

**San Joaquin County Behavioral Health Services
Assessment and Respite Center**

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Instructions:

The MHSA Innovation Component requires counties to design, pilot, assess, refine, and evaluate a “new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges” (Welfare and Institutions Code Section 5830, subdivision (c)). The eventual goal is for counties to implement successful practices without Innovation Funds and to disseminate successful practices to other counties. In this way, the Innovation Component provides the opportunity for all counties to contribute to strengthening and transforming the local and statewide mental health system and contributes to developing new effective mental health practices. (Mental Health Services Oversight and Accountability Commission, Innovative Projects Initial Statement of Reasons)

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Acronyms Used in This Document

AOD	Alcohol or Drug (Counselors)
ARC	Assessment and Respite Center
ASAM	American Society for Addiction Medicine
BHCE	(UC Davis) Behavioral Health Center for Excellence
BHS	(San Joaquin County) Behavioral Health Services
CANSA	Child and Adult Needs and Services Assessment
CATS	(BHS) Community Adult Treatment Services
CBO	Community Based Organization
CCHC	Community Clinics and Health Centers
CCR	California Code of Regulations
CIBHS	California Institute of Behavioral Health Solutions
CMC	Community Medical Centers
CPP	Community Program Planning (process)
CRDP	California Reducing Disparities Project
CSS	Community Services and Supports (an MHS funding category)
CVLIHC	Central Valley Low Income Housing Corporation
FQHC	Federally Qualified Health Center
FSP	Full Service Partners (an MHS funded program)
FTE	Full Time Employee
HUD	US Department of Housing and Urban Development
INN	Innovation (an MHS funding category)
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning/Queer
MCST	Mobile Crisis Support Team
MHP	County operated Mental Health Program
MHS	(local) Mental Health Services
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
NP	Nurse Practitioner
PA	Physician's Assistant
PEI	Prevention and Early Intervention (an MHS funding category)
SAMHSA	(US) Substance Abuse and Mental Health Services Administration
SAS	(San Joaquin County) Substance Abuse Services Division
SBIRT	Screening, Brief Intervention, Referral to Treatment
SJC	San Joaquin County
SMI	Serious Mental Illness
SPD	Stockton Police Department
SSHH	Stockton Self Help Housing
WET	Workforce Education and Training (an MHS funding category)
WIC	(CA) Welfare and Institutions Codes

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Part I: Project Overview

The Innovation Component of the Three-Year Program and Expenditure Plan or Annual Update shall include the reasons that this purpose is a priority for the County for which there is a need for the County to design, develop, pilot, and evaluate approaches not already determined as successful within the mental health system. *CCR Title 9, Division 1, Chapter 14, Sect. 3930(c)(2)*

1. Primary Problem

- a) What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

Too many individuals are not receiving needed mental health services, even after requesting assistance, because there are significant barriers that prevent entry throughout the screening, assessment and referral process.

Primary problem or challenge

San Joaquin County Behavioral Health Services (BHS) believes that individuals with unaddressed mental health concerns, and particularly those with co-occurring substance use disorders, require a warm and inviting place to learn about services, contemplate recovery options, and to receive a comprehensive, culturally sensitive, and client-focused assessment of needs. However instead of this ideal, many consumers and family members report having high levels of confusion surrounding how to “get into” mental health services, which can be discouraging and may result in individuals not getting needed services and supports. Existing mental health assessment processes are also onerous and emotionally draining requiring multiple visits and the sharing of complex (and oftentimes painful) stories.

Perhaps as a result of these challenges, there are high rates of disproportionalities and underutilizations within San Joaquin County’s mental health system of care (see *Key Findings*, pages 7-9, below). This is especially true for very vulnerable populations who, in addition to belonging to racial, ethnic, or cultural groups that are traditionally underserved, also struggle with substance use or have other chronic concerns such as homelessness and/or frequent law enforcement contact. Finally, there are also barriers in accessing services for individuals that are under the influence of alcohol or drugs at the time of the assessment; which can result in incomplete or inaccurate assessments. These challenges combine to create **significant barriers to entry into the mental health system of care for vulnerable and underserved populations**, whereby many of those needing some level of mental health services and supports often have difficulty accessing services due to challenges experienced in seeking treatment services or completing the assessment process.

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County Overview

San Joaquin County, located in California’s Central Valley, is a vibrant community of just over 700,000 individuals, with a diverse population. English is spoken by more than half of all residents, though 170,000 residents are estimated to speak

Race Ethnicity in San Joaquin County	Rate
White (not Hispanic or Latino)	33%
Hispanic or Latino	41%
Asian	16%
African American	8%
Two or More Races	2%
Total	100%

Spanish as their first language. Tagalog, Cambodian, Chinese, Hmong, and Vietnamese are also spoken by large components of the population (approximately 6,000 – 9,000 residents for each language group). *Source: San Joaquin Council of Governments*

The median income of San Joaquin County is \$53,700 with 18.6% of all residents living below the federal poverty level – the average income amongst residents living in poverty is \$11,500 annually (defined as individuals whose incomes fall within the bottom 20% of all residents). Economic and employment gains following the Great Recession continue to lag in San Joaquin County compared to the rest of the State with unemployment at 7.3% in June 2017 compared to 4.7% for California and 4.5% for the nation during the same period. San Joaquin County has the highest unemployment rate of any large county (with a population over 700,000) in California. *Source: CA Employment Development Department*

There are also high rates of homelessness in San Joaquin County. Addressing, ameliorating, and preventing homelessness is one of the strategic priorities adopted by the San Joaquin County Board of Supervisors in 2017. The 2017 Point-in-Time count of sheltered and unsheltered homeless individuals and families occurred in January 2017, in accordance with national guidelines issued by the US Department of Housing and Urban Development (HUD). The Point in Time count identified over 1500 homeless individuals, and a 6% increase in the number of homeless individuals that are unsheltered. Chronically homeless individuals account for nearly 20% of the homeless population and over 250 individuals were identified living on the streets and chronically homeless. Thirty percent of homeless individuals self-reported having a mental health concern. This rate is consistent with national findings for the prevalence of mental illness amongst the homeless. However law enforcement, community groups, and homeless advocates report that behaviors such as lack of hygiene and disorganized thinking lead them to think that there may be higher rates of mental illness amongst the chronically homeless, though this has not been verified.

San Joaquin County has the second highest crime rate of all California Counties. Approximately 100 individuals are booked into the County Jail each day. San Joaquin County Sheriff estimates that 40% of the individuals detained in the jail annually have a behavioral health concern. Unfortunately, due to staffing shortages amongst the correctional health team only those with the most serious mental illnesses are engaged by a mental health professional while detained. The SJC Sheriff estimates that the majority of justice involved individuals detained with a behavioral health concern are released without a treatment plan. Many of these are repeat, non-serious offenders, with frequent arrests for nuisance violations such as disturbing the peace. It is presumed that many have co-occurring disorders that

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would best be served through treatment, not incarceration, but without a process to complete a validated mental health assessment actual mental health status remains undetermined.

Key Findings from the Needs Assessment

In 2016, the MHSA Planning Stakeholder Steering Committee charged BHS to conduct a planning process that focused on addressing the needs and concerns of adults with mental health disorders that have co-occurring disorders, are homeless or at risk of homelessness, or have frequent justice encounters associated with untreated behavioral health concerns. Needs and challenges were shared by consumers, family members, and community stakeholders during public meetings, interviews, and focus groups. The findings and recommendations are listed below. A summary of the CPP is described below in Part 2: Additional Information for Regulatory Purposes.

BHS serves nearly 16,000 individuals annually. The organization’s strategic priorities are increasing access to services, reducing the criminalization of the mentally ill, and improving treatment services. Adults ages 25-59 account for more than 50% of mental health service users. Approximately half of all service recipients are male and half are female. Non-Hispanic Whites account for 38% of all consumers, followed by Hispanics (24%), African American (19%), and Asian (11%).

Through the needs assessment phase of the Community Program Planning process, BHS discovered that more work is needed to improve access to services amongst unserved and underserved populations:

Finding 1: *High utilization of emergency and crisis mental health services by African Americans*

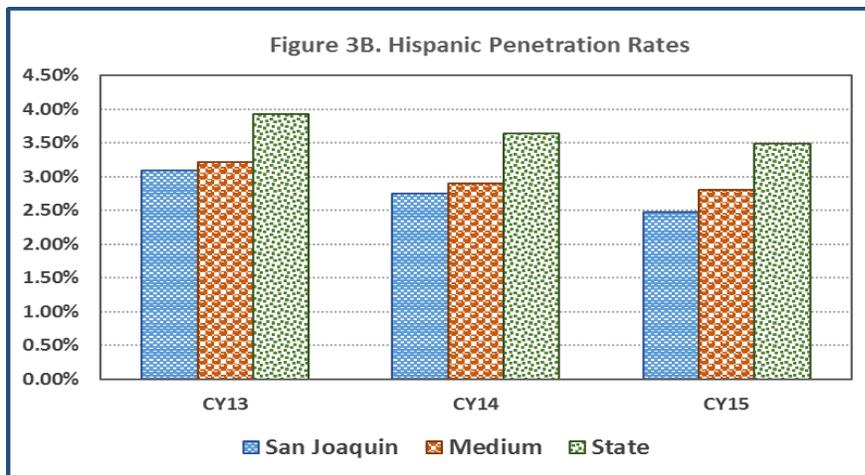
Comparison of BHS Services Utilization by Race/Ethnicity				
All Services vs. Crisis Services only				
	African American	Asian	Hispanic	White
% of All Mental Health Service Users	19%	11%	24%	38%
% of Crisis Service Users	25%	8%	18%	41%
Disproportionality	6% more	3% more	6% less	3% more

African Americans are some of the highest users of acute care services and account for 25% of all crisis and 20% of mobile crisis response team users compared to being 19% of mental health users and 8% of the general population. African Americans also represent 50% of the users in BHS’s homeless mental health programs (Allies and Allies/SOAR) and InSPIRE services, an FSP program for very high service utilizers. Finally, African Americans are also generally overrepresented in other county systems included in the local jail, juvenile detention center, and the foster care system. They also have higher rates of poverty, unemployment and crime victimization, suggesting that various social determinants of health may be negatively impacting the health and wellbeing of African Americans in San Joaquin County.

