitability. Resources will not be used to provide housing assistance in facilities that do not meet local codes or that compromise consumer health and/or safety.

In keeping with identified best practices, all leases signed by consumers will be required to be standard, written rental agreements, and consumers and landlords would retain all normal rights of lease extension/termination; assistance will not be provided without a valid rental agreement in place.

## CSS Project 11: High-Risk Transition Team

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

***Target Population***

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

***Program Components:***

BHS will contract with an Organizational Provider to conduct outreach with referred program participants, assess client needs, and conduct intensive case management and provide 24/7 wraparound supports as needed to prevent the reemergence of symptoms or readmission to a psychiatric facility. Services will be offered for 90 -120 days depending on the assessed client needs. Services should be provided through an Assertive Community Treatment (ACT) team approach – by a range of professionals with differing life skills and professional competencies to meet client needs.

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

## CSS Project 12: FSP Adult Residential Care Facility

### Project Description

The FSP Adult Residential Care Facility (ARF) will provide long-term transitional housing with assisted living services to FSP consumers who are not able to live independently or in a supported housing environment. ARFs operate within communities, and offer a "home-like" setting for residents, including private and semi-private bedrooms and bathrooms, a kitchen, common area, and a dining room. Target program participants are adults and older adult FSP clients who require assistance with daily living. Participating FSP clients will receive clinical mental health treatment through their FSP program and may be eligible for Cognitive Behavioral Intervention services in order to practice daily living skills.

**Program Requirements:**

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

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

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

Per state licensing requirements, services will include:

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

**Program Components:**

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

**Services and Supports shall include:**

- Crisis Intervention
- Individualized Assessments and Evaluations
- Treatment Plan Development
- Comprehensive Therapeutic Environment
- Assistance for Consumers to learn and practice social development , daily living skills and other life skills
- Interventions Focused on Wellness and Recovery
- Collateral Visits
- Medication Supports
- Transportation to medical, mental health, substance use disorder treatment and court appointments
- Aftercare Planning

# General System Development Programs

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

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

**Outreach and Engagement**

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

**General System Development**

- Wellness Centers
- Project Based housing Program
- Employment Recovery Supports
- Community Behavioral Intervention Services
- Housing Coordination Services and Supports
- Crisis Services
- System Development Expansion
- MHSA Administration

## CSS Project 13: Mental Health Outreach & Engagement

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

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

***Target populations***

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

**Mental Health System Outreach and Engagement**

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

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

- *Food, clothing, and shelter to engage unserved individuals*
  - Life Support and Crisis House Programs: providing shelter and motel housing for the immediate placement needs of individuals with SMI who are homeless or at imminent risk of homelessness.
  - Modest support for local emergency food pantries and homeless meal programs to ensure that program participants have their basic nutritional needs met while stabilizing into routine services.

## CSS Project 14: 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.

MHSA funding supports mobile crisis support teams stationed in alternate locations and extend the hours of operations of the existing team to include evening and weekend hours. Services are available daily (Monday – Sunday), and into the evening hours most days of the week.

BHS operates six Mobile Crisis Support Teams

1) Behavioral Health Services Team (Stockton, North)
2) Downtown Stockton Team (Stockton, South)
3) French Camp Team (Hospital, Mary Graham, and Lathrop area)
4) North County Team (Lodi and surrounding areas)
5) South County Team (Tracy, Manteca, and Surrounding Areas)
6) Behavioral Health Services (Floater Team – providing expanded coverage)

Services are partially supported through grant funding allocated through SB82, the Investment in Mental Wellness Act of 2013.

## CSS Project 15: Peer Navigation

### Project Description

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

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

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

### Project Components

BHS will work with one or more community partners to develop a Peer Navigation Program. Community partners will hire and train individuals, with lived experience in mental health recovery, to serve as Peer Navigators. Community Partners will use an evidence based curriculum to train Peer Navigators. Some training activities shall occur in partnership with BHS, in order to ensure that Peer Navigators are familiar with BHS services. Examples of curriculum include:

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

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

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

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

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

Skills and Competencies:

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

## CSS Project 16: 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 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.

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

## CSS Project 17: Project Based Housing

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

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

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

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

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

**Project Components:**

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

1) Establish a Project Based Housing Fund:
   Up to $3.5 million will be transferred to the Housing Fund for the purpose of acquisition, construction or renovation of Project Based Housing Units.

   This fund shall be an irrevocable transfer of money from San Joaquin County Behavioral Health Services to the Housing Authority of San Joaquin for the purpose of creating Project Based Housing Programs.
   - Crossway Residences, located at 448 S. Center Street. The project will include 14 studio apartments and one resident manager apartment. The project will also include a site for program related activities and support services, including therapeutic treatment services.
   - Additionally, BHS and the Housing Authority will commit to securing and renovating one or more properties that can be converted into multi-unit residences for the purpose of creating *at least* 20 additional Project Based Housing Units to be dedicated towards individuals with serious mental illnesses.

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

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

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

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

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

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

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

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

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

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

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

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

## CSS Project 18: Employment Recovery Services

### Project Description

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

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

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

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

### Target Population

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

### Project Components

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

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

- *Vocational Profiles:* Conduct individualized interviews with each consumer to determine their preferences for type of employment, educational and work experiences, aptitudes and motivation for employment. Vocational profiles will be consumer driven and based on

consumers' choices for services. Vocational assessment will be an ongoing process throughout the consumer's participation in the program.

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

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

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

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

## FSP Project 19: 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 20: Housing Coordination Services

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

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

**Project Components:**

**Project 1: Housing Referral and Linkage Team**

The Housing Referral and Linkage Team will coordinate housing placement recommendations for BHS consumers with serious mental illnesses. Located within outpatient Adult Treatment Services Division, the Housing Referral and Linkage Team will manage client placement within a continuum of housing placement options. In general the task of the team will be to assess each client and determine the type of housing best suited to the treatment needs of the individual. Housing options will range from "intensive" such as provided by a crisis residential or adult residential care facility; to more independent or supported living options.

**Project 2: Housing-based Case Management**

The Housing-based Case Management team will work with non-FSP consumers, for a period of 90-120 days, upon placement within a new housing program or facility. The case management team will work with clients and housing operators to ensure that each placement recommendation is a good fit between the client, the program, and other tenants. Case managers will also work with clients to help them maintain treatment compliance and engage in routine appointments, rehabilitation groups, and recommended socialization activities.

**Project 3: Housing Stabilization Resources**

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

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

## CSS Project 21: Crisis Services Expansion

### Project Description

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

**Project Components:**

**Project 1: Warm Line**

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

**Project 2: Community Crisis Response Teams**

CCRT clinicians respond to community requests for crisis services, including mental health evaluations for temporary, involuntary psychiatric inpatient care in situations where the mental health consumer is a danger to self, danger to others or gravely disabled. The clinician may schedule a home visit to assess the consumer's ability to maintain community functioning in the least restrictive environment and determine the most appropriate level of care for that person at that time.

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

The Children Crisis Stabilization Unit (CSU) provides emergency psychiatric evaluations and crisis stabilization to children and youth. Children and youth are admitted upon consent of a parent or guardian.

## CSS Project 22: System Development Expansion

### Project Description

System Development Expansion Services include the outpatient clinic system that provides planned mental health treatment services (scheduled appointments). Prior to the provision of the MHSA, specialty mental health services served a smaller population of consumers. During the original CSS planning process in FY 2005/06, BHS estimated that 11,000 consumers received mental health services. Since 2004, and in accordance with MHSA, BHS has conducted assertive community outreach and engagement to increase access to mental health services amongst unserved and underserved individuals. Over the past ten years, the number of consumers served annually has increased 25%, to 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.
- EPSDT Medi-Cal Specialty Mental Health services to children/youth who are dependents/wards living in a Short Term Residential Therapeutic Programs.

## MHSA Administration and Program Evaluation

The MHSA Administration and Program Evaluation team provides guidance and recommendations to BHS managers in the implementation of MHSA funded programs and activities and 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 contracts to determine if contracted MHSA programs are implemented as planned and to fidelity and if program funds are being expended in accordance with contract budgets.
- *Technical Assistance:* Disseminate regional and statewide information on emerging practices, new regulations, and provide guidance on program implementation.
- *Training Coordination:* Coordinate mental health related trainings for consumers, family members, clinicians, service providers, and community stakeholders.
- *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.
- *Improving Electronic Access to Services*
    - Successive surveys of consumers and family members have shown consistently low scores for the BHS website as pertains to helping consumers and their family members access information about available services and help navigate through the system of care. The website was originally designed more than ten years ago and is missing many of the features consumers have come to provide from a more contemporary interface. BHS will seek assistance from an outside web development firm to update and enhance the current website. Desired components include a more contemporary design; updated summaries of the services and supports available; and features that allow patients to schedule and track appointments, communicate with their care team, and manage their recovery.
    - Los Angeles County Department of Mental Health (LACDMH), with INN funding, is developing a suite of technology based mental health solutions and has invited other County Mental Health Departments to enter into a partnership agreement to use one or more of the technology applications that are being developed. The applications will create an automated screening and assessment process and improve access to mental health services. Services include virtual peer chatting through trained and certified

peers with lived experience; manualized interventions such as mindfulness exercises, and a structured referral process for consumers needing face-to-face mental health services. BHS intends to use CF/TN funds to work with LACDMH and their team of developers to help pilot the platform in San Joaquin County and demonstrate the value and replicability of the technology applications.

# VI. Prevention and Early Intervention

## Overview

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

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

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

Finally, all PEI programs shall apply effective methods likely to bring about intended outcomes, such as the use of evidence based or promising practices. (California Code of Regulations §3740)

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

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

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

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

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

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

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

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

All MHSA funded prevention programs utilize evidence based practices. Evaluation findings from the 2016/17 Fiscal Year are included in the appendix.

## PEI Project 1: Skill-Building for Parents and Guardians

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

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

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

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

Potential evidence-based parenting classes include:

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

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

*Parent Cafes* is a model derived from the Strengthening Families Initiative, and is a distinct process that engages parents in meaningful conversations about what matters most – their family and how to strengthen that family by building protective factors. Parent Cafés are focused on building the 5 research based protective factors that mitigate the negative impacts of trauma. See: http://www.bestrongfamilies.net/build-protective-factors/parent-cafes/

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

## PEI Project 2: Family Therapy for Children and Youth

**Community Need:**

Parents and families of children and youth struggling with either early signs of mental health diagnoses, or serious emotional disorders, delinquency, violence, and substance abuse have few options to address the role that family dynamics or past family trauma may contribute to current behaviors. Research demonstrates that family therapy, in conjunction with a rehabilitative approach to counterproductive family dynamics, can build and engage parent cooperation in treatment and strengthen the extent to which the family system is conducive to recovery and wellness.

**Project Description:**

In 2013, BHS created the Adapting Functional Family Therapy (FFT) program through MHSA Innovation funding. The project sought to determine if the better outcomes could be achieved by adapting FFT to include parent partners within the treatment regime. Overall, participant families benefitted from the intervention, though not at a significantly greater extent than FFT provided as usual. Through ongoing PEI funding, BHS will continue to provide family therapy for at risk youth and families.

***Project Goal:*** *To reduce the incidence of serious emotional disturbances amongst children and youth by providing early therapeutic interventions to support recovery, wellness, and family strengthening.*

**Project Components:**

Provide family therapy and rehabilitation services for children and youth that are at risk for and/or presenting with delinquency, violence, substance use, conduct disorder, oppositional defiant disorder, disruptive behavior disorder, mood disturbances, anxiety symptoms, or trauma. Therapy, in conjunction with rehabilitation services, will be provided by a mental health clinician and paraprofessionals. Treatment goals consist of 8-15 sessions, with up to 26 sessions for serious situations.

Intervention approaches may include:

- *Motivational Interviewing.* Motivational Interviewing is a clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. The approach upholds four principles— expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (client's belief s/he can successfully make a change).
  See: http://www.integration.samhsa.gov/clinical-practice/motivational-interviewing

- *Cognitive Behavioral Therapy (CBT):* CBT focuses on the development of personal coping strategies that target solving current problems and changing unhelpful patterns in cognitions (e.g., thoughts, beliefs, and attitudes), behaviors, and emotional regulation. It is widely used in family therapy and is recognized as a successful early intervention approach for youth. See: http://www.integration.samhsa.gov/integrated-care-models/IOM_Report_on_Prevention.pdf

- *Skill Building, Linkage to Parent Partners:* Parents and guardians often require support and advice during difficult times. Research shows that a caring peer partner, someone with similar lived experience, is an asset to treatment interventions. Parent partners will provide coaching, mentoring, and guidance to parents and guardians of engaged youth on navigating the system, achieving case plan objectives, and discussing tips and strategies for parenting, and strengthening the family system, and reinforce skill training in family communication, parenting problem solving, and conflict management.

## PEI Project 3: Mentoring for Transition Age Youth

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

**Project Description**
Public agencies or community-based organization(s) serving at risk-youth ages 16-25 will provide intensive mentoring and support to 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, and/or self-harm or suicidal thoughts.*

**Project Components**

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

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

  TIP mentoring:
  - engages youth in their own futures planning process;
  - provides youth with developmentally-appropriate, non-stigmatizing, culturally-competent, and appealing services and supports; and

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

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

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

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

## PEI Project 4: Prevention and Early Intervention Transition Services (PEITS)

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

**Project Description**
This project serves children and youth who are

(A) Engaged by the Juvenile Justice System

(B) Engaged by the Child Welfare System

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

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

**Project a: Juvenile Justice Center Intervention Team**

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

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

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

> ***Screening*:** As part of booking and detention procedures, staff of San Joaquin County's JJC conduct a behavioral health screening using the validated, evidence-based Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2). For more information about MAYSI-2 see: http://www.nysap.us/MAYSI2.html
>
> ***Assessment*:** Youth 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 five business days.
>
> ***Crisis intervention:*** Youth who disclose suicidal ideation or threaten suicide during booking or at any time during their detention are immediately referred to BHS clinicians for evaluation.

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

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

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

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

**Project b: Integrated Core Practice Model Response (ICPM) Team**

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

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

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

This project provides screening, assessment, individual and group rehabilitative interventions, and referrals to higher levels of care for children that have been removed from their home (inclusive of children placed in kinship care; home-based care with resource families; or residential group placements). This project is responsive to California's Welfare Reform Act (AB 403) and creates an Integrated Core Practice Model to deliver timely, effective, and collaborative services to children/youth and their families.

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

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

Project Component 1: Timely Trauma-Informed Screening

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

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

Component 2: Trauma-Informed Interventions

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

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

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

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

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

Component 3: Child Family Team

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

Component 4: Resource Family Supports

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

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

BHS and CWS continue to review best practices for supporting resource families. Additional support strategies may be incorporated as new promising practices are identified statewide.

Project Component 5: Collaborative Meetings

San Joaquin County BHS will initiate quarterly meetings with Children's Services. Meetings will involve PEI program staff and Child Welfare staff responsible for program development and referrals. Meeting objectives will include the ongoing development of seamless referral processes to support timely trauma screenings and interventions. The collaborative will explore community needs, service gaps, and effective strategies for addressing childhood and adolescent trauma within the County.

**Project c: Community-based Services**

This project may be implemented in 2018-19; further assessment is ongoing. This project would provide funding to local community based partners for the procurement of mental health clinicians and social workers to work with high-risk youth within accessible, acceptable, and culturally appropriate locations,

including but not limited to community based organizations, faith-based organization, preschools, community centers, family resource centers, and other community institutions that are open and welcoming of all individuals.

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

a. **Screening and Assessment:** Use of a validated screening or assessment tool to screen for trauma, anxiety, depression, or other behavioral health concerns. Examples of validated tools include PHQ-9, Ages and Stages, ACES Screening Tool, MAYSI-2, etc. Screening and Assessment tools will vary by setting and the age of the children and youth targeted for interventions.

b. **Case Plan:** Each individual served through one of the PEITS projects shall have an individualized case plan, based upon the findings of the assessment.

c. **Case Management:** Targeted case management services to help children reach their mental health goals, by providing education on mental health issues, and linking children, youth, and their families to available community services and supports.

d. **Behavioral Wellness Services:** As clinically appropriate, services may include: emotional regulation or skill building groups and activities or other group rehabilitative services provided by trained (bachelors level) social workers, nurses, or other professionals.

e. **Short-term Clinical Treatments** (**Early Interventions):** Individual or group therapy (with or without family present), using one or more of the following evidence based practices approaches by trained (masters level) clinicians.
    i. Seeking Safety
    ii. Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
    iii. Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Disorder (MATCH-ADTC)

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

## PEI Project 5: School-based Interventions for Children and Youth

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

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

This project will operate in schools that provide public education services (including public charter schools) to children and youth who may be at a greater than average risk of developing a potentially serious mental illness. Examples of risk factors include but are not limited, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, etc.