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Finding 2: *Low engagement in mental health services by Hispanics*

Statewide nearly 5% of Medi-Cal beneficiaries receive mental health related services and supports. However, the rate of enrollment in mental health services is significantly lower in San Joaquin County suggesting that there are a significant number of individuals with a mental illness who are unserved by the mental health system of care. Amongst all Medi-Cal beneficiaries statewide, Hispanics appear in general to underutilize mental health services, but are even more underrepresented in San Joaquin County. Only 2.5% of Hispanic Medi-Cal beneficiaries receive public mental health services for a serious mental illness – significantly lower than anticipated treatment rates given the prevalence of the mental illnesses in the general population. BHS program managers understand that stigma with regards to accessing mental health services may be a contributing factor but also acknowledge that more work is needed to improve the cultural competency of the service delivery system.



(Source, San Joaquin County External Quality Review Report. Oct. 2016)

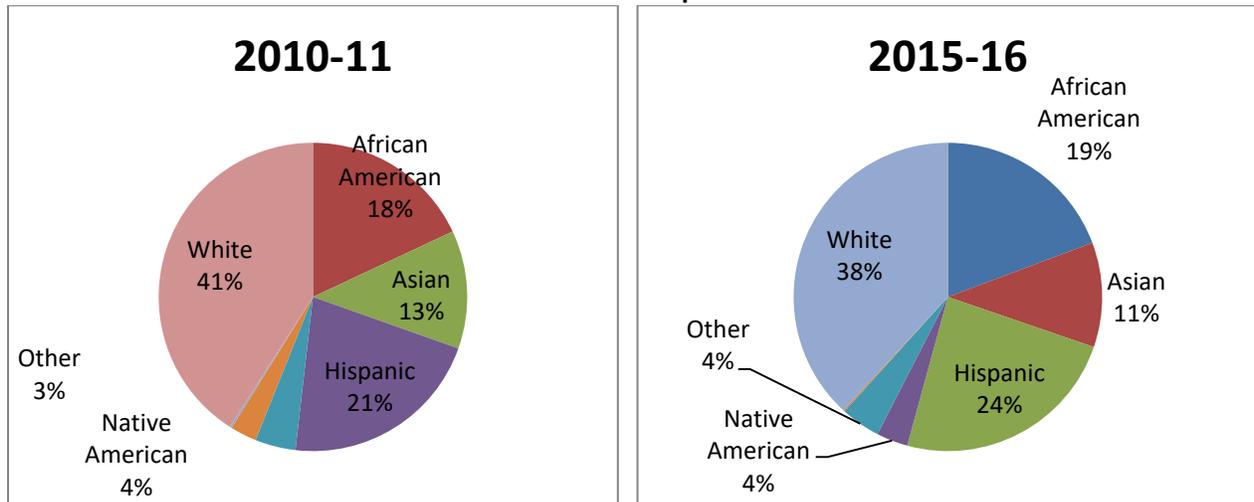
Finding 3: *A range of efforts by BHS to reduce racial and ethnic disparities have made little progress.*

Despite concerted efforts on the part of program managers, staff, and community partners to reduce racial and ethnic disparities in the mental health system of care there have been few improvements to date. BHS has created culturally specific outreach and engagement teams (using a *Promotores* model), created new neighborhood based clinics, and implemented a range of cultural trainings for staff and capacity building programs for community based organizations. However, despite these efforts there has been little change over time in service utilization when looking at either the total proportion of clients served or the rate at which mental health services are provided.

See chart below.

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**Total Number Served by BHS:
A Five Year Comparison**



Finding 4: *Homeless individuals represent only a scant portion of the individuals receiving treatment services, despite high counts of homelessness in the county.*

The 2017 Point in Time Homelessness Count found that 30% of the over 1500 homeless individuals counted (n=600) self-identify as having a mental health concern. However BHS data shows that only 108 of the adult clients receiving Full Service Partnership (FSP) services had been in a shelter or were homeless in the past year – indicating that many of the homeless individuals who self-identified as having a mental health concern are probably not receiving needed services.

The BHS homeless outreach team seeks to engage homeless individuals into services, enroll them into Medi-Cal benefits, and provide mental health treatment services. While there have been good client outcomes, program enrollment numbers remain low. Case managers attest that challenges associated with substance use disorder and homelessness can impede the assessment and enrollment process. According to the program manager *“staff work hard, but sometimes it’s difficult because after you have been working with an individual gaining their trust something will happen, like maybe a sweep will come through, and then they are gone and you can’t find them again. And when we try to do an assessment it can be complicated, because they are often intoxicated and it is difficult to assess whether their condition is due to a mental health concern or a substance use disorder, or both.”*

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Finding 5: *There is insufficient access to mental health services amongst individuals with non-serious or nonviolent offenses who are identified as having behavioral health concerns.*

A group of local stakeholders¹ convened in January 2017 as a component of the Community Program Planning (CPP) process to investigate access to care for non-serious, nonviolent offenders and identify major systemic barriers. The most significant barrier identified included difficulty “passing the assessment” as many individuals are told that they are not “high acuity” enough for services, despite studies suggesting that many offenders have trauma related disorders contributing to offending behavioral and substance use². The San Joaquin County Jail reports that there are several hundred individuals that are booked into the jail on a fairly regular basis for disorderly conduct who have never received a full mental health or substance use disorder assessment. Assessments are not routinely conducted in jail unless there is a clear indication of psychosis or suicidality. Instead most of those arrested for disorderly conduct are instructed to “sleep it off,” and are released without any further assessment. But law enforcement officials are concerned that many of those arrested may have undiagnosed underlying mental health conditions that are contributing to their offending behaviors and/or substance use. These individuals are also more likely to be African American or Latino, both of whom are underserved by behavioral health services and overrepresented in the criminal justice system.

Finding 6: *Systemic challenges, associated with the assessment process, impede access to services for unserved and underserved populations.*

The most significant finding of the needs assessment process is that systemic barriers (and not a lack of services or a disinclination on the part of individuals to receive treatment services) pose the greatest challenges to would-be-consumers who try to access services. Three systemic challenges were highlighted by the planning group as important to address:

Challenge 1: *In California mental health treatment services are available through two separate health systems which have duplicative (but typically non-transferable) assessment processes.*

One challenge in accessing mental health treatment services for low-income residents of San Joaquin County who have Medi-Cal benefits is that California has developed a bifurcated³ mental health system – with some mental health treatment services offered through primary care physicians and others offered through a public mental health system, operated by County Mental Health Departments. In theory this keeps the focus of public mental health departments on the treatment needs of individuals

¹ The Local Advisory Committee (LAC) was convened to support both the MHS Community Program Planning Process and program planning for a Proposition 47 grant released by the California Board of State and Community Corrections. The LAC was comprised of representatives from local government agencies, community based organizations, local health clinics, law enforcement agencies, and various consumers and family members with lived experience.

² Ardino, V. (2012) Offending Behavior: The Role of Trauma and PTSD. *European Journal of Psychotraumatol.* 2012; 3: 10.3402/ejpt.v3i0.18968. Published online July 20, 2012.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3402156/>

³ Bifurcated (*adjective*): Forked or divided into two sections or branches.

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with serious mental illnesses while allowing all other individuals be treated through physicians and private practice therapists through Medi-Cal managed care health plans within each County. In practice this has created an uncomfortable gray area in which some individuals appear to fall through service system cracks– they are neither so obviously mentally ill as to immediately be identified as having serious mental illnesses, but neither are they so well-functioning in their distress that they can necessarily identify and procure a primary care physician or therapist, articulate their behavioral health concerns, and develop an intervention plan with a mental health professional⁴.

- Screening, Assessment, and Referral practices must be developed within BHS and partner agencies that are inclusive of mild, moderate, and serious mental illnesses such that all individuals seeking assistance for a behavioral health concern can receive treatment services and will not fall through the cracks.

Challenge 2: *BHS's assessment process is burdensome and emotionally draining, and may be a causal factor associated with disproportionalities in service utilization.*

Another challenge in accessing mental health services is that the assessment process is onerous, stigmatizing, emotionally draining, and difficult to navigate. The complete screening and assessment process can require multiple appointments, often with different practitioners, and requires sharing sensitive information in order to demonstrate severity of need. These experiences are burdensome and emotionally draining, and may result in unwillingness to aggressively pursue or self-advocate for needed treatment services. As one provider explained, “unless you have someone with a working phone, a high degree of health care savvy, and who is not in emotional distress navigating the assessment process it is very easy to get confused, discouraged, or inappropriately turned away.”

BHS is concerned that these assessment practices are contributing to disproportionalities in mental health service utilization – local data shows that Latinos are underutilizing services and African Americans are over utilizing high-end crisis services. Research findings from the *California Reducing Disparities Project (CRDP): African American Population Report* describe a broken system, in which African Americans have difficulty accessing early treatment interventions despite having higher rates of depression, stress, and anxiety as compared to non-Hispanic White populations⁵. The report found that the greatest challenges associated with access to care were not stigma towards mental health services (as is sometimes suggested) but others which suggest a great need to immediately address the way in

⁴ Between January –June of 2017, BHS received over 2000 telephone inquiries. Of those callers, 250 were referred for an assessment and 180 completed the assessment process. The vast majority (99%) of those assessed were found to have a serious mental illness (of all the assessments conducted only two individuals did not meet the diagnostic criteria for having a serious mental illness). However little is known about those screened out for services and referred to a primary care physician or other service provider. These 1,750 individuals represent a potentially unserved population, though little is currently known regarding them.

⁵ The report sites utilization data received from the California Department of Mental Health, indicating that African Americans are 30% more likely to be diagnosed with serious psychological distress and 50% more likely to report symptoms of depressive episodes. African Americans comprise 6.5% of the population in California but account for 16.6% of mental health service recipients.

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which screening, assessment and treatment services are provided including: dehumanizing social encounters, referrals to inadequate or inappropriate treatment, and structural/system barriers that lead to missed opportunities for early detection and intervention⁶.

- Screening, Assessment, and Referral practices must be culturally sensitive, client-focused and responsive to the emotional state, engagement capacity, and well-being of the individual.
- Screening, Assessment, and Referral practices must be rooted in community based organizations with seamless linkages to higher levels of care if needed.

Challenge 3: *The assessment process is not well designed for individuals who are homeless and/or have substance use disorders, as they may not be sober enough to complete an assessment or have more urgent priorities (such as finding a place to live) that inhibits their readiness to engage in services.*

Completing the entire screening and assessment process is even more difficult for individuals with co-occurring substance use disorders. Individuals who are deemed under the influence of alcohol or drugs at the time of an assessment may be asked to return at another time as the manifestations of intoxication can confuse the assessment of symptoms. Individuals under the influence may also be incoherent, unresponsive, or belligerent making it impossible to complete an assessment. But the consequence of not completing an assessment at that time requested, or not providing services when the person presenting feels that they need assistance, is that the individual may not return for service.