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

High School Criteria (9-12):

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

Elementary / Middle School Criteria (K-8):

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

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

**Implementation:**

Step 1:

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

Minimum qualifications: Program partners must demonstrate:

- Experience providing clinical treatment services to children and youth.
- Experience providing social, emotional, and rehabilitative group services to children and youth.
- Demonstrated training and capacity to provide evidence-based treatment interventions, including cognitive behavioral and trauma-informed services.

- Experience providing services within a school milieu.
- Capacity to work in partnership with schools to provide services around an academic calendar.
- A client management and billing system that meets CA Medi-Cal requirements.
- Adequate supervision plan and ratios for any unlicensed clinical staff.
- Capacity to assign dedicated "Clinicians on Campus" to work with partnering schools for a minimum of two days a week, for periods of at least six hours per on-site day.
- Capacity to provide on-site school-based service to at least ten different schools.

Step 2:

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

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

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

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

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

**Project Components:**

Qualified Organizational Providers shall assign dedicated clinicians to work with participating schools. Program duties and responsibilities will include:

A. On-site School-Based Services

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

Clinical staff will provide:

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

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

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

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

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

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

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

B. Program Operations and Supervision

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

## PEI Project 6: Early Interventions to Treat Psychosis

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

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

Promising models include, but are not limited to:

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

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

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

**Project Components**

**Program Referrals -** Referrals to the EITP can come by a variety of resources, however, approval for program enrollment will be the responsibility of BHS.

**Outreach and Engagement -** Trained clinicians and peers will provide presentations to community agencies and organizations, service providers, and community members about early identification of schizophrenia and the services available to promote remission and recovery. Assessments will be provided in peoples' homes and in locations of their choosing. Active engagement efforts will aim to discourage individuals from dropping services once they are enrolled.

**Assessment and Diagnosis –** Trained clinicians will conduct a strength-based, recovery-oriented assessment using formal clinical assessment tools. There will be a follow up conducted every 12 months to determine exit readiness using an evidenced-based or promising practice tool or method.

**Cognitive Behavioral Therapy (CBT) –** CBT has been demonstrated in numerous research studies to be effective for depression, anxiety disorders, substance abuse, bipolar disorder, and schizophrenia (as an adjunct to medication), and for a variety of medical problems with psychological components. Cognitive Behavioral Therapists use a wide variety of techniques to help patients change their cognitions, behavior, mood, and physiology. Techniques may be cognitive, behavioral,

environmental, biological, supportive, interpersonal, or experimental. Cognitive-behavioral techniques include psycho-education, relaxation, social problem solving and cognitive restructuring.

**Education and Support Groups –** Provide rehabilitation and support groups, based on evidence based or promising practices, for consumers and family members. These groups will be designed to inform consumers and family members about mental illness, educate on how to access services needed, techniques of developing coping skills, and creating a social support system.

**Medication Management:** Provide medication management services to educate consumers regarding their psychiatric medications, symptoms, side effects and individualizing dosage schedules. Medications must be deemed effective and follow the current accepted standards of practice in the psychiatric community.

**Individualized Support and Case Management:** Case managers will work with clients and family members to address depression, substance abuse, family issues, and other challenges that impede recovery. Case managers will work to ensure that clients find and keep meaningful work, education, and permanent housing.

## PEI Project 7: Trauma Services for TAY, Adults and Older Adults

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

**Project Description:** PEI funding will be awarded to one or more community partners with expertise in providing licensed, clinical mental health treatment services to transitional age youth, adults, and older adults with mild/moderate PTSD and associated stress disorders. Partner organizations must also be able to demonstrate a capacity to provide culturally competent services that address the needs of unserved and underserved populations. Funding awards may also include up to six months of funding for start-up and implementation activities including procuring training and fidelity monitoring.

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

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

a. **Screening and Assessment:** Use of a validated screening or assessment tool to screen for trauma, anxiety, depression, or other behavioral health concerns. Examples of validated tools include, but are not limited to, the PHQ-9, PTSD Checklist, Life Event Checklist, Abbreviated PCL-L, Trauma Symptom Checklist -40, Los Angeles Symptom Checklist (Adult Version), etc. Screening and assessment tools must be approved by BHS prior to beginning services.

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

c. **Benefit Assistance:** Each individual shall meet with a benefit assistance specialist to determine eligibility for health care coverage and or other benefits and receive application assistance.

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

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

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

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

A further listing of evidence based programs and practices may be found at:

- National Registry of Evidence Based Programs and Practices
- California Evidence Based Clearinghouse

g. **Referrals:** All TAY, adults and older adults screened will be assessed to determine if they are appropriate for the short-term intervention or whether they should be immediately referred to more specialized services.

## PEI Project 8: Recovery Services for Victims of Human Trafficking

**Community Need**
Human trafficking is a criminal industry plaguing California counties. San Joaquin County recognizes that the Central Valley has a large concentration of sex trafficking, as well as other forms of human trafficking. BHS participates in a county wide Human Trafficking Taskforce with the goal of identifying victims, providing outreach, linkage to community resources, and mental health treatment.

**Project Description**
The San Joaquin County Family Justice Center strives to provide a one-stop location where victims and families can obtain resources to assist them with getting out of "the life". Victims can receive many referrals and resources but often do not understand the value of each resource. Additionally, victims often suffer from low self-esteem; limited access to natural supports; and trauma related symptomology. This often limits the victims' ability to access available resources in a way that will help them meet their goals and find recovery.

BHS will provide funding to a community based organization providing counseling and case management services for San Joaquin County's Commercial and Sexually Exploited Children Prevention and Intervention Project. BHS funding will expand the target population to include all victims of human trafficking regardless of age or gender.

***Project Goal:*** *To identify and provide treatment to individuals who victims of human trafficking or other exploitation that are showing symptoms of post-traumatic stress disorder, recovering from a cycle of abuse and intimidation, and overcoming unhealthy attachments.*

**Project Components**

1. **Screening and Engagement**
   Referrals for mental health screening and program engagement will occur through the San Joaquin County Family Justice Center and may be triggered by a first responder (outreach worker or law enforcement) contact. Potential program participants will be screened for behavioral health concerns, including depression, substance use disorders, trauma exposure and suicide risk. Individuals with serious mental health concerns will be referred to BHS for further assessment and/or crisis intervention.

2. **Case Management and Resource Navigators**
   Program participants will be assigned a resource navigator to help them learn about the resources and opportunities that are available to help victims recover and assist with getting timely and appropriate entry into services, including substance use disorder treatment services. Navigators also provide case management support and may help victims obtain a valid ID, get to appointments, or complete benefits applications or other paperwork.

3. **Clinical Interventions and Support Services**
   All program participants will be eligible to participate in therapeutic group services that will be facilitated by mental health specialists or clinicians. Therapeutic groups may include, but are not limited to:

   - **Education and Support Groups –** Provide rehabilitation and support groups, including multi-family groups, based on evidence based or promising practices, for victims and/or family

members. These groups will be designed to inform victims and family members about human trafficking, educate them on how to access services, and providing techniques for developing coping skills and creating a social support system.

- **Trauma Focused Coping Skills** Provide coping skills therapy to help people attain safety from trauma and regulate their emotions in the context of day-to-day stressors that are faced during the recovery process. Coping skills groups provide brief and targeted interventions to help individuals put knowledge, strategies, and skills into practice. Many coping skills approaches utilize a cognitive behavioral approach. See for example, Seeking Safety for a trauma informed approach to overcoming substance use.
  See: http://www.treatment-innovations.org/
- **Additional Interventions –** Additional interventions may be selected based on the needs of clients, implementation experiences, and emerging best practice research, in consultation with BHS. Promising practices include, but are not limited to:
  - Ending the Game: a **"coercion resiliency"** curriculum that reduces feelings of attachment to traffickers and/or a lifestyle characterized by commercial sexual exploitation, thereby reducing the rate of recidivism among sex trafficking survivors. See http://endingthegame.com/etg/

4. **Supportive Program Milieu**
   Provide training to program staff on creating a safe, trauma informed environment. Utilize emerging best practices to educate and inform program partners on the incidence and consequences of commercial sexual exploitation and create organization partnerships that are sensitive and responsive to the needs of program participants. See for example, the Sanctuary Model for creating trauma informed organizational cultures at:
   http://www.sanctuaryweb.com/.

Project will be implemented in collaboration with activities offered through the San Joaquin County Family Justice Center operated by the Office of the District Attorney.

## PEI Project 9: Recovery Services for Nonviolent Offenders with Behavioral Health Concerns

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

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

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

**Project Components:**

**Project 1: MHSA Diversion Support Team**

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

**Project 2: MHSA Diversion Housing Stabilization Program**

Provide transitional recovery-oriented housing for individuals with a mild/moderate mental health concern and or a substance use disorder that are at risk for further engagement into the criminal justice system. Program services will include a supported sober living housing program offering case management and a range of vocational and/or life skills programming. Services may also include transportation to off-site treatment programs.

## PEI Project 10: Forensic Access and Engagement for Repeat Court Offenders

**Community Need:**

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

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

**Project Components:**

- Outreach: Meet with clients while they are custody or remanded to court to establish rapport, complete a client assessment, and develop a case plan.
- Assessment: Develop an assessment of client needs and strengths. Include both long term and short term mental health needs. Include assessment of alcohol and other drugs and develop a client treatment plan for mental health and substance use treatment services.
- Placement and Stabilization Planning: Work with clients to review housing options. For some clients this may include developing a plan to reunify them with their families.
- Continuing Care Planning: Work with client and or family members to develop a plan for continued engagement in treatment. This may include obtaining assistance with needed medications or arranging transportation to appointments.
- Client Engagement: Provide frequent, low demand contacts with clients where they live or are most comfortable.
- Case Management: Assist clients in accessing primary and behavioral health care services, peer-based services, financial, educational, prevocational, rehabilitative or other community based services and supports needed by clients to meet their personal goals.
- Meaningful Activities: Provide support and linkages for clients to enroll in educational of vocational programs (including pre-vocational readiness to work programs) and /or community service activities.

## PEI Project 11: Whole Person Care Outreach and Engagement

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

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

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

**Project Components: Whole Person Care, Comprehensive Health System Outreach and Engagement**

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

- *MHSA Integration Team* will provide integrated care coordination and case management across county agencies, health plans, providers, and other entities. Care coordination will be expanded through MHSA expenditures to ensure intensive and appropriate care coordination for designated project target populations.
    - Provide integrated care coordination and case management across county agencies, health plans, providers, and other entities.
    - Provide services where individuals are located and best served, whether within the community, shelter, or hospital setting.
    - Conduct, research, data collection, and analysis to ensure project activities are effective and improving outcomes for consumers.

## PEI Project 12: Community Trainings for Potential Responders

**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 identifying individuals in need of treatment interventions early in the emergence of a mental illness and preventing the escalation of mental health crises and promoting behavioral health recovery.*

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

1. **Community Trainings for Potential Responders**

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

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

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

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

## PEI Project 13: Community Education to Reduce Stigma

**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 are also offered to consumers, parents/guardians, and other family members in order to provide information about mental health conditions that encourage individuals and families to overcome negative attitudes or perceptions about mental illnesses, recent diagnosis, and/or help seeking behavior.

***Project Goal:*** *To reduce stigma towards individuals with a mental illnesses, reduce anxiety pertaining to a diagnosis of a mental illness, to encourage discourse and discussion with service providers about mental health related concerns in order to promote behavioral health recovery.*

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

1. **Community Education to Reduce Stigma:**

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

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

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

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

## PEI Project 14: Suicide Prevention in Schools

**Community Need**

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

**Project Description**

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

- CalMHSA will implement a regional universal suicide prevention campaign.
- Comprehensive school-based suicide prevention programs for high school students in San Joaquin County. Targeted suicide prevention activities will include:
  - Evidence-based suicide education campaigns.
  - Depression screenings and referrals to appropriate mental health interventions.

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

**Project Components:**

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

- School personnel at each participating high school will be trained in an evidence-based practice to understand suicide, recognize suicide risk behavior in students, and to refer students for assistance, and
- All sophomores (10th graders) at each participating high school will receive evidence-based suicide prevention education.

Component 1: An Evidence-Based Suicide Education Campaign

Implement one or more of the following evidence-based practices for both school personnel and students:

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

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

- safeTALK Workshops
  Provide *safeTALK* workshops for individuals ages 15 and over at participating schools to assist in the recognition and identification of individuals with thoughts of suicide, and to connect them to mental health resources. *SafeTALK* will be implemented in accordance with the evidence-based program detailed at: https://www.livingworks.net/programs/safetalk/
  SafeTALK workshops teach youth to be "alert helpers" who are better able to move beyond common tendencies to miss, dismiss, or avoid suicide; to identify individuals with suicidal thoughts; and to help connect a person with suicidal thoughts to suicide intervention responders.
  SafeTALK includes the following practice requirements:
  - Workshops must be conducted by a registered safeTALK trainer and held over three consecutive hours;
  - A community support resource (such as a trained volunteer, safety officer, or mental health professional) must be present to support any participants who experience difficulty;
  - Each workshop will have between 10 and 30 participants.

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

Component 2: Depression Screening and Referral

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

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

Following the screenings, youth may be referred to one or more of the following: individual therapy with a qualified mental health clinician; further assessments and screenings for medication evaluation; and/or school-based depression support groups.

Additionally some San Joaquin County funds are assigned be the Department of Health Care Services to CalMHSA for statewide suicide prevention programs.

# VII. INN Project Overview

**Innovation Component Funding Guidelines:**

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

Innovation funding may be used for the following purposes:

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

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

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

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

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

**BHS received approval by the San Joaquin County Board of Supervisors and the Mental Health Services Oversight and Accountability Commission to implement two new INN programs.**

Project 1: Assessment and Respite Center

Project 2: Progressive Housing

## INN Project 1: Assessment and Respite Center

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

**The Challenge:** A range of systemic challenges, many associated with the initial assessment process, continues to impede access and linkages to services amongst unserved and underserved individuals.

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

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

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

This project will operate within a continuum of services that includes:
(1) Whole Person Care Homeless Outreach Teams;
(2) Proposition 47 funded Withdrawal Management and Case Management Services; and

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

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

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

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

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

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

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

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

## INN Project 2: Progressive Housing

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

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

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

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

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

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

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

Progressive Housing will leverage additional program services in order to create a comprehensive program. Mental health services will be provided for all consumers with serious mental illnesses through existing programs. Individuals identified with mild/moderate mental health concerns may be

treated through a partnership with Community Medical Centers. Primary health care services, case management, and other wraparound services will also be leveraged through existing programs. Clients will be asked to contribute a nominal portion of their personal income from Social Security or General Assistance to their own cost of living for food and sundries; this helps build personal responsibility and prepare consumers for more independent living arrangements. All houses will keep basic pantry supplies and necessities stocked to assure no one is hungry. Contributions to the general food budget will vary based on the recovery stage of the clients in the house.

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

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

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

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

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

# VIII. Workforce Education and Training

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

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

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

*Significant Considerations in Workforce, Education and Training*

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

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

(1) Training and Technical Assistance

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

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

(2) Mental Health Career Pathway Programs

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

(3) Residency and Internship Programs

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

(4) Financial Incentive Programs

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

(5) Workforce Staffing Support

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

In 2018/19 BHS will refund the Workforce Education and Training projects with a transfer of funds into the WET account from CSS. Funds must be spent within 10 years from the date of transfer.

## WET Project 1: Training and Technical Assistance Academy

**Community 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. Trainings for BHS staff, volunteers and community partners may include, but are not limited to, the following:
  - *Suicide Prevention and Intervention Trainings*
  - *Mental Health First Aid*
  - *Wellness Recovery Action Plans*
  - *Crisis Intervention Training (for Law Enforcement and first responders)*
  - *Trauma Informed Care*
  - *Addressing the needs of Commercially and Sexually Exploited Children*
  - *Motivational Interviewing*
  - *Stigma Reduction*
- *Specialty Trainings in Treatment Interventions.* Specialty trainings are provided to increase the competencies of staff in core practice modalities. These modalities include the delivery of evidence-based interventions, to fidelity, and as described throughout this MHSA plan. Trainings may include, but are not limited to, the following treatment interventions:
  - *Seeking Safety*
  - *Cognitive Behavioral Therapies*
  - *Dialectical Behavioral Therapy*
  - *Multisystemic Therapy*

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

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

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

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

**Project Objectives**

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*.)

# IX. Capital Facilities and Technological Needs

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

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

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

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

Past CF/TN funding has been used to:

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

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

In 2018/19 BHS will refund the Capital Facilities and Technology Needs project fund with a transfer of funds into the CF/TN account from CSS. Funds must be spent within 10 years from the date of transfer. Proposed new projects are outlined described below.

## CF/TN Project 1: Crisis and Acute Care Service Expansion

San Joaquin County seeks to expand the availability of crisis and acute care services. Currently all crisis and acute care services are located in Stockton or Lodi in the northern half of the County. Stakeholders and community partners have expressed a need for more crisis and acute care services and for services that better serve communities in the southern portion of the county, such as Lathrop, Tracy, Manteca, and French Camp.

BHS has entered into conversations with San Joaquin County Health Care Service Agency and the County Administrator regarding the feasibility of developing additional crisis and acute care services. Proposed services may include but are not limited to crisis assessment center, crisis stabilization unit, short-term crisis or long-term residential treatment programs, a voluntary psychiatric health facility, other residential acute care rehabilitation programs, and/or a co-occurring residential treatment program for individuals dually diagnosed with a serious mental illness and co-occurring substance use disorders.

CF/TN funds will be used to conduct an initial study of the need for expanded crisis and acute care services and to determine best options for locating services. Project funds will enable a planning process to design the project scope and determine feasibility for construction and operations. Additional activities may include, but are not limited to, preliminary architectural design, site mapping, procurement, and other technical assistance related to facility development.

## CF/TN Project 2: Project Planning and Development of a Crisis Residential Treatment (CRT) Facility for Children and Youth

BHS has received notification that the California Health Facilities Financing Authority (CHFFA) that funding will be made available through a competitive bid process for jurisdictions to construct crisis residential treatment facilities for children and youth.

BHS has entered into discussions with San Joaquin County Human Services Agency regarding the imperative for a children and youth CRT. CF/TN funds will be used to conduct an initial assessment of the need for a CRT and facilitate a multi-agency planning process to design the project scope and determine feasibility for construction and operations. Additional activities may include, but are not limited to preliminary architectural design, site mapping, procurement, and other technical assistance.

## CF/TN Project 3: Facility Upgrades and Renovations

Funding will be allocated to upgrade and renovate facility components on the main campus in Stockton CA. Capital Facility funds will be used for three targeted projects that have been identified as critical to ensuring clean, safe and culturally appropriate access to services for all populations. Projects include: roofing, paving, bathroom upgrades, and other facility upgrades and renovations.

## CF/TN Project 4: Digital Health Management Solutions

BHS is exploring opportunities to strengthen digital health management applications. Several new products are available to County Mental Health Departments that provide web-based data platforms for flexible real-time reporting. The purpose of these systems is generally to help Mental Health Departments develop health outcomes tracking systems that align with designated programs and evidence based practices. Products currently in review are the Health Outcomes Management System, developed by UC San Diego and the Electronic Behavioral Solutions, developed through the California Institute for Behavioral Health Solutions. BHS plans to continue to research options and select one or more digital health management platform for implementation in San Joaquin County.

# X. PEI Evaluation Plan

Each year, San Joaquin's PEI evaluation will: 1) measure each PEI program provider's performance and fidelity; 2) measure each program's impact on participants and systems; and 3) provide timely, accurate data to inform contract monitoring and continuous program improvement.

## A. Measure performance and fidelity

Prior to implementation, or at the onset of a new fiscal year, performance expectations will be drafted that include a description of: 1) the services to be provided; 2) the number served and dosage3) a demonstration of fidelity to evidence-based practice; 4) outcome expectations; and 5) the methods of collecting and reporting data.

On a quarterly and annual basis, each program will report: 1) successes and challenges associated with service delivery; 2) program outputs (e.g., numbers served); 3) program outcomes; and 4) demonstration of fidelity (when appropriate).

Each year, in accordance with state regulations, a report will be prepared with state-mandated reporting requirements. In addition, a local supplemental report will provide feedback on each provider's program performance to inform program planning and contract monitoring.

- **Measure program impact on participants and system**

At the beginning of each program year Program Managers and PEI program staff will develop outcome expectations based on: 1) literature on the evidence-based practice; 2) national standards; or 3) previous years' outcomes.[1]

The evaluation will summarize the methods used to assess program impact, including data collection and reporting protocols. Program outcomes will be reported to the state minimally every three years, but as frequently as every year, in accordance with state regulations.

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

BHS will meet with PEI providers to identify and discuss data reporting challenges as they arise. Program staff will have an opportunity to dialogue and learn from one another. Based on evaluation findings and a review of the data for contract monitoring purposes, recommendations may be developed to adjust program scopes of work for the following year.

- **Cost Benefit Analysis**

As part of the Annual Evaluation Report, BHS will describe: 1) the dollar amount per individual served; 2) the dollar amount per individual who graduated and/or demonstrated improvements in symptomology (early intervention) or protective factors (prevention); 3) dollar spent per class, workshop, individual session and/or unit of service.

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

## • Evaluation Methods

The PEI program evaluation will utilize a range of research activities in order to evaluate whether (1) program activities meet stated goals, (2) align overall purpose of PEI funded programs, and (3) performance objectives are met. Selection of evaluation methods will be guided by state regulations, this evaluation plan, and the overarching goals and objectives of the PEI program. Evaluation activities may include one or more of the following, depending on the design of the program.

1. **Staffing, participant, and program activity data tracking**
   Evaluation efforts will create modify existing data systems to track each program's outputs. Data tracking may involve paper intake or assessment forms, excel spreadsheets, or HIPAA compliant web-based databases. The data system will track data mandated by the state and to support contract monitoring. For each program, provider and treatment modality, the administrative data tracking system will capture some or all of the following output data on a quarterly and annual basis:

- Number of FTE staff dedicated to program, including training and educational attainment
- Number of individuals reached out to and methods of outreach
- Number of unduplicated individuals and family members served
- Demographics of individuals served
- Number of individuals completing program
- Number of classes offered, sessions provided and/or units of service provided
- Locations of services provided
- Referrals and linkages to mental health treatment and other PEI programs.

2. **Administration of evidence-based practice fidelity assessment tools**
   For each evidence-based practice, BHS may select an appropriate fidelity measurement tool and train PEI programs to conduct fidelity assessments and record scores.

3. **Pre and Post & Retrospective Outcome Assessments**
   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.

4. **Satisfaction surveys**
   On an annual basis, 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.

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

## • State-Mandated Reporting and Evaluation

San Joaquin County Behavioral Health Services (BHS) will conduct its Annual and 3-Year PEI Program Evaluations in accordance with State Law.[2] The first Annual Prevention and Early Intervention Program and Expenditure Report was submitted in December, 2017.

The Fiscal Year 2016-17 PEI Program Evaluation Report is included for review in the Appendix.

[2] California Code of Regulations, Title: 9, Sections: 3200.245, 3200.246, 3510.010, 3560, 3560.010, 3560.020, 3700, 3705, 3710, 3715, 3720, 3725, 3730, 3735, 3740, 3745, 3750, 3755, and 3755.010.

## Prevention Programs

San Joaquin's **Skill-building for Parents and Guardians, Family Therapy for Children and Youth,** and **Mentoring for Transitional Age Youth** are defined as *Prevention Programs* (3720). Prevention programs must report the following evaluative data:

| Process Measures | Outcome Measures |
|---|---|
| • Number of individuals served<br>• Number of family members served<br>• Demographics of those served (using PEI-defined demographic categories) | Reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational functioning |

## • Early Intervention Programs

San Joaquin's **Trauma Services for Children and Youth, School Based Interventions, Early Interventions to Treat Psychosis, Trauma Services for Adults and Older Adults, Recovery Services for Victims of Human Trafficking and Recovery Services for nonviolent Offenders** are defined as *Early Intervention Programs* (3710). Early Intervention programs must report the following evaluative data:

| Process Measures (Annual) | Outcome Measures (3-Year) |
|---|---|
| • Number of individuals served<br>• Number of family members served<br>• Demographics of those served (using PEI-defined demographic categories) | Reduction in symptoms and/or improved recovery, including mental, emotional, and relational functioning |

## • Access and Linkages to Treatment Programs and Strategy

San Joaquin's **Whole Person Care Outreach and Engagement Project** is defined as an *Access and Linkages to Treatment Program* (3726). Access and Linkages to Treatment Programs and Strategies must report the following evaluative data:

| Process Measures (Annual) | Outcome Measures (Annual) |
|---|---|
| • Number of individuals with Serious Mental Illness referred to treatment<br>• Types of treatment individual was referred to<br>• Average duration of untreated mental illness and standard deviation<br>• Demographics of each referral | Number of individuals who followed through on referral and average interval between referral and participation in treatment, and standard deviation |

## Outreach for Increasing Recognition of Early Signs Mental Illness Programs

San Joaquin's **Community Trainings for Potential Responders** defined as *Outreach for Increasing Recognition of Early Signs Mental Illness Programs* (3715). Outreach for Increasing Recognition of Early Signs Mental Illness programs must report the following evaluative data:

| Process Measures (Annual) |
|---|
| • Numbers of potential responders<br>• Settings in which potential responders were engaged<br>• Types of potential responders engaged in each setting<br>• Demographics of potential responder |

## • Stigma and Discrimination Reduction Programs

San Joaquin's **Community Education to Reduce Stigma** project is defined as a *Stigma and Discrimination Reduction Programs* (3725). Stigma and Discrimination Reduction programs must report the following evaluative data:

| Process Measures (Annual) | Outcome Measures (3-Year) |
|---|---|
| • Numbers of individuals reached<br>• Demographics | Changes in attitude, knowledge or behavior related to mental illness and related to seeking mental health services |

## • Suicide Reduction Programs

San Joaquin's **Suicide Reduction Program** is defined as a *Suicide Prevention Program* (3730). Suicide Prevention programs must report the following evaluative data:

| Process Measures (Annual) | Outcome Measures (3-Year) |
|---|---|
| • Numbers of individuals reached<br>• Demographics | Changes in attitude, knowledge and/or behavior regarding suicide |

## • Timely Access to Services for Underserved Populations Strategy

**All PEI Programs** must include a *Timely Access to Services for Underserved Populations Strategy* (3735(a)(2)). Programs with Timely Access to Services for Underserved Populations Strategies must report the following evaluative data:

| Process Measures (Annual) | Outcome Measures (Annual) |
|---|---|
| • Identification of specific underserved populations<br>• Number of referrals of members of underserved populations to PEI or treatment<br>• Description of ways that the county encouraged access and follow-through<br>• Demographics of referrals | Number of individuals who followed through on their referral and average interval between referral and participation in treatment, and standard deviation |

# Annual Prevention and Early Intervention Program and Evaluation Report

## San Joaquin County Behavioral Health Services

Fiscal Year 2016/2017

## Table of Contents

## A. Introduction

In October 2015 the State of California Office of Administrative Law (OAL) approved new Prevention and Early Intervention (PEI) regulations.[3,4]. Under these regulations, San Joaquin County (SJCBHS) must submit an Annual Prevention and Early Intervention Program and Evaluation Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC).

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

| | | Strategies | | | |
|---|---|---|---|---|---|
| San Joaquin County Projects | PEI Defined Program | Access & Linkage to Treatment | Timely Access to Services for Underserved Populations | Non-Stigmatizing & Non-Discriminatory | Outreach for Increasing Recognition |
| Skillbuilding for Parents/Guardians | Prevention (3720) | x | x | x | |
| Mentoring for Transitional Age Youth | Prevention (3720) | x | x | x | |
| Trauma Services for Children | Early Intervention (3710) | x | x | x | |
| Early Interventions to Treat Psychosis | Early Intervention (3710) | x | x | x | x |
| Juvenile Justice Project | Access and Linkage to Tx (3726) | | x | x | |
| Community Trainings - 1 | Stigma and Discrimination Reduction Program (3725) | x | x | | x |
| Community Trainings - 2 | Outreach for Increasing Recognition (3715) | x | x | x | |
| Suicide Prevention | Suicide Prevention (3730) | x | x | x | x |

This report includes a brief description of each SJCBHS Project along with the required information for each Program and Strategy as specified in Section 3560.010 of the CCR. In addition, this report includes

[3] *(CCR, Title 9, 3200.245, 3200.246, 3510.010, 3560, 3560.010, 3560.020, 3700, 3701, 3705, 3706, 3710, 3717, 3720, 3725, 3726, 3730, 3735, 3740, 3745, 3750, 3755, 3755.010),*
[4] A copy of the regulations may be found at mhsoac.ca.gov/document/2016-03/pei-regulations

interim evaluation findings for Fiscal Year 2016/17, which will be expanded upon in a Three-Year Program and Evaluation Report due December 30, 2018 per Section 3560.020 of the CCR. A separate confidential Excel file is provided to MHSOAC. This file includes a tab for each SJCBHS Project with supplemental demographic data related to service recipients and referrals.

Additionally, this report includes several evaluative features not required by State regulation—namely, a breakdown of data each community-based provider within each PEI Project; a comparative assessment of performance across providers; an analysis of dosage (i.e., how much services are provided per recipient); and a cost benefit analysis that describes cost per individual served, cost per individual completing/graduating from the program, and/or cost per individual who demonstrated positive attitudinal or behavioral change or knowledge gain. [5]

[5] For the purpose of the cost benefit analyses, costs are depicted as the amount invoiced by each provider of PEI services. The actual costs include indirect and administrative expenses, and are available as part of the PEI Annual Revenue and Expenditure Report (Section 3510.010). A cost benefit analysis was not performed for SJCBHS's Juvenile Justice Project.