Individuals that are homeless also have high rates of substance use disorders⁷ – making completing the assessment difficult for the reasons stated above. Compounding this, it is also particularly challenging to conduct good follow-up within individuals when they lack a stable address or phone number. As a result individuals that are homeless, or populations that have disproportionately high rates of homelessness and/or co-occurring disorders, are at grave risk of being unserved by mental health systems of care.

The consequence of untreated mental health concerns amongst high risk populations, such as individuals with substance use disorders or who are homeless, is that behavioral health concerns may continue to escalate if left untreated, precipitating a mental health crisis, law enforcement, or hospital emergency response. For some individuals this can mean repeated encounters with emergency response personnel and law enforcement which is problematic in itself, but a record of justice involvement can also inhibit *future* rehabilitation efforts as pertains to obtaining housing or employment opportunities.

- Screening, Assessment and Referral practices must be flexible and responsive to the immediate needs of at-risk populations such as those that have substance use disorders or are homeless.

⁶ Woods D, King N, Hanna S, and Murray C: We Ain't Crazy! Just coping with a Crazy System: Pathways into the Black Population for eliminating Mental Health Disparities. State of California Legislative Briefing February 2012.

⁷ Substance abuse is much more common among homeless people than in the general population. The Substance Abuse and Mental Health Services Administration (2003) estimates, 38% of homeless people were dependent on alcohol and 26% abused other drugs. Alcohol abuse is more common in older generations, while drug abuse is more common in homeless youth and young adults (Didenko and Pankratz, 2007).

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Recommendations from the Needs Assessment

Based on the key findings, the following recommendations emerged from the Community Program Planning Process.

Improve access to services for unserved and underserved populations:

- **Recommendation 1:** *Create a user friendly and client directed assessment process to address concerns regarding onerous, burdensome, and dehumanizing social encounters.*
- **Recommendation 2:** *Offer therapeutic interventions and stabilization support services early in the assessment process, prior to diagnosis, and serve as early interventions to either transition an individual to a higher level of care or to prevent an emerging mental health concern from worsening. Early interventions and stabilization services may be especially needed for vulnerable and at-risk individuals who have other, more immediate needs, that must be addressed prior to completing the assessment process and in order to facilitate the completion of the assessment process.*

Resolve systemic challenges that cause individuals to fall through service system gaps:

- **Recommendation 3:** *Develop interagency screening, assessment and referral processes which seamlessly link the treatment systems of care for individuals with mild, moderate, and serious mental illnesses (SMI). New protocols are needed to facilitate entry into treatment services, and that allow for the bi-directional movement of consumers from one system to the other more seamlessly and without a duplicative assessment and burdensome re-entry process.*
- **Recommendations 4:** *Improve communication, coordination, and collaboration protocols between BHS and other organizations that provide mental health treatment service for Medi-Cal recipients in San Joaquin County that will allow for the seamless transition of consumers from one system of care to the other. BHS should also explore the opportunity to strengthen the “front door” to mild-moderate mental health services as a way to provide high-risk individuals⁸ better access to early and preventative mental health treatment services.*

⁸ High-risk individuals includes, but is not limited to, those with substance use disorders, who are homeless, and/or who have frequent law enforcement contact associated with their behavioral health concerns.

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b) Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Prioritization of the Assessment and Respite Center

During the planning process it became apparent that simply expanding outreach efforts and opening new services would not be sufficient to address the key challenges related to access to services or to reverse utilization trends. In particular new approaches are also required on the front end of the service delivery system, through the **Screening, Assessment, and Referral** process in order to address the barrier and challenges associated with the bifurcated mental health system and an assessment process that is onerous, burdensome and not immediately responsive to consumer needs.

Therefore, San Joaquin County Behavioral Health Services, in partnership with a local FQHC will create an Assessment and Respite Center (ARC) in Stockton, California. The ARC will (1) pilot a new approach to screening, assessment and referrals to treatment services, and (2) align protocols allowing access to care between a public MHP and an FQHC for individuals with either mild-moderate or serious mental illnesses.

Other challenges directly related to outreach and engagement and/or long-term treatment and stabilization needs are addressed through three separate but related initiatives:

- **Withdrawal Management:** With funding from the Board of State and Community Corrections under CA Proposition 47, San Joaquin County will be developing a Withdrawal Management Center to provide sobering, detoxification, and medication assisted treatment services for individuals with a substance use disorder. The purpose of the Withdrawal Management Center is to stabilize individuals under the influence, encourage and support the contemplation phase of the recovery journey, and link individuals who are ready to appropriate substance use disorder treatment services.
- **Progressive Housing:** Through MHSAs Innovation funds BHS intends to create the Progressive Housing program to provide long term transitional housing and stabilization services for individuals with serious mental illnesses. The model tests a modified approach to Housing First in an effort to address unanswered questions about treating individuals with serious mental illnesses within a housing program that have emerged from previous research.
- **Whole Person Care Outreach and Engagement:** Through funding by the California Department of Health Care Services, San Joaquin County is piloting an aggressive strategy to conduct outreach and engagement with some of the most vulnerable members of our community. The project coordinates and aligns outreach through some existing program centers such as hospital emergency rooms and mobile crisis response teams and increases engagement of homeless individuals through new Homeless Outreach Teams.

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Qualifications of Community Medical Centers to Serve as the Lead Partner.

Community Medical Centers (CMC), a local non-profit community health care provider and a Federally Qualified Health Center (FQHC), was selected as the lead project partner following discussions with the Health Care Services Agency, San Joaquin General Hospital and Family Medicine Clinics, and other community based organizations. CMC was selected because it has a long standing reputation in the community, having started over forty years ago providing health care services in the fields to migrant farm workers. Over the years it has grown to a robust network of trusted community clinics, currently serving over 80,000 patients in sixteen neighborhood health centers, of which twelve are located in San Joaquin County. It has also undertaken a significant expansion of its mental health practice, growing from three providers in 2013 to over a dozen mental health clinicians in 2017. Ninety-seven percent of patients are low-income and 83% identify as ethnic or racial minorities.

CMC provides a broad spectrum of mental health services including medication management and counseling for individuals and families. Behavioral Health Clinicians provide short-term, solution-focused individuals therapy sessions that are culturally sensitive and trauma informed. Most CMC clinics have at least one Behavioral Health Clinician on site, to assist clients with a variety of health and/or mental health concerns.

CMC also has existing robust partnerships with local homeless service providers and other community based organizations including family resource centers, foodbanks, and other grassroots neighborhood organizations. CMC operates the Gleason House Health Clinic, in partnership with the Gospel Center Rescue Mission, to provide medical care for homeless individuals. CMC medical personnel also provide onsite care to homeless individuals and families at the Stockton Shelter for the Homeless and to individuals in recovery at the New Directions Alcohol and Drug Awareness Program – a residential treatment program for men and women seeking to overcome their addictions. Health clinics are held weekly at each facility, with occasional on-call services as needs arise.

CMC's Homeless Health Center program, Care Link, uses a case management approach to ensure that homeless persons are receiving coordinated and integrated health care services. Care Link began in 2001 providing no-cost medical care to homeless individuals and families in San Joaquin County. The program provides weekly medical outreach services at area shelters, on the streets, under bridges or at other locations where the homeless congregate. These outreach activities serve as an initial point of contact with most patients, and as relationships are developed these sites act as a link to clinic based primary care and help encourage patients to accept needed follow-up care.

Finally, CMC is the only FQHC operating in San Joaquin County. This factor is necessary as the long term sustainability model requires a slow withdrawal of INN funds (which are provided to start-up and stabilize operations) with ongoing funding provided through federal reimbursements.

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Purpose of the Innovation

1. Improve access to services for unserved and underserved populations.

Innovation Funds will be used to increase access and linkages to services. The Assessment and Respite Center will eventually serve the general population of all San Joaquin County community members in need of mild-moderate mental health services. However the Assessment and Respite Center is specifically designed to address the needs of an unserved/underserved target population that includes:

- High-risk individuals with substance use disorders, who are homeless, and/or who have frequent law enforcement contact associated with their behavioral health concerns; and
- Very low income individuals from communities of color that are not accessing behavioral health services due to stigma, a lack of culturally competent services, or from prior negative interactions with behavioral health treatment providers.

The Assessment and Respite Center INN program seeks to increase access to services amongst unserved and underserved individuals, as measured by:

- Increased completion of psycho social assessments; and
- Increased linkages to behavioral health treatment services.

2. Resolve systemic challenges that cause individuals to fall through service system gaps

Innovation Funds will be used to reduce systemic challenges associated with the bifurcated behavioral health delivery system; redesign a burdensome and emotionally draining assessment process; and address systemic limitations associated with serving individuals who are homeless and/or have substance use disorders or are otherwise not ready to engage in services.

The ARC will reduce systemic challenges that result in individuals falling through the gap by:

- Creating an integrated and aligned assessment system between the public MHP and a local FQHC, which creates a no-fail approach for individuals seeking behavioral health supports;
- Adopting a client driven approach to the assessment process; allowing clients to dictate the pace and scope of assessment as best suits their needs, while simultaneously providing a range of services and supports to help sustain client engagement in the assessment process;
- Providing early intervention services to help individuals who are homeless and/or have substance use disorders stabilize sufficiently to complete the assessment process.

Specifically, challenges will be addressed by:

- Partnering with a FQHC to open a new Assessment and Respite Center offering seamless linkages to a range of behavioral and primary health care services.
- Developing standardized assessments that are client paced and directed, and that offer entry into both the mild-moderate or SMI systems of care.
- Offering a range of stabilizations services such as respite, withdrawal management, and housing to individuals that require early interventions *in order* to complete the assessment process.

San Joaquin County Behavioral Health Services Assessment and Respite Center

2. What Has Been Done Elsewhere to Address Your Primary Problem?

“A mental health practice or approach that has already demonstrated its effectiveness is not eligible for funding as an Innovative Project unless the County provides documentation about how and why the County is adapting the practice or approach. *CCR, Title 9, Division 1, Chapter 14, Sect. 3910(b)*).

- a) Describe the methods you have used to identify and review relevant published literature regarding existing practices or approaches. What have you found? Are there existing evidence-based models relevant to the problem you wish to address? If so, what limitations to those models apply to your circumstances?