## B. Prevention Program Name: Skill Building for Parents and Guardians

In FY 2016/17, the Skill Building for Parents and Guardian Project was delivered by four community-based providers:

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

### Project Outputs

A total of 1,928 parents/guardians were served in FY 2016/17. The following table shows the number of parents/guardians directly served and the number of children (family members) indirectly served by each provider. The table also includes the number groups delivered, number of sessions delivered, group size, and service dosage.

| | CAPC Parent Cafes | Cath Char NPP | PBC Triple P | CPF Parent Cafes | Total |
|---|---|---|---|---|---|
| Unduplicated parent/guardian participants | 771 | 395 | 428 | 334 | 1928 |
| Total children of participants ages 0-25 (reported) | 395 | 865 | 464 | 675 | 2399 |
| Total number of groups delivered | 42 | 20 | 47 | 46 | 155 |
| Total number of sessions delivered | 525 | 238 | 278 | 235 | 1276 |
| Average number of participants per group (group size) | 18.4 | 19.8 | 9.1 | 7.3 | 12.4 |
| Average number of sessions delivered per group (dosage offered) | 12.5 | 11.9 | 5.9 | 5.1 | 8.2 |
| Average number of sessions attended per participant (dosage received) | 4.8 | 6.3 | 5.3 | 2.6 | 4.8 |

## Participant Demographics

Demographics are reported for Skill Building Project as a whole. Demographic categories with fewer than 10 participants are shown as (*). Demographics broken down by each provider and the true count for small demographic categories are provided to MHSOAC in supplemental confidential materials.

| Demographics | All Skillbuilding Contracts | |
|---|---|---|
| Unduplicated individuals served | 1928 | |
| Number of demographic forms collected | 1617 | 84% |
| **Ages** | | |
| 0-15 | 0 | 0% |
| 16-25 | 120 | 7% |
| 26-59 | 1182 | 73% |
| 60+ | 113 | 7% |
| Decline to answer | 202 | 12% |
| *Number of children <26 of participants* | 2399 | n/a |
| **Race** | | |
| American Indian or Alaskan Native | 59 | 4% |
| Asian | 74 | 5% |
| Black or African American | 141 | 9% |
| Native Hawaiian or other Pacific Islander | 16 | 1% |
| White | 314 | 19% |
| Other | 626 | 39% |
| More than one race | 47 | 3% |
| Decline to answer | 340 | 21% |
| **Ethnicity** | | |
| Hispanic or Latino as follows: | | |
| Caribbean | * | |
| Central America | * | |
| Mexican/Mexican-American | 888 | 55% |
| Puerto Rican | * | |
| South American | * | |
| Other | * | |
| **Non-Hispanic as follows:** | | |
| African | 81 | 5% |
| Asian Indian/South Asian | 11 | 1% |
| Cambodian | * | |
| Chinese | * | |
| Eastern European | * | |
| European | 116 | 7% |
| Filipino | 33 | 2% |
| Japanese | * | |
| Korean | * | |
| Middle Eastern | * | |
| Vietnamese | * | |
| Other | 69 | 4% |
| More than one ethnicity | 64 | 4% |
| Decline to answer | 330 | 20% |
| **Primary Language** | | |
| English | 613 | 38% |
| Spanish | 778 | 48% |
| Other | 32 | 2% |
| Decline to answer | 194 | 12% |

| | | |
|---|---|---|
| **Sexual Orientation** | | |
| Gay or Lesbian | 13 | 1% |
| Heterosexual or Straight | 1107 | 68% |
| Bisexual | * | |
| Questioning or unsure | * | |
| Queer | * | |
| Another sexual orientation | * | |
| Decline to answer | 490 | 30% |
| **Disability** | | |
| Communication - difficulty seeing | 10 | 1% |
| Communication - difficulty hearing & speech | * | |
| Communication - other | * | |
| Mental disability | 13 | 1% |
| Physical/mobility disability | 22 | 1% |
| Chronic health | * | |
| Other | * | |
| Decline to answer | 466 | 29% |
| **Veteran status** | | |
| Yes | 29 | 2% |
| No | 1240 | 77% |
| Decline to answer | 348 | 22% |
| **Gender assigned at birth** | | |
| Male | 246 | 15% |
| Female | 1166 | 72% |
| Decline to answer | 205 | 13% |
| **Current Gender identity** | | |
| Male | 244 | 15% |
| Female | 1136 | 70% |
| Transgender | * | |
| Genderqueer | * | |
| Questioning or unsure of gender identity | * | |
| Another gender identity | * | |
| Decline to answer | 237 | 15% |
| **Residence** | | |
| *Stockton* | 896 | 55% |
| *Lodi* | 172 | 11% |
| *Manteca* | 111 | 7% |
| *Tracy* | 128 | 8% |
| *Other* | 96 | 6% |
| *Decline to answer* | 214 | 13% |

## Participant Outcomes

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

| Child Abuse Prevention Council - Parent Cafés<br>**Instrument:** Protective Factors Survey<br>**Freq. of admin:** First and last session<br>**Graduation expectation:** 50% of 15 sessions | | |
|---|---|---|
| Unduplicated individuals served | 771 | |
| Number of graduates | 282 | *37%* |
| Number of graduates w/ matched pre/post | 282 | *100%* |
| **Number who showed improvement in:** | | |
| Knowledge of parenting skills | 279 | *99%* |
| Access to support | 282 | *100%* |
| Parental resiliency | 277 | *98%* |
| Social connections | 280 | *99%* |
| Parent/child relationships | 280 | *99%* |
| **Total partcipants who showed improvement*** | **280** | ***99%*** |

| Catholic Charities - Nurturing Parents Program<br>**Instrument:** Adult Adolescent Parenting Inventory (AAPI)<br>**Freq. of admin:** First and last session<br>**Graduation expectation:** 6 sessions | | |
|---|---|---|
| Unduplicated individuals served | 395 | |
| Number of graduates | 219 | *55%* |
| Number of graduates w/ matched pre/post | 214 | *98%* |
| **Number who showed improvements in:** | | |
| Inappropriate expectations | 164 | *77%* |
| Low level of empathy | 189 | *88%* |
| Belief in corporeal punishment | 185 | *86%* |
| Reverse family roles | 153 | *71%* |
| Restricts power and independence | 142 | *66%* |
| **Total partcipants who showed improvement*** | **167** | ***78%*** |

| Parents by Choice - Triple P<br>**Instruments for regular Triple P classes:** Parenting Tasks Checklist (PTC) & Parenting Scale (PS)<br>**Instruments for Parents of Teen classes:** Conflict Behavior Questionnaire (CBQ) & Parenting Scale (PS)<br>**Freq. of admin:** First and last session<br>**Graduation expectation:** 80% of six sessions | | |
|---|---|---|
| Unduplicated individuals served | 428 | |
| Number of graduates | 328 | *77%* |
| Number of graduates w/ matched pre/post | 328 | *100%* |
| Triple P Regular | 282 | *86%* |
| Triple P for Parents of Teens | 46 | *14%* |
| **Number (regular participants) who showed improvement in:** | | |
| Setting self-efficacy (PTC) | 251 | *89%* |
| Behavioral self-efficacy (PTC) | 245 | *87%* |
| Laxness and Overreactivity (PS) | 244 | *87%* |
| **Total partcipants who showed improvement*** | 247 | *87%* |
| **Number(parents of teens) who showed improvement in** | | |
| Conflict behavior (CBQ) | 38 | *83%* |
| Laxness (PS) | 37 | *80%* |
| Overreactivity (PS) | 34 | *74%* |
| **Total partcipants who showed improvements*** | 36 | *79%* |
| **Total participants for both programs** | **283** | **86%** |

| Community Partnership for Families - Parent Cafés<br>**Instrument:** Protective Factors Survey<br>**Freq. of admin:** First and last session<br>**Graduation expectation:** 3 sessions | | |
|---|---|---|
| Unduplicated individuals served | 334 | |
| Number of graduates | 135 | *40%* |
| Number of graduates w/ matched pre/post | 135 | *100%* |
| **Number who showed improvement in:** | | |
| Knowledge of parenting skills | 64 | *47%* |
| Access to support | 32 | *24%* |
| Parental resiliency | 55 | *41%* |
| Social connections | 49 | *36%* |
| Parent/child relationships | 58 | *43%* |
| Child social/emotional competency | 67 | *50%* |
| **Total partcipants who showed improvement*** | **54** | ***40%*** |

* Based on average number who showed improvement across all domains

## Cost/Benefit Analysis

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

| Participant Count | CAPC-Parent Café | CC-NPP | PBC-PPP | CPF-Parent Café | **Skillbuilding Contracts** |
|---|---|---|---|---|---|
| **Program Costs (i.e., $ invoiced by contractor)** | $144,874 | $118,096 | $146,948 | $149,164 | **$559,082** |
| **Unduplicated individuals served** | 771 | 395 | 428 | 334 | **1928** |
| ***Cost per individual served*** | *$188* | *$299* | *$343* | *$447* | ***$290*** |
| **Number who graduated** | 282 | 219 | 328 | 135 | **964** |
| ***Cost per graduate*** | *$514* | *$539* | *$448* | *$1,105* | ***$580*** |
| **Number who showed improvement** | 280 | 167 | 247 | 54 | **747** |
| ***Cost per individual who showed improvement*** | *$518* | *$709* | *$595* | *$2,754* | ***$748*** |

## Comparative Analysis

- CAPC offered the most group sessions and served the greatest number of participants, but had the lowest graduation rate. This was in part because they had the highest graduation expectation (50% of 15 sessions). For those who did graduate and complete a pre post survey, 99% showed increased protective factors. Their cost per graduate was lower than average and their cost per individual who showed improvement was the lowest of any provider.

- Catholic Charities provided the fewest groups and correspondingly the fewest number of sessions, and had the largest class size. However, their participants on average attended the greatest number of sessions, suggesting high levels of satisfaction. Because graduation expectation was high (6 sessions) graduation rates were relatively low (55%). Among those who did graduate, 78% showed reduced risk factors. Cost per graduate and cost per individual who showed improvement were less than average but significantly higher than two other providers.

- PBC served the second highest number of participants and provided the second highest number of sessions. The group size was relatively small (~9 participants) and on average participants attended a relatively high number of sessions. Graduation expectations were slightly lower than two other providers, and by far the provider achieved the highest graduation rate (77%). Eighty-six percent (86%) of participants showed reduced risk factors/increased protective factors. Cost per graduate was the lowest of any provider, and cost per individual who showed improvement was also comparatively low.

- CPF served the fewest number of individuals and provided the fewest number of sessions. Participants attended the fewest number of sessions on average. Graduation rates were lower than average (44%) in spite of low expectations (3 sessions). At program conclusion only 40% of participants showed increased protective factors. The cost per graduate was more than double that of other providers, and the cost per individual who showed improvement was nearly four times higher than the average across all four providers.

## Access and Linkage to Treatment Strategy

In FY 2016/17, PEI programs began tracking how many referrals were made to mental health treatment. In early FY 2016/17, SJCBHS and PEI contractors developed more comprehensive referral tracking policies, procedures and data systems, and began tracking more comprehensive information on referrals and linkages to treatment and to other PEI programs in 4$^{th}$ quarter. Detailed data on referrals, including demographic information, is provided to

MHSOAC in a secure confidential file. The following is a summary of data on referrals from the Parents/Guardians Skill Building Project.

- During FY 2016/17, the Skill Building for Parents/Guardians Project made 16 referrals to mental health treatment.
- In the 4th quarter of the fiscal year, a total of 8 individuals identified by the Skill Building Project were referred to SJCBHS for screening and assessment and to determine eligibility for treatment.
- None of these individuals engaged in treatment, as defined by participating at least once in treatment.
- Three of the 8 individuals provided information on their duration of untreated mental illness. All three stated they were feeling symptoms for 6 months.
- Due to the small sample, demographic information on referrals is included in the confidential supplemental file.

### Timely Access to Services for Underserved Populations Strategy

San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

- In the fourth quarter, a total of three referrals were made for members of underserved populations (one of the three referred individuals met the criteria for underserved population in two demographic categories).
- None of the individuals participated in the services to which he/she was referred.

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

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

- Participants of *Catholic Charities' NPP Program* (predominantly Latino/Hispanic) are encouraged to find professional help for mental health when needed for themselves and other members of their family. Staff of the NPP program reach out to and provider referrals to members of the community who do not attend NPP classes. A follow up call is made to every client who has been referred to treatment; in cases that they are not receiving the MH services to which they were referred, other services or agencies are suggested to them.

- *CAPC's Parent Café* encourages access to services by first making the services in the community known to program participants. There is a section in the Parent Cafe Curriculum dedicated solely to community resources (*Concrete Support for Parents, We All Need Help Sometimes),* in which parents are provided with resource lists from CAPC and San Joaquin County as a whole. CAPC's Parent Café staff also make it a point to let participants know on the first day of the program that they are in a safe place, and what is discussed in the group remains confidential so there is a sense of trust and morale within the group. The participants are encouraged to come to staff if they need any help for themselves or their children. Usually Parent Cafe staff refers participants to CAPC's Family Intervention Program and from there they are linked to SJCBHS mental health services or other community based services. Staff in both programs will then follow-up to discuss a participant's progress and the outcome of treatment.

- *Parents by Choice* staff members have recently begun emphasizing referrals to SJCBHS and other providers. The program has invited other programs to attend team meetings to discuss their programs and how Triple P clients might benefit from referrals.

- All *Community Partnership for Families Parent Cafe* participants complete an intake Welcome Form (WF) that allows staff to assess the family's immediate needs and long-term goals. Based on the assessment, staff members connect participants and their families to both internal CPF services and external services, and follow through with families throughout their enrollment in the program. Some "external referrals" such as WorkNet, Public Health, WIC, CHD, Catholic Charities and CMC are located at CPF Family Resource Center locations, allowing for a seamless handoff and collaborative case management. CPF's case management model includes home visitation and weekly meetings.

## C. Prevention Program Name: Mentoring for Transitional Age Youth

In FY 2016/17, the Mentoring for Transitional Age Youth (TAY Mentoring) Project was delivered by two community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC)
- Women's Center Youth and Family Services of San Joaquin County (Women's Center)

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

### Project Outputs

In FY 2016/17, the TAY Mentoring Project served a total of 419 individuals. The following table shows the number of youth directly served and the number of individual service delivery sessions delivered by each provider. The table also includes TIP model fidelity scores. The Organizational Survey fidelity scores, rated by program managers, are a composite of 9 items related to staffing, services, supervision and other system-level items, and the TIP Practice Probes are a composite of the scores of three interview questions posed to program staff related to their knowledge and practices.

| | CAPC-TIP | Women's-TIP | **All TAY Mentoring** |
|---|---|---|---|
| **Unduplicated individuals served** | 228 | 191 | **419** |
| **Number of sessions delivered** | 902 | 1237 | **2139** |
| **Average number of sessions delivered per individual** | 4.0 | 6.5 | **5.1** |
| **Organizational Survey fidelity scores (average)** | 88% | 82% | **85%** |
| **TIP Practice Probes fidelity scores (average)** | 81% | 82% | **82%** |

### Participant Demographics

Demographics are reported for TAY Mentoring Project as a whole. Demographic categories with fewer than 10 participants are shown as (*). Demographics broken down by each provider and the true count for small demographic categories are provided to MHSOAC in a supplemental confidential file

| Demographics | All TAY Mentoring | |
|---|---|---|
| Unduplicated individuals served | 419 | |
| Number of demographic forms collected | 419 | 100% |
| **Ages** | | |
| 0-15 | * | |
| 16-25 | 419 | 100% |
| 26-59 | * | |
| 60+ | * | |
| Decline to answer | * | |
| **Race** | | |
| American Indian or Alaskan Native | 16 | 4% |
| Asian | 14 | 3% |
| Black or African American | 103 | 25% |
| Native Hawaiian or other Pacific Islander | * | |
| White | 64 | 15% |
| Other | 85 | 20% |
| More than one race | 64 | 15% |
| Decline to answer | 66 | 16% |
| **Ethnicity** | | |
| Hispanic or Latino as follows: | | |
| Caribbean | * | |
| Central America | * | |
| Mexican/Mexican-American | 186 | 44% |
| Puerto Rican | * | |
| South American | * | |
| Other | 73 | 17% |
| **Non-Hispanic as follows:** | | |
| African | 69 | 16% |
| Asian Indian/South Asian | * | |
| Cambodian | * | |
| Chinese | * | |
| Eastern European | * | |
| European | * | |
| Filipino | 14 | 3% |
| Japanese | * | |
| Korean | * | |
| Middle Eastern | * | |
| Vietnamese | * | |
| Other | 32 | 8% |
| More than one ethnicity | 41 | 10% |
| Decline to answer | 65 | 16% |
| **Primary Language** | | |
| English | 380 | 91% |
| Spanish | 34 | 8% |
| Other | * | |
| Decline to answer | * | |

| | | |
|---|---|---|
| **Sexual Orientation** | | |
| Gay or Lesbian | 14 | 3% |
| Heterosexual or Straight | 356 | 85% |
| Bisexual | 19 | 5% |
| Questioning or unsure | * | |
| Queer | * | |
| Another sexual orientation | * | |
| Decline to answer | 20 | 5% |
| **Disability** | | |
| Communication - difficulty seeing | 16 | 4% |
| Communication - difficulty hearing & speech | * | |
| Communication - other | * | |
| Mental disability | 44 | 11% |
| Physical/mobility disability | 13 | 3% |
| Chronic health | * | |
| Other | * | |
| Decline to answer | 19 | 5% |
| **Veteran status** | | |
| Yes | * | |
| No | 416 | 99% |
| Decline to answer | * | |
| **Gender assigned at birth** | | |
| Male | 183 | 44% |
| Female | 235 | 56% |
| Decline to answer | * | |
| **Current Gender identity** | | |
| Male | 180 | 43% |
| Female | 232 | 55% |
| Transgender | * | |
| Genderqueer | * | |
| Questioning or unsure of gender identity | * | |
| Another gender identity | * | |
| Decline to answer | * | |
| **Residence** | | |
| *Stockton* | 385 | 92% |
| *Lodi* | * | |
| *Manteca* | * | |
| *Tracy* | 13 | 3% |
| *Other* | * | |
| *Decline to answer* | * | |

## Participant Outcomes

Graduation from this program was defined as participants having completed at least one of his or her program goals at discharge. According to staff of CAPC, 67% of youth graduated, and according to Women's Center staff, 77% of their youth participants graduated from the program.

The program used two other methods to measure outcomes. The TIP Tracker rated each participant, at discharge, on progress towards or the completion of their self-identified goals in up to 8 categories. The following table shows the number of participants who had goals in each of the 8 categories and the number and percent who showed improvement in meeting these goals. The bottom row summarizes the outcomes by showing the average number of participants who had a goal in each outcome category (92 or 48% of youth from Women's

Center versus 66 or 29% of youth from CAPC). On average, 69% of Women's Center participants who had self-identified goals showed improvement on these goals whereas 66% of CAPC participants showed improvement.

| | Child Abuse Prevention Council - TIP Program | | | Women's Center- TIP Program | | |
|---|---|---|---|---|---|---|
| Unduplicated individuals served | 228 | | | 191 | | |
| **Participant-identified goals** | # with goals in this category | # who showed improve-ment | *% who showed improve-ment* | # with goals in this category | # who showed improve-ment | *% who showed improve-ment* |
| Education | 131 | 104 | *79%* | 129 | 82 | *64%* |
| Employment and career | 138 | 98 | *71%* | 140 | 93 | *66%* |
| Living situation | 58 | 37 | *64%* | 111 | 80 | *72%* |
| Social support and connections | 62 | 39 | *63%* | 76 | 57 | *75%* |
| Emotional and wellbeing | 56 | 37 | *66%* | 88 | 63 | *72%* |
| Physical health | 29 | 11 | *38%* | 37 | 30 | *81%* |
| Financial | 27 | 9 | *33%* | 98 | 78 | *80%* |
| Parenting | 25 | 11 | *44%* | 53 | 19 | *36%* |
| **Average** | **66** | **43** | ***66%*** | **92** | **63** | ***69%*** |

The third method of measuring outcomes involved a set of 8 objective measures selected by SJCBHS. Staff first identified the number of participants who had risk related to these issues, and for those who had risk, determined the number who showed improvement between intake and discharge. These outcomes were measured only for those youth whose status was known at discharge. The table below shows that on average, across all of the measures, Women's Center participants were less likely to display risk factors at intake than CAPC participants (across risk factors, on average, 28 Women's Center participants demonstrated risk at intake versus 36 CAPC participants. Women's Center participants who exhibited risks at intake were less likely to show improvement on the objective measures than CAPC participants (36% vs. 62%).

| | Child Abuse Prevention Council - TIP Program | | | Women's Center- TIP Program | | |
|---|---|---|---|---|---|---|
| | # at risk at intake | # who showed improve-ment | *% who showed improve-ment* | # at risk at intake | # who showed improve-ment | *% who showed improve-ment* |
| Employment, volunteering, education | *110* | 69 | *63%* | 69 | 23 | *33%* |
| Arrests | *13* | 10 | *77%* | 15 | 7 | *47%* |
| Incarceration | *12* | 9 | *75%* | 10 | 3 | *30%* |
| Homelessness | *22* | 13 | *59%* | 38 | 18 | *47%* |
| Alcohol, drug use | *41* | 10 | *24%* | 40 | 9 | *23%* |
| Suicide | *6* | 5 | *83%* | 5 | 3 | *60%* |
| Trauma exposure | *32* | 26 | *81%* | 19 | 10 | *53%* |
| Mental health symptoms | *54* | 37 | *69%* | 26 | 6 | *23%* |
| Average | *36* | *22* | 62% | 28 | 10 | 36% |

### Cost/Benefit Analysis

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

| | CAPC-TIP | Women's-TIP | **All TAY Mentoring** |
|---|---|---|---|
| **Program Costs (i.e., $ invoiced by contractor)** | $389,609 | $416,718 | **$806,327** |
| **Unduplicated individuals served** | 228 | 191 | **419** |
| ***Cost per individual served*** | *$1,709* | *$2,182* | ***$1,924*** |
| **Number of participants exiting program** | 196 | 169 | **365** |
| **Number who graduated (exited having completed goals)** | 131 | 130 | **261** |
| ***Cost per graduate*** | *$2,974.11* | *$3,205.52* | ***$3,089*** |

### Comparative Analysis

In summary 261 youth (131 from CAPC and 130 from Women's Center) exited the TAY Mentoring Project having met at least one goal. Women's Center served fewer individuals (191 v 228) but provided more intensive services than CAPC, as evidenced by the fact that the Women's Center, on average, delivered a greater number of sessions per participant (6.5) than CAPC (4.0). Women's Center participants had more self-identified goals and showed greater improvement in self-identified goals, but had fewer risk factors and showed less improvement in objective measures. Due to serving fewer participants and invoicing slightly higher, Women's Center cost per participant and cost per participant who achieved his/her goals was higher than CAPC.

### Access and Linkage to Treatment Strategy

In FY 2016/17, PEI programs began tracking how many referrals were made to mental health treatment. In early FY 2016/17, SJCBHS and PEI contractors developed more comprehensive

referral tracking policies, procedures, and data systems, and began tracking more comprehensive information on referrals and linkages to treatment and to other PEI programs in 4th quarter. Detailed data with demographic information is provided to MHSOAC in a confidential Excel file. The following is a summary of data on referrals from the TAY Mentoring Project.

- During FY 2016/17, the TAY Mentoring Project made 33 referrals to mental health treatment.
- In the 4th quarter of the fiscal year, a total of 21 individuals identified by the TAY Mentoring Project were referred to SJCBHS Access for screening and assessment, and to determine eligibility for treatment.
- Three of these individuals engaged in treatment, as defined by participating at least once in treatment. The average duration from referral to treatment was 23.7 days (s= 32.4).
- Sixteen (16) of the 21 individuals provided information on the duration of untreated mental illness. On average, they were experiencing symptoms for 12.1 months (s = 8.2).
- Due to the small sample, demographic information on referrals in included in the confidential supplemental file.

### Timely Access to Services for Underserved Populations Strategy

San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

- In 4th quarter of FY 2016/17, all 21 treatment referrals were made for members of underserved populations (many met the criteria for underserved population in two or more demographic categories)

- Three of the individuals participated in the program to which they were referred. The average duration from referral to treatment was 23.7 days (s= 32.4). (A more detailed breakdown of each underserved demographic group is included in the supplemental file.)

The following are ways in which SJCBHS and the TAY Mentoring Project encourage access to services and follow through:

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

- CAPC's TAY Mentoring program provides community resources to and informs youth of their options. Staff offers the option of a warm handoff and offers ongoing support to ease the transition to new service providers. Practices from the TIP Model are used to encourage youth to seek services and help maintain treatment if it is needed.

- The Women's Center TAY Mentoring program encourages access to mental health services by offering in-house therapy and referrals to external services when appropriate. The Women's Center helps participants identify what insurance they have, and refers to both private insurance and County behavioral health services. The Women's Center also offers free and confidential peer counseling for victims and their family's dealing with domestic violence and sexual assault.

## D. Early Intervention Program: Trauma Services for Children

In FY 2016/17, the Trauma Services for Children Project was delivered by Valley Community Counseling Services (VCCS). VCCS provided Child Welfare Trauma Training Toolkit's evidence-based trauma training to educators in San Joaquin County elementary schools; screened students exposed to traumatic events using Trauma Symptom Checklist (TSCL); and provided Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to those experiencing symptoms of traumatic exposure.

### Project Outputs

In FY 2016/17, 300 unduplicated individuals received early intervention (TF-CBT) services. The following table shows the number of schools participating in the Trauma Services for Children Project, the number of educators who were trained in recognizing signs and symptoms of traumatic exposure, the number of screenings completed, the number of students receiving TF-CBT as a result of positive screenings for trauma, and the average number of TF-CBT sessions provided per TF-CBT participant.

| | VCCS - Trauma Services |
|---|---|
| Number of elementary schools served | 66 |
| Number of educators trained | 1714 |
| Number of trauma screenings | 641 |
| Number of students receiving TF-CBT | 300 |
| Average number of TF-CBT sessions provided per child | 7.8 |

### Participant Demographics

Demographics are reported for Trauma Services for Children Project as a whole. Demographic categories with fewer than 10 participants are shown as (*). The true count for small

demographic categories with fewer than 10 participants are provided to MHSOAC in a secure confidential Excel file.

| Demographics | Valley Trauma | |
|---|---|---|
| Unduplicated individuals served (325 screened positive; 312 opened to services; 300 received services) | 300 | |
| Number of demographic forms collected | 312 | |
| **Ages** | | |
| 0-15 | 312 | 100% |
| 16-25 | * | |
| 26-59 | * | |
| 60+ | * | |
| Decline to answer | * | |
| *Number of children <26 of participants* | * | |
| **Race** | | |
| American Indian or Alaskan Native | * | |
| Asian | * | |
| Black or African American | 30 | 10% |
| Native Hawaiian or other Pacific Islander | * | |
| White | 180 | 58% |
| Other | * | |
| More than one race | 49 | 16% |
| Decline to answer | 46 | 15% |
| **Ethnicity** | | |
| Hispanic or Latino as follows: | | |
| Caribbean | * | |
| Central America | * | |
| Mexican/Mexican-American | * | |
| Puerto Rican | 102 | 33% |
| South American | * | |
| Other | * | |
| **Non-Hispanic as follows:** | | |
| African | 30 | 10% |
| Asian Indian/South Asian | * | |
| Cambodian | * | |
| Chinese | * | |
| Eastern European | * | |
| European | 64 | 21% |
| Filipino | * | |
| Japanese | * | |
| Korean | * | |
| Middle Eastern | * | |
| Vietnamese | * | |
| Other | * | |
| More than one ethnicity | 49 | 16% |
| Decline to answer | 46 | 15% |
| **Primary Language** | | |
| English | 225 | 72% |
| Spanish | 49 | 16% |
| Other | * | |
| Decline to answer | * | |

| | | |
|---|---|---|
| **Sexual Orientation** | | |
| Gay or Lesbian | * | |
| Heterosexual or Straight | * | |
| Bisexual | * | |
| Questioning or unsure | * | |
| Queer | * | |
| Another sexual orientation | * | |
| Decline to answer (unasked) | 312 | |
| **Disability** | | |
| Communication - difficulty seeing | * | |
| Communication - difficulty hearing & speech | * | |
| Communication - other | * | |
| Mental disability | * | |
| Physical/mobility disability | * | |
| Chronic health | * | |
| Other | * | |
| Decline to answer | 22 | 7% |
| **Veteran status** | | |
| Yes | * | |
| No | 312 | 100% |
| Decline to answer | * | |
| **Gender assigned at birth** | | |
| Male | 170 | 54% |
| Female | 141 | 45% |
| Decline to answer | * | |
| **Current Gender identity** | | |
| Male | 170 | 54% |
| Female | 141 | 45% |
| Transgender | * | |
| Genderqueer | * | |
| Questioning or unsure of gender identity | * | |
| Another gender identity | * | |
| Decline to answer | * | |
| **Residence** | | |
| *Stockton* | 147 | 47% |
| *Lodi* | 36 | 12% |
| *Manteca* | 38 | 12% |
| *Tracy* | 69 | 22% |
| *Other* | 22 | 7% |
| *Decline to answer* | * | |

## Participant Outcomes

During the reporting period, 151 children completed TF-CBT. This represents a completion rate of 50%. Of those who completed TF-CBT, 148 (98%) had matched pre and post TSCL scores. A total of 103 (70% of matched pre post surveys) children demonstrated improvements in trauma symptoms.

| Valley Trauma Program | | |
|---|---|---|
| **Instrument:** Trauma Symptom Checklist<br>**Freq. of admin:** First and last session | | |
| Unduplicated individuals served | 300 | |
| Number of program completions | 151 | *50%* |
| Number of graduates w/ matched pre/post | 148 | *98%* |
| **Number who showed improvement in:** | | |
| Trauma Symptoms | 103 | *70%* |

### Cost/Benefit Analysis

The following table shows several key indicators of performance for the Trauma Services Project, including: costs of the project (represented by amount invoiced), cost per participant, cost per graduate, and cost per individual who showed reduced trauma symptoms.

| | VCCS - Trauma Services |
|---|---|
| Program Costs (i.e., $ invoiced by contractor)* | $715,950 |
| Unduplicated individuals receiving TF-CBT | 300 |
| *Cost per individual receiving early intervention* | *$2,387* |
| Number of individuals completing TF-CBT | *151* |
| *Cost per individual completing program* | *$4,741* |
| Number who showed improvement | 103 |
| *Cost per individual who showed improvement* | *$6,951* |

* Program invoiced a total of $744,075 of which $28,125 was used for Trauma Training. The $715,950 represents costs associated with screening and providing TF-CBT

### Access and Linkage to Treatment Strategy

In FY 2016/17, PEI programs began tracking how many referrals were made to mental health treatment. In early FY 2016/17, SJCBHS and PEI contractors developed more comprehensive referral tracking policies, procedures, and data systems, and began tracking more comprehensive information on referrals and linkages to treatment and to other PEI programs in 4th quarter. Detailed data with demographic information is provided to MHSOAC in a secure

confidential Excel file. The following is a summary of data on referrals from the Trauma Services for Children Project.

- The Trauma Services Project reported making 73 referrals to treatment in FY 2016/17.
- In the 4th quarter of the fiscal year, a total of 10 individuals identified by the Trauma Services Project were referred to SJCBHS for screening and assessment, and to determine eligibility for treatment.

- Nine (9) of these individuals engaged in treatment, as defined by participating at least once in treatment. The average duration from referral to treatment was 8.8 days (s = 11.8).

- The program did not capture data on duration of untreated mental illness during the Fiscal Year, but has received additional training to do so in subsequent reporting periods.

- Due to the small sample, demographic information on referrals in included in the confidential supplemental file.

### Timely Access to Services for Underserved Populations Strategy

San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

- Seven (7) treatment referrals were made for members of underserved populations (many met the criteria for underserved population in two or more demographic categories)

- Six (6) of the individuals participated in the program to which he/she was referred. Average duration from referral to treatment was 3.3 days (s = 5.2). (A more detailed breakdown of each underserved demographic group is included in the supplemental file.)

The following are ways in which SJCBHS and the Trauma Services Project encourage access to services and follow through:

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

- VCCS makes direct referrals from its PEI program to its treatment program if an individual is identified as meeting medical necessity. In these circumstances, the individual may in fact experience no service provider transition. All VCCS staff have a directive to keep routine contact with school administrators and teachers regarding referrals and active cases. Staff members make routine calls to parents and solicit assistance from school personnel to schedule intakes for students who are screened and in need of services.

## E. Early Intervention Program: Early Intervention to Treat Psychosis

The Early Intervention to Treat Psychosis Project (EITP) was provided by Telecare Corporation. The EITP Project follows the evidence based Portland Identification and Early Referral (PIER) model, and provides an integrated set of promising practices designed to slow the progression of psychosis early in its onset.

### Project Outputs:

Thirty-eight (38) unduplicated individuals receiving EITP intervention services in FY 2016/17. Several of these individuals enrolled in the previous fiscal year. The following table shows the number of psychosis screenings completed during the fiscal year, the number of screenings that resulted in program eligibility, and the number of individuals and family members who participated in the program.

| | EITP Program |
|---|---|
| Number of early psychosis screenings completed | 36 |
| Number of screenings that resulted in program eligibility | 23 |
| Total unduplicated count of individuals receiving early intervention (includes participants enrolled in prior FY) | 38 |
| Number of family members who participated in program | 13 |

### Participant Demographics

All 38 participants were between the ages of 16-25. With regards to race, the largest proportion, 13 (34%) participants, identified as "other," and 13 (34%) identified as Mexican/Mexican American ethnicity. All 38 declared their primary language to be English. Thirty-five identified as heterosexual (93%); none were veterans. Twenty-six (32%) were female whereas 26 (68%) were male at birth, and 14 (37%) were currently female and 23 (61%) were currently male. Thirty-three (87%) lived in Stockton. A more detailed count of demographics is provided to MHSOAC in a secure confidential Excel file.