The proposed Assessment and Respite Center seeks to address several systemic gaps/barriers that may exist in other jurisdictions. As described above, San Joaquin County is home to a significant number of transient and chronically homeless adults and otherwise marginalized individuals who cycle in and out of jail due to a confluence of substance use and behavioral health disorders. Some of these individuals suffer from severe and persistent mental health disorders and qualify for specialty mental health services and supports; others have less severe mental illnesses with co-morbid substance use disorders that contribute to homelessness and law-breaking which would be better addressed in community health and primary care settings. Regardless of the severity of symptoms and diagnosis, these individuals face challenges accessing and navigating the healthcare system. They may not have a primary care physician or a relationship with a health clinic; they may have been told in the past that they don't qualify for specialty mental health services; they may have had multiple interactions with local law enforcement, and as a result, avoid seeking help.

The challenge of serving this population, whether they qualify for specialty mental health services or not, has to do with creating a welcoming environment and rapid response at the front-end of the service delivery system. Neither BHS's telephone assessment system nor its Behavioral Health Crisis Clinic is able to meet both of these goals. Getting an assessment is a multi-day process, and for individuals experiencing homelessness or are otherwise unstable or disfranchised from receiving services in traditional health care settings, such a delay may contribute to hospitalizations and incarceration. On the other hand, the Crisis Clinic is not the best environment for a front-door into managed health and wellness care, especially for those who may not qualify for specialty mental health services.

San Joaquin County Behavioral Health Services

Assessment and Respite Center

Literature Review

Research suggests that initial barriers to entering services, such as those created by an assessment process that is designed to determine who is eligible for services, can be a significant deterrent to accessing treatment. “Reducing organizational red tape and developing pre-treatment programming that can engage clients while they wait for availability of intake and treatment appointments may increase treatment enrollment” (Grella et al., 2004; Johnson et al., 2014). Our research into best practices for reducing behavioral health disparities also found that co-locating physical and behavioral health services helps to eliminate access barriers and stigma (California Reducing Disparities Project Draft Strategic Plan, 2014; Treatment Access Barriers and Disparities among Individuals with Co-Occurring Mental Health and Substance Use Disorders, 2015; Community-Defined Solutions for Latino Mental Health Care Disparities, 2012).

In California, Federally Qualified Health Clinics (FQHCs) provide co-located behavioral health services for people with mild and moderate mental health and substance use disorders as part of their core services, and are skilled at assessing and linking patients to appropriate levels of care.⁹ However in most clinics the rates in which mental health services are growing within clinics remains slow. Mental health as a service consists of 3-10% of total health care demand within FQHC Clinics.¹⁰ A rapid expansion of mental health services within primary care clinics is a critical need to address large systemic gaps in the system of care for individuals with mild to moderate mental health care needs, particularly for those who are disenfranchised from health care systems in general.

Our innovation seeks to develop a model of serving transient, homeless, frequently incarcerated, and otherwise marginalized adults by increasing access and linking them to physical health treatment and the most appropriate level of behavioral health care.

Investigation of Models

Community Medical Centers is aggressively implementing programs and policies that create integrated and bidirectional health and behavioral health care services. In the past year they have increased depression screening from occurring in less than 7% of patients, to over 15% of all patients served and have expanded mental health service offerings to include a broader range of therapeutic interventions.

CMC is not alone in efforts to provide integrated health and behavioral health care, but much more work and study is clearly needed to help document effective practices for FQHCS and community health providers. In particular few of the counties interviewed had developed joint assessment practices, or worked with health care providers to specifically address the mild-moderate mental health concerns of very vulnerable and disenfranchised individuals with an intention of providing early interventions and reducing referrals into higher level systems of care.

⁹ <http://www.cpc.org/index.cfm/policy-advocacy/policy/behavioral-health/>

¹⁰ See: <https://bphc.hrsa.gov/uds/datacenter.aspx> for a searchable database of service utilization by federally funded clinics.

San Joaquin County Behavioral Health Services Assessment and Respite Center

The section below describes how several county health systems are creating partnerships with FQHCs to provide integrated behavioral health services. Through interviews it was revealed that each county is developing its own model and that there is little validated research documenting challenges, opportunities and best (or emerging) practices. Further, all programs interviewed suggested that more work is needed to improve operations and that significant barriers still hinder access to treatment services amongst vulnerable and at-risk populations.

Interview comments further suggested that while part of the solution is creating better protocols to integrate public mental health systems of care with health care providers, it is not enough to deliver services in a community friendly location. Other significant system issues must also be addressed in order to increase participation and utilization of mental health services, even within community-based and culturally competent settings. In particular all of the programs interviewed struggled with serving (or did not consider them as their target population) homeless individuals or those at risk of incarceration for non-serious non-violent offenses such as those associated with public intoxication or disorderly conduct.

In general a better and more robust process for assessment and linkage to services may be needed to better support individuals that are episodic/crisis-driven users of health care services such as those who are homeless, frequently incarcerated, have serious substance use disorders, or are otherwise marginalized.

b) Describe the methods you have used to identify and review existing, related practices in other counties, states or countries. What have you found? If there are existing practices addressing similar problems, have they been evaluated? What limitations to those examples apply to your circumstances?

Methodology

Our research focused on learning about existing models of collaboration between County Mental Health Programs (MHPs) and FQHCs in California. We researched California-based models due to the fact that the State carves mild and moderate behavioral health disorder services into Medi-Cal Managed Care, and thus FQHCs and other community clinics and health centers (CCHCs) are most likely to be meeting the demand for behavioral health care to existing Medi-Cal populations.

Our research questions included:

1. Which county MHPs have demonstrated successful collaboration with local FQHCs?
2. What is the focus of these partnerships (i.e., what models have already been developed)?
3. To what extent do they target homeless and otherwise vulnerable, marginalized populations in order to support their access and linkage to services?
4. To what extent do they offer mid-assessment stabilization services such as primary health care services, withdrawal management, respite or housing?

San Joaquin County Behavioral Health Services Assessment and Respite Center

We contacted Greg Tate, the former MHSOAC County Liaison assigned to San Joaquin County and Allie Budenz, Associate Director of Quality Improvement, California Primary Care Association, to find out which California county behavioral health departments had developed successful partnerships with FQHCs. Between the two organizations, we were encouraged to research the models developed in Alameda, Kern, Merced, Nevada, Shasta and Yolo Counties.

Key Findings from County Interviews

We contacted the MHSA Coordinators in each of the six counties listed above and learned the following:

- All of the partnerships serve adults and/or children in *existing* FQHC or specialty mental health service locations.
- Two MHPs provide MHSA and other funds to FQHCs for the provision of *full-service specialty mental health services, including* to individuals with serious mental illness (Kern, Shasta). One county FQHC provides a Full Service Partnership (Shasta). One county (Kern) shares medical records and psychosocial assessments between FQHC and MHP; one county (Shasta) does not.
- The other MHPs provide a) *psychiatric and clinical consultation*, b) *short-term PEI clinical therapies*; and/or c) *case management/care coordination/peer navigation* to better integrate physical and behavioral health care for underserved individuals with mild to moderate behavioral health needs (Alameda, Yolo, Merced, Nevada)
- Target populations are often Latino (Merced, Yolo) and rural (Shasta, Nevada)
- All counties fund *promotores* or other peer educators or navigators, health coaches, case managers and/or care coordinators to educate, reduce stigma, support referrals and linkages.
- Two counties offer FQHC routine health care at behavioral health clinic (Alameda) or in a van outside of behavioral health clinic (Nevada)
- One county behavioral health department has on-site nurses who serve as care coordinators and provide integrated care, including connecting clients to primary care providers, scheduling routine health screenings, issuing health report cards and coordinate medications (Nevada).
- One county uses a specific coordination strategy between MHP, managed care, and FQHCs to ensure patients do not fall through the cracks until eligibility is established (Nevada)
- One county has contracted with a CBO who runs several FQHCs in the county to provide a separate after hours drop-in respite center, that includes crisis support, assessment, referral and linkages to appropriate level of care in a downtown location (Shasta). Target populations are individuals with serious mental illnesses who are frequent users of crisis service, and services are intended to de-escalate crisis and prevent involuntary hospitalizations.

San Joaquin County Behavioral Health Services

Assessment and Respite Center

Systemic Gaps Requiring Further Study

Our research into existing partnerships between MHPs and FQHCs identified the following gaps, which our INN model seeks to fill:

- While one county (Shasta) partners with a CBO to provide a pre-crisis respite center, no counties specifically contract with an FQHC to offer a stand-alone center for the explicit purpose of assessment and guiding un-served individuals, particularly homeless and those at risk of incarceration, to appropriate level of care.
- While one of the FQHC partnerships seeks to reduce psychiatric hospitalizations by serving frequent users of emergency rooms, none targets transient, homeless, and frequently incarcerated individuals who are medically and behaviorally under- or un-served because their psychiatric diagnoses are below threshold for specialty mental health services - yet are nonetheless affecting their housing, employment, and other functional statuses.
- Only one FQHC appears to share findings from psycho-social assessments with county behavioral health departments (Kern) but this FQHC serves as a specialty mental health provider. No FQHCs provide pre-treatment services, stabilization services, or conduct psycho-social assessments specifically for the purpose of identifying need, and seamlessly and efficiently linking individuals to an appropriate level of care.

Model Outside California

The San Antonio Restoration Center in Bexar County, TX offers a potential model for the Assessment and Respite Center. BHS and CMC conducted two telephone interviews with Restoration Center program managers to learn more about their operating model and develop ideas for this INN project. The Texas Restoration Center is operated by a local health care provider and provides 24/7 access to behavioral health assessments in conjunction with withdrawal management services. However, there are some notable differences in the service scope of the Restoration Center versus the proposed ARC.

- The Restoration Center primarily receives referrals from law enforcement. Individuals and family members would not typically be able to self-refer for services.
- The Restoration Center does not offer linkages to ongoing mental health clinical services for individuals with mild-moderate mental health concerns.
- The Restoration Center does not have dedicated housing resources for the purpose of stabilization during the course of the assessment process.
- The Restoration Center is funded largely through local philanthropy and county funding, and does not see self-sustaining services as a feasible option.

Conclusion

None of the programs interviewed offer stabilization services such as medically-monitored withdrawal management, rapid re-housing, and primary care services in an accessible location to address some of the underlying issues that lead to mental health crises. By addressing these issues in a single location, the ARC is expected to generate more accurate psycho-social assessments and better identify and rapidly link those who can be effectively treated at a lower level of care.

San Joaquin County Behavioral Health Services Assessment and Respite Center

3. The Proposed Project

Provide a description of the new or changed mental health approach that the County will develop, pilot, and evaluate. Differentiate the elements that are new or changed from existing practices in the field of mental health already known to be effective.