### Participant Outcomes

During the reporting period, 10 participants discharged from services, of those, three (30%) completed program objectives. It is important to note that EITP is a 2-year program and most participants served in FY 2016/17 were not expected to discharge during the year. Those who did discharge early were more likely to do so without completing their goals. It is anticipated that the proportion of individuals who discharge having completed program objectives will increase in subsequent years. Participants were assessed at intake and again at 12 months and at discharge. Twenty-two (22) of the participants were either in the program for 12 months or had discharged, and thus had a matched pre post assessment. Of those with matched pre and post assessments, 10 (45%) showed improvements in employment and education participation and 3 (14%) showed decline. Three participants were homeless at intake and two at 12 month or discharge. Four participants were arrested or incarcerated while in the program and 7 had been hospitalized for psychiatric reasons.

| EITP Program | # | % |
|---|---|---|
| Unduplicated individuals served | 38 | |
| Number of discharged clients | 10 | *26%* |
| Number who dischraged having completed program objectives or transitioned successfully to similar program | 3 | *30%* |
| **Number who showed changes at 12 month or discharge:** | | |
| Number of participants w/ matched 12-month assessments and/or discharge assessment | 22 | |
| Number who showed Improvement in employment and education | 10 | *45%* |
| Number who showed decline in employment and education | 3 | *14%* |
| Number who were homeless at intake | 3 | *14%* |
| Nmber who were homeless or unknown housing status at discharge | 2 | *9%* |
| Arrests/incarcerations between intake and discharge or 12 months | 4 | *18%* |
| Psychiatric hospitalizations between intake and discharge or 12 months | 7 | *32%* |

### Cost/Benefit Analysis

The following table shows several key indicators of performance for the EITP Project, including: costs of the project (represented by amount invoiced), cost per participant, and cost per individual having completed program objectives. Again, it is important to note that the program is designed to serve participants for two years. Most of the participants have been in services fewer than two years. Those who discharged in FY 2016/17 did so prior to expected discharge date. We therefore expect higher rates of program completion with positive outcomes in FY 2017/18 and beyond, as a greater number of participants reach their two-year anniversary. Cost per participant demonstrating improvement should be viewed as interim findings.

| | EITP Program |
|---|---|
| **Program Costs (i.e., $ invoiced by contractor)** | $526,429 |
| **Unduplicated individuals receiving early intervention** | 38 |
| ***Cost per individual receiving early intervention*** | *$13,853* |
| **Number of individuals discharging from program** | 10 |
| **Number of individuals exiting program having completed their objectives** | *3* |
| ***Cost per individual demonstrating improved outcomes*** | *$175,476* |

### Outreach for Increasing Recognition of Early Signs of Mental Illness Strategy

The EITP Project conducted 45 outreach presentations and events reaching a total of 822 potential responders.

| Outreach | |
|---|---|
| Number of individuals reached via outreach (i.e., potential responders) | 822 |
| Settings in which potential responders were engaged | |
| Mental Health/Behavioral Health | 4 |
| Other Social Service | 14 |
| Primary Health Clinics/Hospitals | 5 |
| Educational settings | 14 |
| Faith-based | 0 |
| Other | 8 |
| Total number of outreach presentations/events | 45 |
| Types of potential responders: general public; family members; legal support staff; employers | |

### Access and Linkage to Treatment Strategy

In FY 2016/17, PEI programs began tracking how many referrals were made to mental health treatment. In early FY 2016/17, SJCBHS and PEI contractors developed more comprehensive referral tracking policies, procedures, and data systems, and began tracking more comprehensive information on referrals and linkages to treatment and to other PEI programs in 4th quarter. Detailed data with demographic information is provided to MHSOAC in a secure confidential Excel file. The following is a summary of data on referrals from the EITP Project.

- The EIPT Project reported making 8 referrals to treatment in FY 2016/17.
- In the 4th quarter of the fiscal year, EITP reported it had referred 4 individuals to adult outpatient services for screening and assessment, and to determine eligibility for treatment.
- Two (2) of these individuals engaged in treatment, as defined by participating at least once in treatment. The average duration from referral to treatment was 171 days (s = 29.7)
- The average duration of untreated mental illness for the 4 referrals was 5.5 months (s=3.5)
- Due to the small sample, demographic information on referrals in included in the confidential supplemental file.

### Timely Access to Services for Underserved Populations Strategy

San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

- Four (4) treatment referrals were made for members of underserved populations (several met the criteria for underserved population in two or more demographic categories).

- Two (2) of the individuals from underserved populations participated in the program to which he/she was referred. The average duration from referral to treatment was 171 days (s = 29.7).

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

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

- If an individual does not qualify for EITP but still meets medical necessity, s/he is referred to treatment. Staff maintain contact until they begin receiving the services to which they were referred. Telecare also offers welcoming environment by having a bilingual (Spanish) receptionist who focuses on hospitality and building rapport at the initial visit. Telecare has a collaborative relationship with its partner organizations. Staff from these organizations who work with the EITP team to help them identify relevant resources and services.

## F. Access and Linkage to Treatment: Juvenile Justice Project

In FY 2016/17, the Juvenile Justice Project was delivered by San Joaquin County Behavioral Health Children and Youth Services (CYS). CYS provides behavioral health evaluations and and transition services for youth detained at San Joaquin County's Juvenile Justice Center (JJC).

### Project Outputs and Referrals to Treatment:

In FY 2016/17 CYS staff conducted 717 mental health evaluations of youth. Evaluations were conducted on all youth with high and medium MAYSI-II risk scores who were detained for 24 hours and all youth with low MAYSI-II risk scores who were detained for at least 5 days.

All evaluated youth, regardless of risk score, were offered brief behavioral health interventions while at the JJC. Of the 717 evaluated youth, 596 agreed to participate in behavioral health interventions.

During the year, 294 youth who were eligible for SJCBHS services (Medi-Cal recipients meeting medical necessity) were released from JJC to the community. Of those, 171 accepted the referral and 74 participated in treatment within 3 months of release.

During FY 2016/17, SJCBHS developed data systems to comply with state regulations. In FY 2017/18, in addition to reporting numbers referred to treatment, program will report demographics of those referred, duration of untreated mental illness, and duration from referral to treatment in the community. The program will also document the number of individuals from underserved populations who were referred to treatment and PEI programs, along with data on those who were linked to treatment. In order to document the impact of intervention activities occurring at the JJC for those detained for 60 days or longer, in FY 2017/18, the program will report reduction in risk factors and symptoms using the CANSA outcome instrument.

## G. Stigma and Discrimination Reduction Program: Community Trainings

In FY 2016/17, stigma and discrimination workshops and trainings were delivered throughout the County by National Alliance on Mental Illness San Joaquin (NAMI).

### Project Outputs:

A total of 1,067 individuals were reached through the Stigma and Discrimination Reduction Project in FY 2016/17. The following table shows the type and number of each of training/workshop offered and the number of individuals reached.

| | | Number of trainings/ workshops | Number of individuals reached |
|---|---|---|---|
| In Our Own Voice (IOOV) | 60-90 minute presentations by two trained speakers describing personal experiences living with mental helath challenges and achieving recovery | 55 | 987 |
| Family to Family (F2F) | 12-session educational program for family members of adults living with mental illness taught by trained teachers who are also family members. | 2 | 39 |
| Peer to Peer (P2P) | 10-session class to help adults living with mental illness challenges achieve and maintain wellness taught by Peer Mentors living in recovery | 2 | 27 |
| NAMI Basics | 6-session class for parents and caregivers of children and adolescents living with mental illness | 1 | 14 |

### Participant Outcomes

Following each presentation or series of classes, NAMI facilitators distributed evaluation forms with a set of retrospective Likert Scale items asking participants to rate the degree to which they agreed with certain statements. IOOV and F2F used one set of statements whereas P2P and Basics used a different set of questions. These statements were then distributed into two reporting categories identified by state regulations, namely, number of participants who showed positive change in attitudes, knowledge and/or behavior related to *mental illness*; and number who sowed positive change in attitudes, knowledge and/or behavior related to *seeking*

*mental health services.* Our analysis demonstrated that taking a weighted average of those participants who "agreed" or "strongly agreed" with each statement, 193.5 individuals (78%) showed positive change in statements related to mental illness and 208 (84%) showed positive change in statements related to seeking mental health services.

| | Because of the class or presentation…. | # of survey responses | # who "agreed" or "strongly agreed" | % |
|---|---|---|---|---|
| Items included in IOOV & F2F Survey | A: I am comfortable with the idea of working with someone who has a mental illness | 238 | 190 | 80% |
| | B: I do not believe mental illness is anyone's fault | 238 | 175 | 74% |
| | C: Recovery from Mental Illness is possible | 238 | 194 | 82% |
| | D: ndividuals have a right and an obligation to actively engage and question their treatment provider | 238 | 201 | 84% |
| Items included in P2P & NAMI Basics survey | A: I am better able to recognize the signs and symptoms of mental illness | 11 | 11 | 100% |
| | B: I am able to manage the stresses and negative impacts that the stigma of mental illness may cause | 11 | 11 | 100% |
| | C: I am better able to understand the type of services people with mental illness need. | 11 | 10 | 91% |
| | D: I am able to access the care and support servcies that I or my family members need | 11 | 11 | 100% |
| Number of responses that showed positive change in attitudes, knowledge and/or behavior of items *related to mental illness* (Items A&B, avove) | | | 193.5 | 78% |
| Number of responses that showed positive change in attitudes, knowledge and/or behavior of items*related to seeking mental health services* (Items C &D, above) | | | 208.0 | 84% |

## Outreach for Increasing Recognition of Early Signs of Mental Illness Strategy

The Stigma and Discrimination Reduction Project also involved an Outreach for Increasing Recognition of Early Signs of Mental Illness strategy. Potential responders were defined as those facilitating or teaching the presentations and classes. Since these classes focused primarily on stigma and discrimination, the participants were not considered potential responders. There were 20 teachers/facilitators. The following is a demographic breakdown potential responders. More detailed demographic information, including for demographic categories of fewer than 10 respondents, is included in the supplemental files. Eighty percent (80%) of facilitators were adults; the remainder were older adults. Sixty percent (60%) identified as white and 55% as European, all 20 spoke English as their primary language, 80% identified as heterosexual, 60% reported having a mental disability, none were veterans, 75% were female at birth and currently

identified as female and 60% lived in Stockton. All potential responders were either consumers and/or family members of mental health consumers.

Potential responders were engaged (i.e., presentations/classes were delivered) in the following settings

| Settings in which potential responders were engaged | |
|---|---|
| Family resource centers | 1 |
| Schools/Universities | 13 |
| Cultural organizations | 3 |
| Primary heatlh care or health clinics | 2 |
| Libraries | 1 |
| Support groups | 1 |
| Shelters | 3 |
| Behavioral healthcare provider offices | 30 |
| Residential Substance Abuse Treatment Center | 6 |
| Total | 60 |

### Access and Linkage to Treatment Strategy

In FY 2016/17, PEI programs began tracking how many referrals were made to mental health treatment. In early FY 2016/17, SJCBHS and PEI contractors developed more comprehensive referral tracking policies, procedures, and data systems, and began tracking more comprehensive information on referrals and linkages to treatment and to other PEI programs in 4$^{th}$ quarter. The Stigma and Discrimination Reduction Project made no referrals to treatment in FY 2016/17.

### Timely Access to Services for Underserved Populations Strategy

San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for

underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

- The Stigma and Discrimination Reduction Project made no referrals of underserved populations to PEI or behavioral health treatment.

The following are ways in which SJCBHS and the Stigma and Discrimination Project encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.
- NAMI teachers/facilitators announce and promote SJCBHS services in all classes and presentations.

## H. Outreach for Increasing Recognition of Early Signs of Mental Illness Program: Community Trainings

In FY 2016/17, Outreach for Increasing Recognition of Early Signs of Mental Illness was delivered by National Alliance on Mental Illness San Joaquin (NAMI) in the form of NAMI Provider Education. NAMI also offered Parents and Teachers as Allies Courses as part of this project but was unsuccessful attracting participants in FY 2016/17.

### Project Outputs and Participant Demographics

NAMI delivered a total of two 15-hour Provider Education classes. Classes were taught by a team consisting of an adult with mental illness, a family member, and a mental health professional.

In FY 2016/17 the Outreach Project reached a total of 35 unduplicated individuals. Including the three instructors, the total number of potential responders was 38 (potential responders refers to both trainers and trainees).

The settings in which potential responders engaged (i.e., classes were held) included behavioral healthcare offices and at and independent living center. The types of responders engaged in both settings all identified as behavioral health providers.

Of the 39 potential responders, 19 completed demographic forms. Eighty-nine percent (89%) identified as adults (age 26-59), 58% identified as white; 79% spoke English as their primary language; none were veterans; 74% identified as heterosexual; 63% identified as female; and 74% lived in Stockton. More detailed demographic information, including for demographic categories of fewer than 10 respondents, is included in the supplemental files.

### Access and Linkage to Treatment Strategy

In FY 2016/17, PEI programs began tracking how many referrals were made to mental health treatment. In early FY 2016/17, SJCBHS and PEI contractors developed more comprehensive referral tracking policies, procedures, and data systems, and began tracking more comprehensive information on referrals and linkages to treatment and to other PEI programs in 4th quarter. The Outreach for Increasing Recognition Project made no referrals to treatment in FY 2016/17.

### Timely Access to Services for Underserved Populations Strategy

San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

- The Stigma and Discrimination Reduction Project made no referrals of underserved populations to PEI or behavioral health treatment.

The following are ways in which SJCBHS and the Outreach for Increasing Recognition of Early Signs of Mental Illness Project encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.
- NAMI teachers/facilitators announce and promote SJCBHS services in all classes and presentations.

### Cost/Benefit Analysis

NAMI's community training programs reached a total of 1,105 individuals (1,067 from the Stigma and Discrimination Reduction Project and 38 from the Outreach for Increasing Early Recognition of Mental Illness Project). The cost of the combined Stigma/Discrimination and Outreach programs, as defined by total invoiced, was $31,538 or $28.54 per individual reached. Only a portion of the participants completed retrospective surveys to determine if there were changes in behaviors, knowledge or attitudes related to mental health or seeking behavioral health treatment, so it is impossible to measure the precise cost per person who demonstrated a positive change. Of those who were surveyed, however, between 78-84% showed positive change. If we extrapolate from these figures, we can estimate that approximately 884 (80%) of participants experienced knowledge gain or positive behavioral or attitudinal change, and therefore conclude that the cost per individual showing positive change was $35.68.

## Program Name: Suicide Prevention

In FY 2016/17, the Suicide Prevention Program was delivered in 12 San Joaquin County high schools by Child Abuse Prevention Council of San Joaquin County (CAPC). The program involved the evidence-based Yellow Ribbon (YR) Suicide Education Campaign and ancillary Be a Link Adult Gatekeeper and Ask 4 Help Youth Gatekeeper Trainings. In addition, CAPC provided SafeTALK workshops to youth over age 15 to assist in the recognition of individuals with suicidal thoughts and to connect them to mental health resources. The Suicide Prevention Project also included depression screenings, referrals, and school-based depression support groups.

### Project Outputs:

In FY 2016/17, the Suicide Prevention Project reached a total of 5,559 unduplicated individuals. The following table is a detailed breakdown of the number of individuals reached by program activities:

| **Numbers reached** (some counts are duplicated) | |
|---|---|
| Total reached | 5559 |
| Yellow Ribbon campaign messaging | 4891 |
| Depression Screening | 323 |
| *Be a Link*® Adult Gatekeeper Training | 60 |
| *Ask 4 Help*® Youth Gatekeeper Training | 190 |
| *Safetalk* Training | 107 |
| CAST Support Groups | 32 |
| Break Free from Depression Support Groups | 24 |

### Results of Depression Screenings:

The following table shows the outcomes of school-based depression screenings and the types of programs students were referred to. A more detailed description of referrals made in the 4th quarter is provided below and in the supplemental Excel file:

| Screening and Referrals | # | % |
|---|---|---|
| Number of Depression Screening | 323 | |
| Number of depression screenings indicating high risk | 46 | 14% |
| Number of depression screenings indicating moderate risk | 44 | 14% |
| Number of depression screenings indicating mild risk | 233 | 72% |
| Number of depression screenings referred to BHS for further assessment | 67 | 21% |
| Number of depression screenings referred to school-based depression group | 299 | 93% |
| Number who participated in school-based depression groups | 56 | 19% |

### Participant Outcomes

Retrospective surveys were delivered to all students who attended Yellow Ribbon Presentations. Of the 4,891 who received YR messaging, 3,838 (78.5%) reported increased knowledge of warning signs, risk and protective factors of suicide, and increased understanding of how to ask for help for themselves and others.

Retrospective surveys were also delivered to Adult and Youth Gatekeepers and Safe Talk workshop attendees. CAST and BFT group participants received pre post surveys, but insufficient matched responses (n=4) were collected to accurately measure outcomes. The following table illustrates outcomes for the four suicide prevention activities from which sufficient data was collected.

| Activity | Change Reported | # of surveys collected | # showing improvement | % |
|---|---|---|---|---|
| Yellow Ribbon campaign messaging | Increase in knowledge of warning signs, risk and protective factors of suicide and increased understanding of how to ask for help for self and others | 4891 | 3838 | 78% |
| *Be a Link*® Adult Gatekeeper Training | Increase in knowledge of warning signs of suicide, increased understanding of protocols for referring youth to helping resources, and increased knowledge of help resource | 60 | 52 | 87% |
| *Ask 4 Help*® Youth Gatekeeper Training | Increase in knowledge of warning signs of suicide and depression, increased knowledge of how to respond to those at risk and increased knowledge of local and community referral points and local resources. | 190 | 167 | 88% |
| *Safetalk* Training | Increase in ability to understand the dynamics of suicide, identify people who have thoughts of suicide and apply the TALK steps (Tell, Ask, Listen and Keep Safe). | 107 | 95 | 89% |

Note: insufficient matched pre and post surveys were collected to report outcomes of the school-based Breaking Free from Depression (BFD) and Coping and Support Training (CAST) support groups.

## Participant Demographics

Demographics are reported for participants of all Suicide Prevention activities.

| Demographics | Suicide Prevention | |
|---|---|---|
| Total reached | 5559 | |
| **Ages** | | |
| 0-15 | 2927 | 53% |
| 16-25 | 2269 | 41% |
| 26-59 | 69 | 1% |
| 60+ | 15 | 0% |
| Decline to answer | 347 | 6% |
| **Race** | | |
| American Indian or Alaskan Native | 80 | 1% |
| Asian | 880 | 16% |
| Black or African American | 410 | 7% |
| Native Hawaiian or other Pacific Islander | 156 | 3% |
| White | 880 | 16% |
| Other | 1674 | 30% |
| More than one race | 886 | 16% |
| Decline to answer | 728 | 13% |
| **Ethnicity** | | |
| Hispanic or Latino as follows: | | |
| Caribbean | 10 | 0% |
| Central America | 114 | 2% |
| Mexican/Mexican-American | 2150 | 39% |
| Puerto Rican | 40 | 1% |
| South American | 21 | 0% |
| Other | 137 | 2% |
| **Non-Hispanic as follows:** | | |
| African | 223 | 4% |
| Asian Indian/South Asian | 119 | 2% |
| Cambodian | 144 | 3% |
| Chinese | 93 | 2% |
| Eastern European | 65 | 1% |
| European | 209 | 4% |
| Filipino | 279 | 5% |
| Japanese | 51 | 1% |
| Korean | 13 | 0% |
| Middle Eastern | 107 | 2% |
| Vietnamese | 111 | 2% |
| Other | 329 | 6% |
| More than one ethnicity | 753 | 14% |
| Decline to answer | 714 | 13% |
| **Primary Language** | | |
| English | 3794 | 68% |
| Spanish | 1024 | 18% |
| Other | 433 | 8% |
| Decline to answer | 437 | 8% |

| | | |
|---|---|---|
| **Sexual Orientation** | | |
| Gay or Lesbian | 122 | 2% |
| Heterosexual or Straight | 4199 | 76% |
| Bisexual | 239 | 4% |
| Questioning or unsure | 57 | 1% |
| Queer | 34 | 1% |
| Another sexual orientation | 50 | 1% |
| Decline to answer | 931 | 17% |
| **Disability** | | |
| Communication - difficulty seeing | 428 | 8% |
| Communication - difficulty hearing & speech | 60 | 1% |
| Communication - other | 0 | 0% |
| Mental disability | 140 | 3% |
| Physical/mobility disability | 36 | 1% |
| Chronic health | 42 | 1% |
| Other | 77 | 1% |
| Decline to answer | 743 | 13% |
| **Veteran status** | | |
| Yes | 27 | 0% |
| No | 5084 | 91% |
| Decline to answer | 520 | 9% |
| **Gender assigned at birth** | | |
| Male | 2575 | 46% |
| Female | 2662 | 48% |
| Decline to answer | 391 | 7% |
| **Current Gender identity** | | |
| Male | 2495 | 45% |
| Female | 2581 | 46% |
| Transgender | 19 | 0% |
| Genderqueer | 12 | 0% |
| Questioning or unsure of gender identity | 16 | 0% |
| Another gender identity | 23 | 0% |
| Decline to answer | 406 | 7% |
| **Residence** | | |
| *Stockton* | 3259 | 59% |
| *Lodi* | 1113 | 20% |
| *Manteca* | 13 | 0% |
| *Tracy* | 757 | 14% |
| *Other* | 101 | 2% |
| *Decline to answer* | 386 | 7% |

### Cost/Benefit Analysis

The following table shows the cost per unduplicated individual reached by the Suicide Prevention Program as well as the cost per individual who demonstrated improvement. It is important to note that the number who showed improvement is a duplicated count, meaning that some individuals participated in more than one activity.

| | CAPC - Suicide Prevention |
|---|---|
| **Program Costs (i.e., $ invoiced by contractor)** | $445,423 |
| **Unduplicated individuals served** | 5559 |
| ***Cost per individual served*** | *$80.13* |
| **Number who showed improvement/positive change** | 4152 |
| ***Cost per graduate*** | *$107.28* |

### Access and Linkage to Treatment Strategy

In FY 2016/17, PEI programs began tracking how many referrals were made to mental health treatment. In early FY 2016/17, SJCBHS and PEI contractors developed more comprehensive referral tracking policies, procedures, and data systems, and began tracking more comprehensive information on referrals and linkages to treatment and to other PEI programs in 4th quarter. Detailed data with demographic information is provided to MHSOAC in a secure confidential Excel file. The following is a summary of data on referrals from the Trauma Services for Children program.

- CAPC reported having made 319 referrals to BHS for screening, assessment and possible treatment in FY 2016/17.
- In the 4th quarter of the fiscal year, a total of 23 individuals identified by the Suicide Prevention were referred to SJCBHS for screening and assessment, and to determine eligibility for treatment.
- Five (5) of these individuals were opened to SJCBHS services for treatment.

- Twenty-one (21) of the 23 individuals provided information on the duration of untreated mental illness. The average duration was 29 months (s = 64.8).

- Of the 5 individuals opened to SJCBHS service, the average duration between referral and treatment for the two for whom we have data was 159.5 days (s = 51.6)

- Due to the small sample, demographic information on referrals in included in the confidential supplemental file.

### Timely Access to Services for Underserved Populations Strategy

San Joaquin County has identified the following underserved populations. In some instances, these populations are represented in treatment, but less so in prevention and early intervention. A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental confidential file.

- A total of 17 referrals were made for members of underserved populations (several individuals referred met the criteria for underserved population in two demographic categories)

- Three (3) of the individuals who were members of underserved populations participated in the program to which he/she was referred.

The following are ways in which SJCBHS and the Suicide Prevention Program encourage access to services and follow through.

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

- As a result of a positive screening, youth are referred to a variety of mental health services, ranging in intensity from group to individual to crisis services. CAPC staff follow up with students 30, 60, and 90 days after a referral is made to ensure they receive the services and support they are in need of and that they are not forgotten about while they navigate the mental health system.

# XI. MHSA Funds Subject to Reversion

## A. Introduction and Overview

On December 28, 2017 San Joaquin County Behavioral Health Services (BHS) received Information Notice (IN) 17-059 from California Department of Health Care Services (DHCS) Mental Health & Substance Use Disorders Services (MHSUDS).

The purpose of Information Notice 17-059 was to inform counties of the following:

- The process the Department of Health Care Services (DHCS) will use to determine the amount of unspent Mental Health Services Act (MHSA) funds subject to reversion as of July 1, 2017;
- The appeal process available to a county regarding that determination; and
- The requirement that by July 1, 2018, counties have a plan to expend the reverted funds by July 1, 2020.
- Background and Local Impact for IN 17-059:

Assembly Bill (AB) 114 (Chapter 38, Statutes of 2017) became effective July 10, 2017. The bill amended certain Welfare and Institutions Code (WIC) Sections related to the reversion of MHSA funds. AB 114 implemented provisions concerning funds subject to reversion as of July 1, 2017. Funds subject to reversion as of July 1, 2017, were deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated (WIC Section 5892.1 (a)).

Funds that could be subject to reversion as of July 1, 2017, were distributed to counties from Fiscal Year (FY) 2005-06 through FY 2013-14, in a letter dated January 5, 2018.

**In San Joaquin County this includes $2,294,908 of Innovation funds as follows:**

| Fiscal year affected | Amount of reverted/ reallocated funds |
|---|---|
| FY 08-09 | $1,193,220 |
| FY09-10 | No funds identified |
| FY10-11 | $466,354 |
| FY11-12 | $27,076 |
| FY12-13 | $381,025 |
| FY13-14 | $227,233 |
| **Total:** | **$2,294,908** |

***No Community Services & Supports (CSS) funds or Prevention Early Intervention (PEI) funds are included in this calculation or at risk for reversion.***

## B. Requirements

By July 1, 2018, DHCS is required to prepare a report to the Legislature identifying the amounts of funds subject to reversion by county. Prior to releasing the report, DHCS is required to provide each county with the amount of funds they have determined are subject to reversion and a process for counties to appeal that determination (WIC Section 5892.1 (b)).

Additionally, by July 1, 2018, counties are required to have a plan to spend those funds by July 1, 2020 (WIC Section 5892.1 (c)). Pursuant to WIC Section 5892.1, subdivision (e), 1 DHCS provided counties with IN 17-059 to implement those requirements. Additionally, IN 17-059 supersedes all other reversion policies contained in past Information Notices developed by the former Department of Mental Health and DHCS.

Information Notice 17-059 specified the following instructions for counties to plan to spend the funds:

- Every county must develop a plan to spend its reallocated funds and post it to the county's website;*(This document constitutes the required Plan to Spend for San Joaquin County)*
- The county must submit a link to the plan to DHCS via email at MHSA@dhcs.ca.gov by July 1, 2018;
- Each county's Board of Supervisors (BOS) must adopt a final plan within 90 days of the county posting the plan to the county's website; *(BHS anticipates this will occur by June 2018)*
- Each county must submit its final Plan to Spend to DHCS and the MHSOAC within 30 days of adoption by the county's BOS; *(Anticipated to occur before June 30, 2018)*

A county may not spend funds that are deemed reverted and reallocated to the county until the county's BOS has adopted a plan to spend those funds;

The expenditure plan must account for the total amount of reverted and reallocated funds for all impacted FYs, as indicated in the applicable notice of unspent funds subject to reversion or in the final determination on an appeal;

The county must include the Plan to Spend in the County's Three-Year Program and Expenditure Plan or Annual Update, or as a separate plan update to the County's Three-Year Program and Expenditure Plan, and comply with WIC Section 5847(a*); (This document meets the requirement and is included in the Annual Update)*

Reallocated funds must be expended on the component for which they were originally allocated to the county. *(This only affects Innovation fund in San Joaquin County)*

## C. Summary of Reallocation Plan:

**BHS has adopted the following plans to spend reverted/reallocated Innovation funds:**

| Expenditure item* | Years to be spent | Amount to be spent | From Fiscal Year |
|---|---|---|---|
| Assessment and Respite Center | FY 2018-2019 | $3,348,803 | 2008-2009 |
| Progressive Housing | FY 2018-2019 | | 2010-2011 |
| Program Evaluation (both projects) | FY 2018-2019 | | 2011-2012 |
| | | | 2012-2013 |
| ***Total amounts for items were approved by the MHSOAC on January 25, 2018 and there is no expansion in this plan to spend.*** | | | |

This Plan accomplishes the following steps:

- Reconciles with DHCS the amount of funds that were reverted / reallocated to San Joaquin.
- Brings San Joaquin County in compliance with IN 17-059 by developing a plan to spend identified reverted/reallocated funds prior to June 30, 2020.
- Identifies guidelines for future expenditures of Innovation (INN) funds.
- Clarifies funds available for future planning processes utilizing funds from FY 2017-2018 forward.

## D. Local Review Process:

MHSA Plan to Spend Reverted/Reallocated Funds FY17-18 (MHSA Plan to Spend) was discussed with the San Joaquin County Behavioral Health Board on March 21, 2018 for clarification and input.

The MHSA Plan to Spend is available for 30-day public review and comment April 16, 2018 – May 16, 2018. Notification of the public review dates and access to copies of the document is made available through the following methods:

- An electronic copy was posted on the County's MHSA website: www.sjcbhs.org
- MHSA Stakeholders was e-mailed notification that the Annual Update with the MHSA Plan to Spend Reverted/Reallocated Funds is posted for review.
- Announcement to the public was made at the Behavioral Health Board Meeting on April 18, 2018

## E. Public Comment:

***To be added following the 30 day public review and comment period.***

# SAN JOAQUIN REVERSION CERTIFICATION

County/City: __San Joaquin County_____

| **Local Mental Health Director** | **County Auditor-Controller / City Financial Officer** |
|---|---|
| Name: | Name: |
| Telephone Number: | Telephone Number: |
| E-mail: | E-mail: |
| **Local Mental Health Mailing Address:** | |

I hereby certify that the Adjustments Worksheet 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.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached Appeal Worksheets are true and correct to the best of my knowledge.

_____ _____

Tony Vartan, Date
Mental Health Director

I hereby certify that for the fiscal year ended June 30, 2018, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City'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, _____ . I further certify that for the fiscal year ended June 30, 2018, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City 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 Date
County Auditor Controller

# XII. Appendix

1. Community Program Planning Meeting Announcements and Materials
2. Comments from the Stakeholder Planning Process

San Joaquin County Behavioral Health Services

# Transforming Mental Health Services

## Community Planning Meetings
## Mental Health Service Act (MHSA)
## Annual Update

The Mental Health Services Act (MHSA), intended to transform public mental health care for children, youth, adults and seniors. MHSA provides funding allocations for community mental health services in five program areas:

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

Please join us at one of the following community meetings to discuss the needs and opportunities to strengthen mental health services in San Joaquin County. These meetings will include an update on how MHSA funds are currently being used, as well as a chance to share your opinion and recommendations on how to expand or enhance programs and services. Your feedback is needed to inform next year's 2018-19 Program and Expenditure Plan.

*We are counting on your voice to help guide us!*

| Monday<br>February 26, 2018 | Tuesday<br>February 27, 2018 | Thursday<br>March 8, 2018 | Thursday<br>March 22, 2018 |
|---|---|---|---|
| 2:30 – 4:30 pm | 2:30 – 4:30 pm | 2:30 – 4:30 pm | 5:30 – 7:30 pm |
| Public Health<br>Conference Room<br>1601 E. Hazelton Avenue<br>Stockton, CA 95205 | Robert J. Cabral<br>Agriculture Center<br>2101 E. Earhart Ave.<br>Stockton, CA 95206 | Dorothy L. Jones<br>Cuff Center<br>2044 Fair St.<br>Stockton, CA 95206 | BHB Meeting at<br>Tracy Library<br>20 E. Eaton Ave.<br>Tracy, CA 95376 |

Meeting accessibility is important. Please contact us at 209-468-8750 to discuss accessibility questions. All meetings are held in accessible locations. Translation assistance is available upon request. Families are welcome.

Please post this notice in a public location and distribute via your mailing lists.
Thank you for passing this invitation along.

San Joaquin County Behavioral Health Services

# Transforming Mental Health Services

## Community Planning Meetings
## Mental Health Service Act (MHSA)
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*We are counting on your voice to help guide us!*

| **Monday**<br>**March 12** | **Thursday**<br>**March 15** |
|---|---|
| 10:00am – 11:30am | 10:00am – 11:30am |
| **Martin Gipson Socialization Center**<br>405 E. Pine Street<br>Stockton, CA 95204 | **The Wellness Center**<br>1109 N. California St.<br>Stockton CA 95202 |

Meeting accessibility is important. Please contact us at 209-468-8750 to discuss accessibility questions. All meetings are held in accessible locations. Translation assistance is available upon request. Families are welcome.

Please post this notice in a public location and distribute via your mailing lists.
Thank you for passing this invitation along.