Support Innovation approaches by doing one of the following:

- a. Introducing new mental health practices or approaches, including but not limited to, prevention and early intervention.
- b. Making a change to an existing mental health practice or approach, including but not limited to adaptation for a new setting or community.
- c. Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.
- d. Participating in a housing program designed to stabilize a person's living situation while also providing supportive services on site.

Mental Health Services Act, as Amended April 2017

- | |
|--|
| a) Provide a brief narrative overview description of the proposed project. |
|--|

The CMC Assessment and Respite Center will pilot a new collaborative approach to providing mental health assessments and linkages to behavioral health services for individuals with mild to moderate mental health concerns for the purposes of prevention and early intervention. The new model creates a stand-alone clinic location for the purpose of providing assessment and respite services for individuals that are unserved, underserved, and inappropriately served by existing behavioral health systems of care. Other on-site services will include brief treatment interventions, peer support, and case management. The Assessment and Respite Center will also provide structured linkages to a range of stabilization services and supports; understanding that assessments and referrals to treatment services may not be completed if clients are (a) distrustful of services, (b) intoxicated, or (c) more concerned with resolving other more immediate needs, such as getting food or finding a safe place to live, prior to addressing underlying chronic health or behavioral health care concerns.

Introduces a new mental health practice or approach, including but not limited to prevention and early intervention.

The Assessment and Respite Center is anticipated to have the following major outcomes:

- 1) Increase access to mental health services amongst unserved and underserved populations.
- 2) Reduce symptoms of untreated illnesses, including mental, emotional, and relational functioning.

San Joaquin County Behavioral Health Services Assessment and Respite Center

Proposed Program Services

The Assessment and Respite Center (ARC) will provide a centralized hub for mental health assessments and referrals to the appropriate level of care. Traditional models consider three main tasks in getting individuals into treatment services: screening, assessment, and the initial referral to treatment services. Some also include a follow-up or case management step as necessary to the process to ensure that individuals with behavioral health needs are warmly guided into treatment services. San Joaquin County will test a model that considers five distinct tasks associated with access to services.

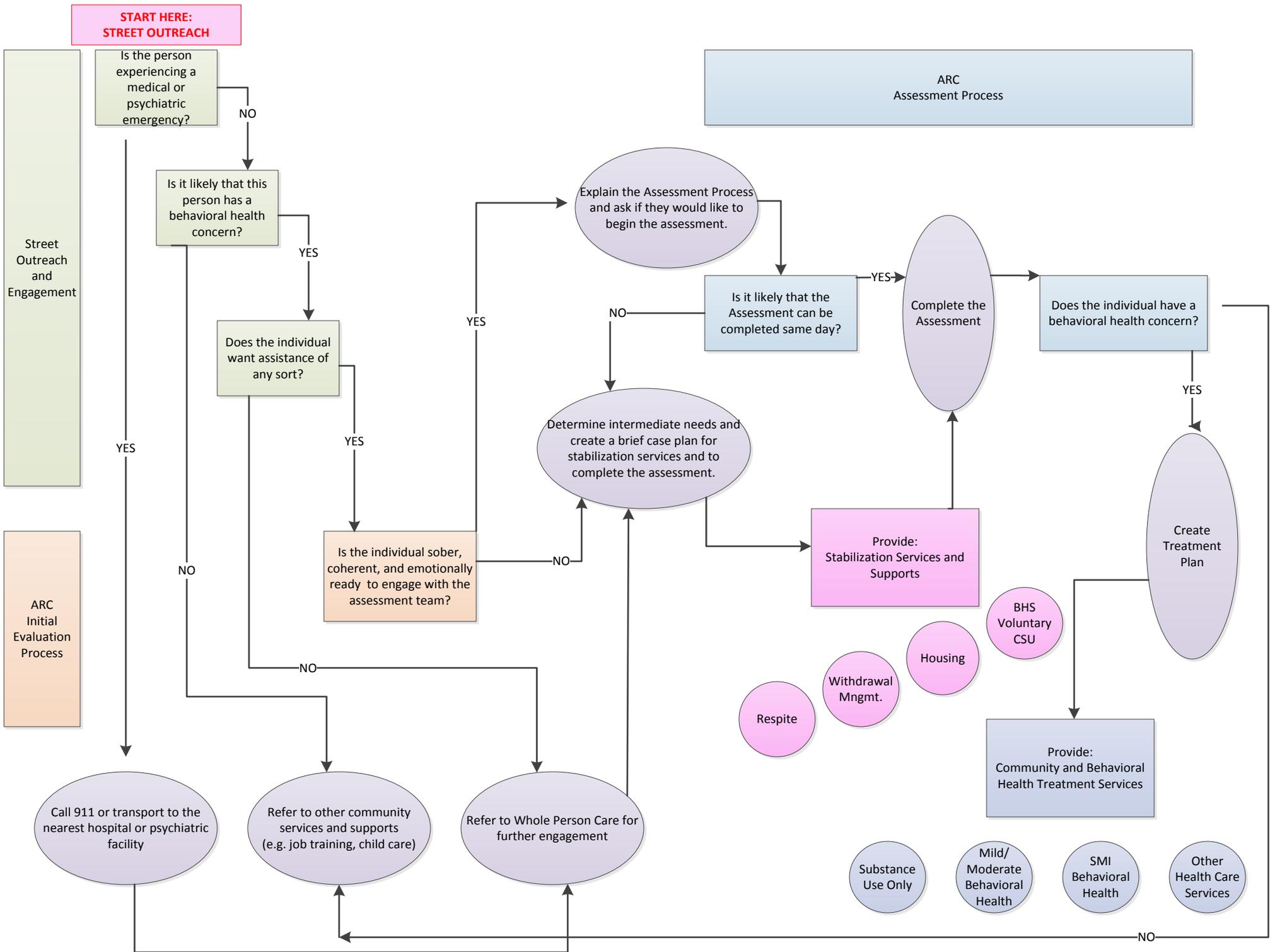
- 1) Outreach, Screening and Engagement
- 2) Initial Triage and Evaluation
- 3) Respite or Referral to Stabilization Services
- 4) Assessment of Symptoms and Needs
- 5) Case Plan & Linkage to Treatment Services

Two new service considerations are added to the traditional model. (1) The initial assessment period will be client driven and consistent with the pace and scope that each individual client is ready for. Traditional models see completion of the assessment as a discreet event. But experience demonstrates that for very high-risk populations completing the assessment is rarely a one-day event and multiple encounters may be required before the assessment is complete and an accurate diagnosis is made. (2) Completing the assessment may not be feasible until after the individual is stabilized and/or has more trust in those offering program services. A respite space will be created in the ARC for potential clients to observe operations, engage with peer partners, and contemplate their readiness for recovery. A series of stabilization services, including withdrawal management, basic health care services, and housing, are provided through separately funded programs.

The Assessment and Respite Center will provide non-therapeutic services designed to facilitate clients (1) completing a psychosocial assessment and (2) successfully engaging into clinical services at the appropriate treatment level following assessment. The Assessment and Respite Center will also utilize the following evidence based practices:

- 8-Question Mental Health Screen for homeless outreach teams and law enforcement
- Brief Treatment Interventions
- Wellness Recovery Action Plans
- Validated psychosocial and ASAM substance use disorder assessment tools
- Child & Adult Needs and Strengths Assessment (A county-specific version of a validated instrument, developed in partnership with the original tool developers at Chapin Hall)
- At least some program services are provided by staff with lived experiences and/or are from the same unserved / underserved communities targeted by the program

The flow chart below describes client experiences and the decision-points that occur during the different phases of the assessment process:



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Leveraged Services

Services are offered in coordination with a range of outreach, stabilization, and therapeutic services that are provided outside of the scope of this INN project. Program partners include:

- **Outreach and Engagement:** CMC Care Link, BHS Homeless Outreach Teams, The Stockton Shelter for the Homeless, St. Mary's Dining Hall, community based organizations, inpatient and crisis residential programs, local law enforcement, and others who will identify potential program participants and link them to the Assessment and Respite Services.
- **Housing and Housing Support Services:** Various supportive housing programs; Proposition 47 funded independent housing voucher program for those who do not qualify for Section 8 due to prior offenses or substance use history; Progressive Housing long-term transitional program for individuals with serious mental illnesses; and readiness to rent education and case management support services. Program partners include the Housing Authority of San Joaquin and Central Valley Low Income Housing Corporation (CVLIHC), the HUD designated Continuum of Care coordinator for the County.
- **Substance Use Disorder Treatment Services:** Community Medical Centers (CMC) withdrawal Management Center, BHS residential and outpatient treatment programs, and local medication assisted treatment (methadone) providers and other community-based recovery programs including recovery residences, outpatient recovery groups, 12-Step programs and recovery support groups.
- **Mental Health Treatment and Support Services:** BHS and CMC Mental Health Services, Wellness Center, Martin Gipson Socialization Center, and various community based organizations which provide ongoing mental health treatment services, recovery services, therapeutic groups, social and emotional support services, case management, and advocacy.

Additional Program Details

1. Target Population: Homeless individuals; non-serious, nonviolent offenders; and other unserved or underserved populations with behavioral health concerns.
2. Referrals: Referrals will be received initially from designated and trained program partners. For the first phase (program start-up) referrals will be received from CMC Clinics and outreach teams *and* BHS Access, Warm-line, Crisis Unit, Mobile Crisis Response Team, and Homeless Outreach team. Referrals will be only for those individuals who have been screened as *not likely* to have a serious mental illness but as *likely* to have mild/moderate behavioral health concerns that should be addressed. Once program operations and referring protocols are established CMC and BHS will jointly train select program partners and expand the referral base. Expanded referring partners are likely to include homeless services providers and a trained team of law enforcement officers that conduct community policing within Downtown Stockton.

San Joaquin County Behavioral Health Services Assessment and Respite Center

3. Street Outreach and Engagement Services: Provided through existing programs. Homeless outreach teams, homeless service providers, and others will conduct outreach to individuals deemed likely of having a behavioral health concern. Individuals screened as likely for having a mild-moderate mental illness will be referred to the CMC Assessment and Respite Center for an introduction to services, a full psycho social assessment, and engagement by Peer Navigators.
4. Primary Health Care Services: All individuals will receive a brief examination to determine fitness for services. The examination may include a screen for alcohol use and/or depression. Positive findings on either screen will result in a brief intervention to encourage treatment¹¹ Individuals will also receive a referral to a community clinic for a full health examination and information on access to coverage if they are uninsured.
5. Screenings, followed by a Brief-Intervention, and Referrals to Treatment (SBIRT) will be conducted with all individuals as part of the initial evaluation process when individuals arrive at the ARC. Brief therapeutic interventions have been found to be clinically beneficial in encouraging individuals to complete an assessment and contemplate treatment and recovery services. A brief intervention of 5-15 minutes have been found to be effective strategies for helping individuals consider personal risk, options for treatment or support, and to help individuals develop optimism towards change. Research is currently underway to investigate the applicability of SBIRT in Mental Health settings through UC Los Angeles Integrated Substance Abuse Programs.
6. Screening Protocols: Homeless service providers, law enforcement or other community based partners will be trained to use an eight-question mental health screening tool designed for use in the field. The tool was initially developed by law enforcement in Maryland and has since been adopted by jurisdictions across the country.
7. Substance Use Disorder Treatment Services: Co-located medically monitored withdrawal management services are funded through a grant award under Proposition 47. Existing substance use disorder treatment services include outpatient and residential treatment programs, medication assisted treatment, and 12-step or other recovery support groups.
8. Housing Services: Some individuals, who are at grave risk of being lost to follow-up, may receive a housing placement referral. Progressive Housing provides pre-contemplation and recovery houses for individuals with substance use disorders and suspected mental illnesses. Longer term housing is available for individuals with co-occurring mental health and substance use disorders, though a diagnosis of serious mental illness is required for stays longer than 90 days. Project funding is pending approval of INN plan by the MHSOAC. Additionally there are several

¹¹ Screenings by health care providers, followed by a brief intervention and a referral to treatment (SBIRT), are recommended practices by SAMHSA for all health care professionals.

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recovery residences and supported housing programs operating in the County that offer housing to individuals who are able to maintain sobriety.

9. Behavioral Health Treatment Services: Treatment services are provided through existing mental health programs and services. Treatment may include clinical care coordination teams, intensive case management, medication management, and range of social and behavioral support groups. Individuals with mild to moderate symptoms will be referred to CMC care teams. Individuals with serious mental illnesses will be referred to BHS for further evaluation.
10. Case Management Services: Individuals at high risk of being lost to follow-up, such as those that are homeless, have co-occurring substance use disorders, or who are frequent users of unplanned services, may be assigned a case manager until routine services are established¹².
11. Peer Partners in Recovery: CMC peer counselors are individuals with lived experience, as a consumer or family member, in recovery from a substance use disorder, mental health concern, and/or homelessness. Peer counselors serve as a warm welcome to services by providing friendly encouragement from “someone who has been there before.”
12. Operating Hours: Once fully implemented the ARC intends to offer respite and stabilization services 24-hours a day, seven days a week; however referral and assessment protocols will be designed to be consistent with programming capacities during late evening/graveyard shifts.

Discharge Plan

Following the completion of the assessment process, individuals will meet with a member of the clinical team to develop a discharge case plan which transitions the client to ongoing services and supports. Support services may include one or more of the following:

- Referrals to CMC clinics for ongoing behavioral health or primary care services
- Referral to CMC withdrawal management center
- Referrals to Substance Use Services for enrollment in outpatient or residential treatment programs
- Referrals to scattered site housing – low barrier houses for further contemplation
- Referrals to BHS for individuals with serious mental illnesses
- Referrals to BHS Crisis for individuals experiencing acute psychiatric distress (voluntary transport through mobile crisis support team)
- Referrals to community case management teams for further follow-up and support during contemplation phase
- Referrals to CBO partners for engagement / social-emotional support groups

¹² Various teams dedicated to this population and purpose are launching in 2017/18: one with funding through the Proposition 47 grant award and the Homeless Outreach Team which is funded by the Whole Person Care grant.

San Joaquin County Behavioral Health Services Assessment and Respite Center

b) Identify which of the approaches the project will implement

The project tests the application of a new approach to assessing mental health disorders within high-risk populations which are chronically unserved or underserved by mental health systems of care.

This project also tests whether a new assessment process, that allows clients to direct the pace and scope of interactions and provides for a range of stabilization services during the assessment phase, leads to more individuals completing the assessment and accessing treatment interventions services that are best suited to their needs.

The project will further test whether the provision of stabilization services reduces symptoms and/or improves recovery, including mental, emotional, and relational functioning amongst individuals who receive stabilization services during the assessment process.

c) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply to mental health a practice from outside of mental health, briefly describe how the practice has been applied previously.

The project combines a series of common practices traditionally used to improve access to services for hard to reach populations. These practices are often provided through public mental health departments. Our research found no evidence of the assessment services being provided in a coordinated fashion by an FQHC for a public mental health department as a standalone service for individuals who are not necessarily clients of the health clinic.

The project design addresses some of the largest barriers in access to services:

- **Appropriate Engagement** is addressed by utilizing peer partners and by partnering with the Homeless Outreach Teams and the Proposition 47 funded Case Management team to conduct initial outreach and engagement and ongoing “lite case management and support services” to help consistently re-engage clients in assessment and stabilization services.
- **Stigma** is addressed by having assessments conducted within a facility operated by an organization known to offer community based health services, not a mental health agency.
- **Cultural competency** is addressed by having a community based organization operate the ARC. A recent study by UC Davis recommends co-locating mental health resources within community-based locations as a strategy for increasing access to mental health services¹³.
- **Substance use** is addressed by providing co-located substance use disorder treatment services, including withdrawal management. Substance use is also addressed by having a series of respite and stabilization services to support individuals through their contemplation process. The assessment process is lengthened to accommodate the contemplation phase of treatment.

¹³ Community Defined Solutions for Latino Mental Health Disparities. UC Davis Center for Reducing Health Disparities, June 2012

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- **Housing** is addressed by offering a range of independent and supported housing options for individuals at different stages in the recovery process. Pre-contemplation houses will operate in partnership with the Assessment and Respite Center for individuals that need a safe place to stay while they contemplate their readiness for recovery. Those who elect to continue with the assessment and engage in program services may also be eligible for additional housing support services to sustain their recovery efforts.
- **Bifurcated system** is addressed by creating an Assessment and Respite Center that can seamlessly refer all individuals into mental health treatment services at any level of need including mild to moderate and serious mental illnesses.

The Assessment and Respite Center Project is an appropriate use of San Joaquin County's INN funding for the following reasons:

1. It is responsive to a major concern identified by consumers and family members and aligns with the strategic priorities identified by the San Joaquin County Board of Supervisors.
2. It is reflective of statewide efforts to improve access to mental health services amongst individuals who are homeless, non-violent non-serious offenders, and other chronically underserved individuals; and proposes a project design and research study that will help advance learning within the field of mental health.
3. It is a time-limited project. Program funds are intended to jump start operations. Once programming is stabilized federal FQHC reimbursements and other revenue sources will sustain funding for the ARC.
4. No other MHSA related funds are currently appropriate for this use.
 - a. CSS funding is not appropriate as the majority of individuals served may not yet have a serious mental illness.
 - b. PEI funds may be applied at a later date to sustain early intervention components of the program that are deemed promising enough to meet the criteria for PEI funding.
5. It will operate under the umbrella of a large county-wide collaborative initiative. Aligned projects include:
 - a. Outreach and Engagement – Homeless Outreach Teams (Whole Person Care Grant)
 - b. Screening and Assessment – Assessment and Respite Center (this INN Project)**
 - c. Sobering and Detox – Withdrawal Management Center (Prop 47 Grant Award)
 - d. Low-Barrier / Recovery Housing – Progressive Housing (INN Funding Proposal)
 - e. Re-Entry Employment Training – Ready to Work (Private Philanthropy and Grants)
 - f. Mobile Crisis Support Teams and Crisis Stabilization Unit (CHFFA grant awards)
6. It is consistent with the primary purpose of Innovation projects.

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4. Innovative Component

“A mental health practice or approach that has already demonstrated its effectiveness is not eligible for funding as an Innovative Project unless the County provides documentation about how and why the County is adapting the practice or approach. *CCR, Title 9, Division 1, Chapter 14, Sect. 3910(b)*).

Describe the key elements or approach(es) that will be new, changed, or adapted in your project (potentially including project development, implementation or evaluation). What are you doing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

Defining Characteristics of Assessment and Respite Center model that distinguish the project from existing models:

San Joaquin County’s Innovation Project demonstrates a new model for assessment and linkages to services that introduces new protocols for brief interventions and stabilization services, and allows for the client to dictate the pace of the assessment. The new components of the approach are described below:

Approach

- **Outreach, Screening and Engagement:** *no innovation, program activities are leveraged through existing services*
- **Initial Evaluation:** *innovation:* Introduces a deliberate period of observation, examination, and relationship building between the screening and assessment process. Develops a structure in which the initial evaluation supports the assessment process without asking the individual to commit to sharing personal information. Allows for a period of contemplation to develop readiness for interventions in a safe and structured manner. Delivers a brief intervention to encourage behavior changes necessary to participate in treatment services (such as reducing alcohol consumption prior to next visit).
- **Respite or Referral to Stabilization Services:** *innovation:* Incorporates a period of respite or stabilization into the assessment process – allowing for a lengthy gap in time between first contact and completion of the assessment in order to meet the first and most critical needs of the client before attempting to engage in treatment for a chronic health care concern.
- **Assessment of Symptoms and Needs:** *innovation:* Lengthens the traditional assessment period from 7-10 days to 7-10 weeks or as needed to stabilize the client, and to build enough trust and rapport to complete the assessment process. Changes the emphasis from timely access to services, to proportion of individuals who access services following first contact. Reduces barriers to entry by allowing assessments to occur in phases at the clients own pace. Introduces a new tool into the assessment process, the CANSA, jointly developed by BHS and Chapin Hall.
- **Case Plan & Linkage to Treatment Services:** *no innovation, program activities are leveraged through existing services.*

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Services will be provided in the community and within neighborhood health centers. Referrals to assessment services will originate through multiple partners, including BHS, Law Enforcement, and community based homeless service providers – all using validated screening instrument. Respite services will provide “resting” or “down-time” to ensure that clients are engaging in a psychosocial assessment at their best physical and emotional readiness. Discharge planning services will facilitate entry into additional services provided outside the scope of the innovation project, including withdrawal management services and temporary placement in low-barrier housing to determine readiness for supportive housing and housing stabilization services. Services will be provided in coordination with BHS, eliminating the duplication of assessment services and fast-tracking individuals deemed as needing higher levels of care into clinical services.