SAN JOAQUIN COUNTY

*Greatness grows here.*

# MHSA Annual Update

## 2018 Community Presentation

# Mental Health Services Act (MHSA)

## Funding Components

- **Prevention and Early Intervention**
- **Innovation**
- **Community Services and Supports**
- **Workforce Education and Training**
- **Capital Facilities and Technology Needs**

San Joaquin County
mhsa
Mental Health Services Act

# Overview of Prevention and Early Intervention (PEI Activities and Services)

**16/17 PEI Budget = $ 5.7M**

- Community Based Organizations (60%)
- County Partnership Programs (40%)

- Suicide Prevention & Community Trainings (15%)
- Direct Services & Interventions (85%)

- School-based Programs (26%)

# 2016/17 Prevention Activities

| PEI Programs | Participants | Number completed / Improvement shown |
|---|---|---|
| Parenting Classes | 1,928 (at least 1 class) | 747 / 77% improved in parenting skills |
| Youth Mentoring | 419 youth (enrolled) | 261 / 72% improved life skills & functioning |
| Trauma Services for Children (TF-CBT) | 300 children (at 66 elementary schools) | 103 / 70% reduced trauma symptoms |

| Community Trainings | Venue | Number Attending |
|---|---|---|
| Trauma Trainings | 66 Elementary Schools | 1,714 educators |
| Signs and Symptoms | 45 Schools, clinics, CBOs and other settings | 822 potential responders |
| Stigma & Discrimination | 60 Schools, shelters, clinics and other settings | 1,067, students, clinic staff, and care givers |

# 2016/17 Suicide & Trauma Prevention Activities

| Trainings | Venue | Number Attending |
|---|---|---|
| Yellow Ribbon Suicide Prevention Presentation | Schools | 4,891 Students<br>*78% increased knowledge* |
| *Be a Link* Adult Gatekeeper Training | Schools | 60 School Personnel<br>*87% increased knowledge* |
| *Ask 4 Help* Youth Gatekeeper Trainings | Schools | 190 Youth<br>*88% increased knowledge* |
| *Safetalk (Tell, Ask, Listen, and Keep Safe)* | Schools | 107 Youth<br>*89% increased knowledge* |

| Screenings | | School-based Services for Youth | |
|---|---|---|---|
| Depression | 323 | Support Groups | 56 |
| Trauma | 641 | Trauma Focused CBT | 300 |

# Additional Prevention & Early Intervention

- **Early Interventions to Treat Psychosis**
- **Mandated Programs**
  - Probation / JJC
  - Child Welfare Services
- ***Providing early and very intensive interventions to at-risk children, youth, and their families.***

# New or Potential PEI Programs

## Launching:

- Family Therapy
- Trauma Response for Victims of Human Trafficking

## Under Consideration:

- Triage and/or Case Management
- Brief Treatment Interventions

## Planning:

- Child Family Teams
- Peer Navigators

## BHS Target Populations for PEI:

- Hispanic/Latino
- Asian / Filipino
- Black / African American
- American Indian
- LGBTQ
- Transitional Age Youth
- Older Adults
- Homeless
- Veterans
- Non-English Speaking

# PEI Planning Questions

**Thinking about the summary of PEI activities and services, what recommendations do you have to strengthen or expand PEI programming?**

- **Are projects on the right track?**
- **What do you think is missing?**
- **What target populations need more services?**

# Innovation (INN) [INN planning is closed]

**Launching in 2018!**

**Approved by MHSOAC**

- Progressive Housing ($6M)
- Assessment and Respite Center ($11M)

**Appreciations:**

- Supervisor Villapudua, Supervisor Miller, Michael Fields, Karen Ivy, Tasso & Gertie Kandris, Cary Martin,

# Additional MHSA Activities [no funds available]

## Workforce Education & Training (WET)

- Clinician Supervision and Training
- Psychiatric Consultation
- Medication Assisted Treatment

Needs:

- Staff Trainings

## Capital Facilities & Technology Needs (CF/TN)

- Completing CSU Addition
- Electronic Health Record

Needs:

- Website / Client Portal
- Expand 24/7 Services
- Residential Programs

# Overview of Community Service and Supports (CSS) Programs and Services

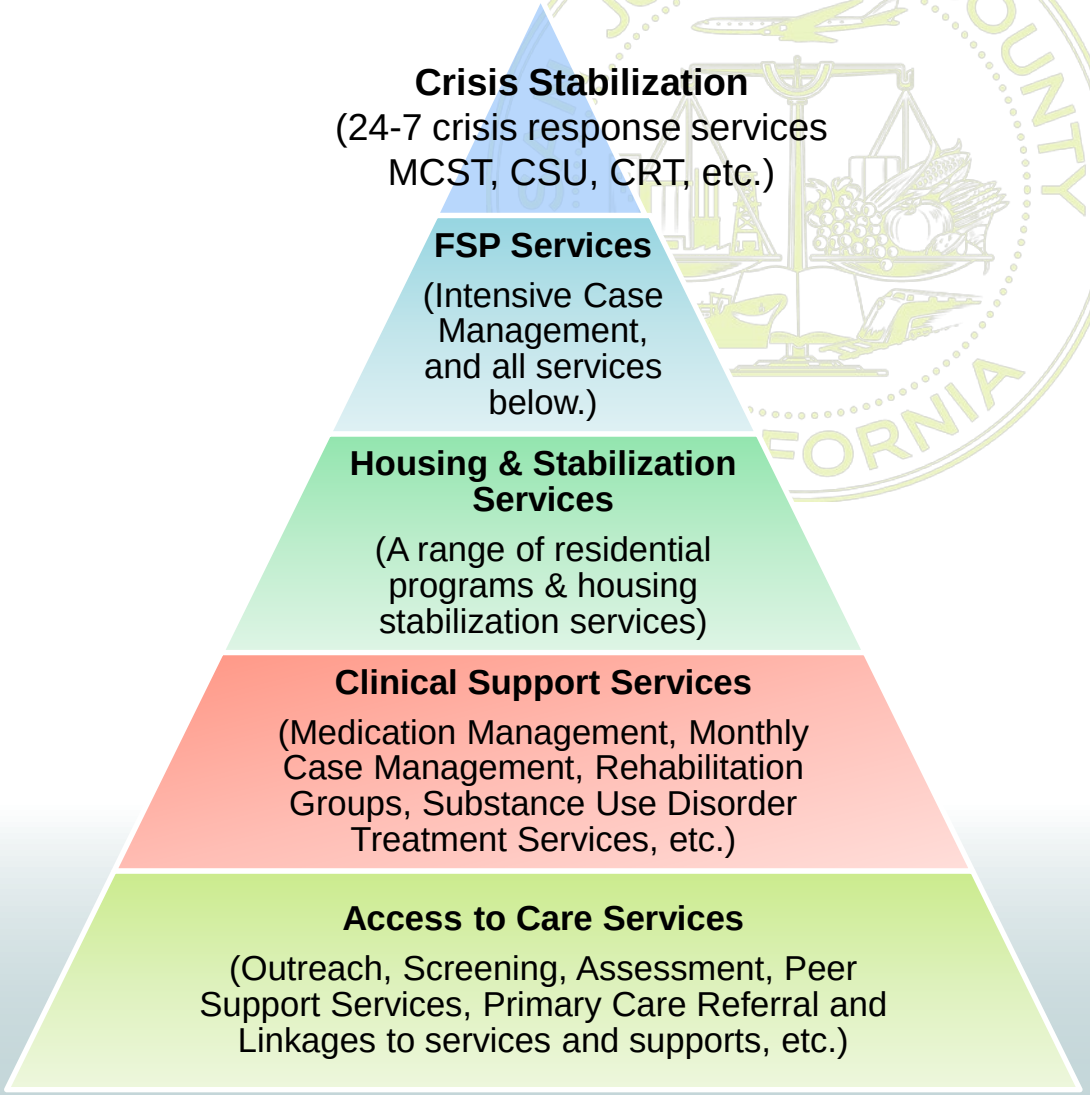
- Full Service Partnership Programs
- Housing, Residential Programming
- Crisis and Mobile Response
- Other Services and Supports
  - Outreach and Engagement Services to Underserved Communities
  - Case Management for non FSP-Clients
  - Peer wellness, Warm Line, and Socialization Programs
  - Employment and Life Skills Development

# Outpatient Continuum of Care

**Mental Health Services Act Goals:**

***Expand and Enhance Treatment Services in order to:***

- ***Reduce long term adverse impacts of mental illness***
- ***Reduce the incident and duration of untreated mental illnesses***
- ***Improve access to services for unserved and underserved populations***
- ***Create services that are recovery-oriented, consumer driven, & community-based***



# CSS Planning Questions

**Thinking about the summary of CSS Programs and Services, what recommendations do you have to strengthen or expand CSS programming?**

- **Are projects on the right track?**
- **What do you think is missing?**
- **What target populations need more services?**

# Next Steps:

- **Continued Data Analysis**
  - Utilization Data
  - Disproportionalities
- **Community Meetings**
- **Focused Discussion Groups**
  - Children and Youth Services
  - Adult Services
  - Housing and Homelessness Services
  - Substance Use and Co-occurring Disorder Treatment Services
- **Consumer Input**
  - Surveys
  - Focus Groups

Consumer Focus Groups:
- 3/ 12/18 Martin Gipson Socialization Center
- 3/15/18 Wellness Center

# Closing and Final Input

**via e-mail:** mhsacomments@sjcbhs.org

**or:** kaycerane@ranecd.com

- Do you want to host a meeting of stakeholders?
- Can you host a focus group of consumers or family members?
- Can you help coordinate the distribution of surveys?

## Upcoming Dates:

- **Upcoming Community Meetings 2/26, 2/27, 3/8**
- **March 22, 2018 – Next Presentation to BH Board**

## Final Activities:

- **Make sure you signed-in, and we have your contact info**
- **Complete the Demographic and Meeting Feedback forms**

# San Joaquin County Behavioral Health Services
# Community Program 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
- ☐ Housing or housing services provider
- ☐ Advocate
- ☐ Other: _____

What is your race ethnicity?
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Southeast Asian
- ☐ Other Asian or Pacific Islander
- ☐ American Indian/Native American/First Nations (including Hawaiian and Alaskan Native)
- ☐ Mixed Race: _____
- ☐ Other: _____

**Please return to facilitator** upon concluding the meeting. The demographic information is confidential. Your name WILL NOT be connected to your response.

# San Joaquin County Behavioral Health Services
# Proceso de Planificación de Programas Comunitarios

En acuerdo con las directrices del estado de California, debemos reportar información demográfica de participantes del plan. Esta información se mantendrá confidencial y se usara con fines informativos. Usted puede negarse a responder estas preguntas.

- ☐ Yo me niego a responder estas preguntas demográficas

Por favor indique su rango de edad:
- ☐ Menor de 18
- ☐ 18-25
- ☐ 26-59
- ☐ 60 o mayor

Por favor indique su genero:
- ☐ Masculino
- ☐ Femenino
- ☐ Transgenero

Por favor indique el idioma principal que es hablado en su hogar:
- ☐ Ingles
- ☐ Español
- ☐ Otro: _____

Afiliacion de consumidor (marque todos los que apliquen)
- ☐ Cliente de salud mental/consumidor
- ☐ Familiar de un consumidor de salud mental

Afiliacion de Intereses (marque todas las que aplican)
- ☐ Personal del condado del departamento de salud mental
- ☐ Proveedor de servicios de abuso de sustancias
- ☐ Proveedor de servicios de salud mental comunitarios/ sin fines lucrativos
- ☐ Organizacion comunitaria (no un proveedor de servicios de salud mental)
- ☐ Servicios de niños y familias
- ☐ Proveedor de educacion k-12
- ☐ Orden publico
- ☐ Servicios para Veteranos
- ☐ Servicios para personas mayores
- ☐ Proveedor de Hospital/cuidado de salud
- ☐ Proveedor de vivienda/servicios de vivienda
- ☐ Defensor
- ☐ Otro: _____

¿Cual es su raza etnica?
- ☐ Blanco/Caucasico
- ☐ Negro/Afro-Americano
- ☐ Hispano/Latino
- ☐ Asiatico Sudeste
- ☐ Asiatico o Isleño del Pacifico
- ☐ Indigena Americano/Indio Americano/Primeras Naciones (incluyendo Hawaino y Nativo de Alaska)
- ☐ Raza Mesclada: _____
- ☐ Otro: _____

**Por favor regrese al facilitador** una vez que haiga concluido la junta. La información demografica es confidencial. Su nombre NO sera conectado a su respuesta.

**Feedback Form:**
**San Joaquin MHSA Planning 2018**

| |
|---|
| Overall, how well did this meeting meet your expectations? (Please check one)<br>☐ Very Well ☐ Well ☐ Slightly ☐ Not At All |
| What about this meeting worked well? |
| How would you improve this meeting? |

**Feedback Form:**
**San Joaquin MHSA Planning 2017**

| |
|---|
| Overall, how well did this meeting meet your expectations? (Please check one)<br>☐ Very Well ☐ Well ☐ Slightly ☐ Not At All |
| What about this meeting worked well? |
| How would you improve this meeting? |

**Forma de Comentarios:**
**Planificación de San Joaquín MHSA 2018**

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| |
|---|
| ¿En general, que tan bien a cumplido con sus expectativas esta junta? (Por Favor Marque Uno)<br>☐ Muy Bien ☐ Bien ☐ Un Poco ☐ Para Nada |
| ¿Que parte de esta junta funciono bien? |
| ¿Como mejoraría usted esta junta? |

**Forma de Comentarios:**
**Planificación de San Joaquín MHSA 2018**

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| |
|---|
| ¿En general, que tan bien a cumplido con sus expectativas esta junta? (Por Favor Marque Uno)<br>☐ Muy Bien ☐ Bien ☐ Un Poco ☐ Para Nada |
| ¿Que parte de esta junta funciono bien? |
| ¿Como mejoraría usted esta junta? |

**San Joaquin County Mental Health Services Act (MHSA) Community Program Planning Process**
**2018 Stakeholder Input and Recommendation Form**

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**Section I. Prevention and Early Intervention (PEI)**

1. **Based on the summary of PEI Activities and Services, how well do you think programming is responding to the prevention and early intervention needs of the community?**

2. **Based on your knowledge of the community, and understanding of Prevention and Early Intervention programming funds, what issues or challenges should BHS be looking at for further investments?**

3. **Thinking about the recommendations you have made above, do you have any further thoughts on target populations that we should be addressing? If possible, tell us a little more about this population and why more PEI services are needed.**

**San Joaquin County Mental Health Services Act (MHSA) Community Program Planning Process**
**2018 Stakeholder Input and Recommendation Form**

**Section II. Community Services and Supports (CSS)**

1. **Based on the summary of CSS Services, how well do you think programming is responding to the treatment needs of people with serious mental illnesses?**

2. **Based on your knowledge of the needs experienced by people with mental illnesses, and understanding of Community Services and Supports programming funds, what treatment or service areas should BHS be looking at for further investments?**

3. **Thinking about the recommendations you have made above, do you have any further thoughts on target populations that we should be addressing? If possible, tell us a little more about this population and why more CSS services are needed.**

**2018 MHSA Community & Stakeholder Planning Process for**
**FY 18/19 Annual Update**
**Issue Resolution Log**

| Issue or Challenge | Date | Resolution | Date |
|---|---|---|---|
| | | | |
| Several people suggested that more time be given for the meeting | Feb 21 | This meeting was held during a scheduled BHB meeting. One hour was allotted for discussion. For the follow-up discussion with the BHB in March, 1.5 hours were allotted for discussion. | March 2018 |
| Two people recommended that snacks be served at community meetings. | Feb 26 | Snacks were provided at the meetings that were targeted to consumers. Snacks including a meat and cheese platter, beverages, crackers, and donuts were provided. | March 2018 |
| One person recommended providing questions in advance so attendees can be prepared with quality responses. | Mar 8 | For a subsequent meeting targeting education professionals, questions were provided in writing to participants so that they would be prepared for responses | March 2018 |
| Conflicting feedback was received about time spent prior to each meeting on training on the mental health services act, what it is and how funds are used. Some wanted more information about how programs worked and impact. Others wanted more time to talk about issues. | March 2018 | For future meetings more time will be spent checking in with meeting participants about expectations. "Training" time will be tailored to the needs of the audience. | April 2018 |
| Several participants requested that special presentations be made to the staff or participants of a particular organization. | March 2018 | List of requested presentations was forwarded to BHS Administration for consideration and scheduling. | April 2018 |