Justification for New Model Design

This model was designed for the following reasons:

- Interviews, surveys and focus group discussions with consumers and (high-risk) non-consumers revealed that the process of getting “approved” for needed mental health services can be confusing and challenging. Community partners also expressed confusion as to why many of the individuals they refer for services who experience acute mental distress are told that they “do not meet criteria.” It became clear that in the absence of an easy and universal pathway to mental health services for all individuals too many people were falling through the cracks in the mental health delivery system.
- The current system is a *bifurcated system*, one where there is a separate (but astonishingly similar) assessment process that needs to be completed in order to access treatment services. Thus if an individual fails to gain access to care through one system they must start all over through the second system.
- The current system is also based on an outdated model of private insurance and disability. Hence individuals with wealth, or private health care coverage, can generally secure mental health treatment for more general (mild) mental health concerns. Individuals who are gravely disabled by a serious mental illness can also access services through public MHPs. But individuals who are neither so wealthy as to be able to pay for treatment, nor so disabled that it is provided by a public MHP can have far greater difficulties obtaining treatment services.
- San Joaquin County has high rates of disproportionalities when examining penetration and utilization of services. It also has high numbers of individuals who are known to law enforcement agencies and homeless service providers as *likely* to have some level of co-occurring mental health and substance use disorder, but like many jurisdictions, has not developed a successful approach of engaging, assessing, and linking these high risk individuals into treatment.
- In examining these issues no suitable models were discovered that addressed these interrelated concerns in a deliberate manner to increase access to services amongst unserved/underserved populations and to reduce systemic challenges that cause individuals to “fall through the cracks” in the service system.

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5. Learning Goals / Project Aims

Describe the learning goals identified for the Innovation Project. There is no maximum number of learning goals required, but at least two are suggested. Goals might revolve around understanding processes, testing hypotheses, or achieving specific outcomes.

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the spread of effective practices in the mental health system.

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.

Mental Health Services Act, 2004, 2012, and 2017

San Joaquin County's Assessment and Respite Center will test a new model of assessing and linking unserved and underserved target populations to mental health services by expanding the traditional components of an assessment process to include a period of respite and stabilization.

- Does the new model of assessment lead to a greater proportion of high-risk individuals completing the assessment process and getting successfully linked to services?

Secondarily the project will investigate whether a collaborative approach to assessment will lead to a greater proportion of individuals utilizing community-based treatment services to address mild-moderate behavioral health concerns and a greater proportion of unserved and underserved populations more appropriately utilizing routine mental health treatment services for serious mental illnesses.

- Does utilization of CMC mental health services increase at a greater rate?
- Will a community-based assessment process increase mental health participation by individuals from unserved/underserved communities?

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- a) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

Whether and how the Innovation improved access to services for unserved and underserved populations.

- (1) Whether the provision of a range of early intervention and stabilization services within the context of the assessment process results in more individuals: (a) completing a psychosocial assessment, and (b) continuing on into treatment services, compared to screening and assessment as usual;

Whether and how the Innovation reduced systemic challenges that cause individuals to fall through service system gaps.

- (2) Whether the development of uniform and standardized assessment processes can reduce confusion associated with a bifurcated system, and lead to greater utilization of mental health services.

Whether and how the Innovation offers a financial model that may be useful to other jurisdictions seeking to increase access to mental health services for unserved /underserved populations.

- (3) Whether a time-limited investment, to improve access to services will result in a large enough increase in utilization (of billable clinic services) to sustain new programs over time.

- b) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

1) Provision of early intervention and stabilization services:

- Introduces a new approach to the assessment process, including the use of brief interventions and stabilization, in order to better engage and retain very high risk individuals throughout the duration of the assessment period and to improve linkages to needed treatment services.

2) Development of uniform and standardized assessment protocols:

- Introduces a new collaborative approach to mental health assessments that bridges the divide between the primary health care and public mental health service delivery systems such that there is a seamless point of entry for all individuals regardless of the diagnostic level (mild, moderate, or serious mental illness) determined through the assessment process.

3) Allocation of capital to expand mental health services within an FQHC:

- Introduces new research for other MHPs and FQHCs to consider on how to increase community mental health program services and to develop sustainable funding over time through a joint effort to increase the client base of the FQHC by targeting individuals with mild-moderate mental health concerns that are unserved or underserved by the mental health system of care.

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6. Evaluation or Learning Plan

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. What observable consequences do you expect to follow from your project's implementation? How do they relate to the project's objectives? What else could cause these observables to change, and how will you distinguish between the impact of your project and these potential alternative explanations?

a) Describe the approach you will take to determine whether the goal or objective was met.

UC Davis Behavioral Health Center for Excellence (BHCE) will lead evaluation activities for San Joaquin County. Preliminary discussions with Cameron Carter, the Center Director and other researchers from BHCE have occurred to help develop the learning questions and establish the general evaluation needs. Final determination of the evaluation scope and design will be determined through comprehensive discussion between BHCE and BHS. A contract and scope of work will be executed upon approval of the project by the MHSOAC.

UC Davis BHCE brings a talented and dedicated research team to the project. Over the past two years of operations BHCE has published numerous articles innovative clinical care best practices and presented at multiple national conferences. They also publish *Innovate*, a brief bulletin highlighting evidence-based mental health research.

Amongst the first tasks of the design phase will be selecting the most appropriate research approaches. Some options include:

- 1) A full descriptive summary of the program, detailing utilization rates, rate of progression through the client-centered assessment model, dropout (lost to follow-up) rates, referrals to stabilization service and supports, diagnosis trends, and length of time from first contact to diagnosis and enrollment into clinical treatment program. This data will be used to identify any potential bottle-necks in the system, and help refine policies and protocols regarding assessments and referrals.
- 2) Client outcome study, investigating short and long term impacts to clients following participation in Assessment and Respite Center services. A comparison study may be possible of those that receive stabilization services compared to clients that do not receive stabilization services. Short term outcomes may include increased psycho-social functioning, increased physical health, decreased substance use, and increased optimism / aspirations for the future. Long term client outcomes may include increased housing stability, decreased incarceration / recidivism rates. Findings will help determine which, if any, of the respite and stabilization services are leading to improved outcomes and are worth adopting for the long term.
- 3) System outcome study, investigating impacts of collaborative effort on the mental health service delivery system. Anticipated short term outcomes include an increase in utilization of CMC mental health services. Desired long term impacts include increased awareness and

San Joaquin County Behavioral Health Services Assessment and Respite Center

understanding of how to refer clients for mental health services amongst community program partners; and confidence that clients will receive needed services. Findings will be used to strengthen the program design.

- 4) Utilization and Cost study, to determine whether service utilization has increased enough to support long term sustainability through federal FQHC reimbursements. The cost study will help other community health partnerships understand what they can expect in terms of service demand and costs associated with creating similar services.

b) Who are the target participants and/or data sources (e.g., who you plan to survey to or interview, from whom are you collecting data); How will they be recruited or acquired?

1. Target participants for the evaluation: All program clients will be notified that program services are part of a pilot research study and program service records will be reviewed by outside evaluators. Individuals will be notified of their rights and how their confidential information will be protected. Individuals will also be given information about how to opt out of research. Opting out of the study will not preclude getting services.
2. Recruitment: The evaluation team may elect to conduct direct research (interviews or focus groups) with clients who have received different types of services through the Assessment and Respite Center. Recruitment and study design will be outlined in the final evaluation plan, due June 2018, and approved by the IRB.
3. Comparison Group: To be determined in consultation with UC Davis BHCE during the evaluation design phase. One consideration is to conduct a modified comparison of individuals that receive stabilization services and those that do not to determine if a longer period between first contact and referral to treatment services results in better engagement and participation in recommended treatment services.

c) What is the data to be collected? Describe specific measures, performance indicators, or type of qualitative data. This can include information or measures related to project implementation, process, outcomes, broader impact, and/or effective dissemination. Please provide examples.

De-identified client data will be analyzed in order to examine program outputs (number served, etc.) and outcomes (client outcomes). The evaluation design may suggest a comparison group of those that receive specific services, compared to those that do not receive those services. Clients and/or family members may also be asked to participate in surveys, focus groups, or interviews. Depending on the study design, some research (e.g. surveys) will be anonymous; other research (e.g. interviews) may be confidential. UC Davis will work with the IRB to ensure client protections. All research involving unique clients (as opposed to aggregated de-identified data) is subject to informed client consent.

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Data to be collected will *likely* include:

- Client history / demographics
- Baseline and ongoing housing status
- Baseline and ongoing criminal justice status
- Baseline and ongoing assessment of the level of care needed (through the CANSA)
- Baseline and ongoing utilization of treatment services and service costs (BHS/CMC clinical databases)
- Timeliness of services – length of time to enroll in routine treatment services from assessment
- Client and Stakeholder program satisfaction, perceptions of effectiveness

The evaluation team may also wish to collect information regarding the program design, implementation, and community impact from program staff, partners, and other community stakeholders. The study design may recommend surveys, interviews, focus groups, or observations of community meetings or services. Other data collection techniques may include reviews of financial reports, related data from community partners, and/or a matched data set of clients who receive services in two systems. All research involving unique clients (as opposed to aggregated de-identified data) is subject to informed client consent.

d) What is the method for collecting data (e.g. interviews with clinicians, focus groups with family members, ethnographic observation by two evaluators, surveys completed by clients, analysis of encounter or assessment data)?

The evaluation design will determine the method for collecting the data. *Potential* data collection strategies include, but are not limited to:

- Pre and post psycho social assessments
- Treatment utilization and cost data – units of service by service type, treatment cost per client
- Planned vs. Unplanned service utilization by client demographics
- Program participation data – Utilization of services by type, drop-out rates, etc.
- Key event tracking – hospitalizations, jail days, etc.
- Confidential client impact surveys
- Client focus groups
- Program Staff focus group
- Key Partner interviews

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e) How is the method administered (e.g., during an encounter, for an intervention group and a comparison group, for the same individuals pre and post intervention)?

CMC and BHS may collect the following information on program clients and make this data available to the UC Davis evaluation team for analysis.

- Routine client encounter data is entered into electronic health records
- Referrals and utilization of stabilization services will be entered into program specific databases designed in partnership with the evaluation team
- Aggregate service utilization and cost data runs, provided annually for a comparison group, of similar clients not enrolled in stabilization services

Additionally, the project team will support client and/or partner recruitment for the following qualitative evaluation activities:

- Client surveys, administered annually.
- Focus groups, conducted annually.
- Key partner interviews, collected at baseline, mid-way through the program, and toward project completion to determine perceived goals, perceived progress in meeting goals, and perceived effectiveness of the program in meeting project goals.

f) What is the *preliminary* plan for how the data will be entered and analyzed?

CMC will enter and store the following client information in existing databases:

- Clinical data will be kept in existing electronic health records.

Qualitative data, from surveys and focus groups, will be managed by the project evaluator.

Data analysis will be conducted by the project evaluator through a Business Services Agreement.

- Aggregate and de-identified client data will be provided to the project evaluator using secure protocols for the transfer of information. The pre and post analysis of changes experienced by clients will be conducted through a unique identifier (which is not the medical record number, social security number, or other common identifier) that will be attached to each client.

All evaluation efforts will be reviewed by the San Joaquin County Health Care Services Institutional Review Board (IRB) and/or the UC Davis IRB through the evaluation contract.

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7. Contracting

- | |
|---|
| a) What project resources will be applied to managing the County's relationship to the contractor(s)? |
|---|

Administration and Oversight

The two BHS Deputy Directors with oversight for the Justice Decriminalization Unit (JDU) and MHSA Projects will be jointly responsible for managing the County's relationship with the program and evaluation contractors. The JDU Deputy Director (BHS Program Administrator for the project) will oversee program implementation and performance. The MHSA Deputy Director will oversee the program evaluation contract and help coordinate evaluation efforts between related projects.

Routine Activities in Support of the Collaboration

The BHS Program Manager will be responsible for the daily coordination of clinical services and supports with the Assessment and Respite Center. This includes ensuring that there are regular check-ins with between BHS clinicians, case managers, and street outreach and engagement staff and the staff at the Respite and Assessment Center and that communication and referral policies and practices are working as intended. The Program Manager will also oversee the referral, screening, and assessment processes of outside program partners to ensure that all other referring partners (homeless shelters, law enforcement, etc.) align with BHS expectations for using validated and approved screening instruments and protocols.

Contract Monitoring

Ongoing contract monitoring and quality control is undertaken through the contract monitoring team at BHS, per the protocols outlined by the organization. Protocols include comprehensive contract review and auditing protocols, including annual site visits to program service locations.

FTE allocations for all project staff are described in the budget narrative.

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Consumer and Community Stakeholders

For the Assessment and Respite Center Project, oversight will also be conducted through the **Community Collaborative**. The Community Collaborative will meet quarterly for the duration of the project to review program implementation, evaluation findings, and to make recommendations for program improvements and sustainability. Meetings will be convened by the BHS Program Administrator. The Community Collaborative will be comprised of key stakeholder partners, including (at a minimum):

- Behavioral Health Services
- Community Medical Centers
- Stockton Self Help Housing
- Health Care Services Agency
- A representative of a local government agency
- Partner community-based organizations
- At least one consumer
- At least one family member

b) How will the County ensure quality as well as regulatory compliance in these contracted relationships?

BHS contract monitoring is a year-long process of evaluating a contractor's performance based on measurable deliverables and verifying contractor compliance with the terms and conditions of the contract with the County. The purposes of the monitoring are to 1) improve program performance, thereby mitigating program inefficiencies; 2) evaluate contractor performance controls to ensure there is a reliable basis for validating service deliverables; 3) to assure that the financial documentation is adequate and accurate; 4) and review compliance with applicable regulatory requirements.

The contract monitoring process consists of five major elements:

1. Analysis of each contract, scope of work and budget proposed by the manager and the contractor prior to finalization of the contract.
2. Review and analysis of monthly or quarterly fiscal invoices submitted by contractors.
3. Review and analysis of program data submitted via contractor's quarterly progress reports.
4. In-person review of program and fiscal data conducted during annual site visits.
5. Review of contractor's annual financial audit, IRS Form 990, quarterly payroll tax returns and insurance certificate.

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Part II Additional Information for Regulatory Purposes

1. Certifications

Innovative Project proposals submitted for approval by the MHSOAC must include documented evidence of County Board of Supervisors review and approval as well as certain certifications.

Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors to the Mental Health Services Oversight and Accountability Commission and the State Department of Health Care Services within 30 days after adoption.

- Adoption by the County Board of Supervisors See Appendix.
Resolution Date: _____

Include a Certification by the county mental health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

- Certification Date: _____ See Appendix.

Include a Certification by the county mental health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.

- Certification Date: _____ See Appendix.

Provide assurance that five percent of the total funding for each county mental health program shall be utilized for innovative programs.

- Documentation that the source of INN funds is 5% of the County's PEI allocation and 5% of the CSS allocation. See Budget.

Provide assurance that the County submitted, to the Department of Health Care Services, an Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report, no later than December 31 following the end of the fiscal year.

- Annual Mental Health Services Act Revenue and Expenditure Report See Budget.

The County shall expend Innovation Funds for a specific Innovative Project only after the Mental Health Services Oversight and Accountability Commission approves the funds for the Innovative Project.

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2. Community Program Planning

The Community Program Planning Process shall, at a minimum, include:

- 1) Involvement of clients with serious mental illness and/or serious emotional disturbance and their family members in all aspects of the Community Program Planning Process.
- 2) Participation of stakeholders, as stakeholders is defined in Section 3200.270.
- 3) Training.

Mental Health Services Act, 2012 and 2017

- | |
|---|
| a) Describe the Stakeholders that participated in the Community Program Planning Process. |
|---|

The Community Program Planning (CPP) 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.

Per recommendations of the San Joaquin County Planning Stakeholder Steering Committee, 2017 INN project planning outreach and engagement process was specifically focused towards a target population of unserved and underserved adults. This planning focus was determined based on several factors:

- 1) A current INN project is focusing on children and youth
- 2) Feedback from 2015 and 2016 community planning processes identified growing concern for unserved and underserved adults
- 3) Feedback from Children and Youth Services providers and partners resulted in a finding that the that necessary service enhancements would be best funded through CSS or PEI funds; that service needs were not innovative, nor time limited.

A summary of the stakeholders that participated in the CPP process is described below:

Clients with serious mental illnesses and or serious emotional disturbances and their family members comprise the majority of stakeholders that participated in the 2017 INN planning process - accounting for 53% of community meeting participants and 51% of survey respondents.

In 2017, stakeholders were able to participate in the planning process and provide feedback through many different input strategies, including:

- Community meetings
- Focused discussion groups
- Client and Stakeholder Surveys

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Stakeholders that participated in the general community meetings included a range of community based service providers, consumers, and family members. Outreach was also conducted to other public agencies including law enforcement and education to encourage their participation.

Three consumer serving programs hosted client discussion groups. Participants included a diverse array of clients with the majority of discussion group participants inclusive of underserved consumers. Of the nearly 30 consumers who participated in the discussion groups, three spoke Spanish as a first language and were included in the group discussion through translation assistance. Nearly all consumers participating in the discussion groups reported having co-occurring mental health and substance use disorders.

Focused discussion groups were also held with dozens of 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) and per the stipulations of the Mental Health Services Act which stipulates that one of the essential purposes of INN funds is to promote interagency and community collaboration. The BHS planning team met with housing providers, substance use disorder treatment providers, primary health care providers, and law enforcement and justice partners in order to brainstorm innovative strategies to address local needs and challenges.

The greatest challenge in the community program planning process is reaching out to clients that speak Spanish or other languages. This is somewhat addressed by conducting targeted discussion groups with translation assistance, though overall participation of individuals for whom English is a second language suggests that this strategy could be improved. Recommended improvements to future community program planning processes is the inclusion of a Spanish Language survey.

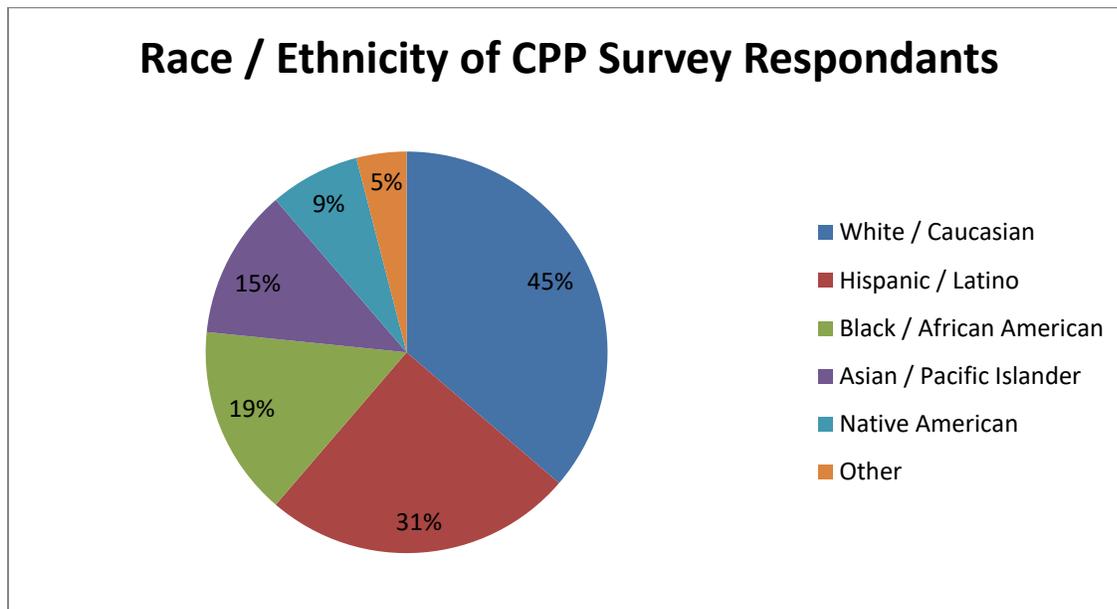
b) Demonstrate that Stakeholders included representatives of unserved or underserved populations, and individuals that reflect the cultural, ethnic, and racial diversity of the County's community.

During the 2017 Community Program Planning process the largest proportion of feedback was received through the Client and Stakeholder Surveys. The surveys were distributed through local community based organizations and mental health clinics, helping to ensure that a broad cross section of individuals were able to complete the survey. In general the racial and ethnic diversity of survey respondents was representative of the population of clients served by BHS.

Surveys were distributed to individuals seeking mental health and substance abuse treatment services at clinic and treatment programs throughout San Joaquin County. Over 600 surveys were returned (N=665) allowing for a statistically significant sample. Slightly more females than males completed surveys (53% compared to 46%) and nine individuals identified as transgender.

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Half of all surveys were completed by individuals self-identifying as a mental health consumer and nearly 20% of survey respondents identified as a family member of a consumer; corresponding to a high rate of returns received from clients of the Children and Youth Services clinics. Forty percent of respondents also reported working for an agency that provides mental health or substance use treatment services, suggesting that some of those who report as professionals also are parents, family members, or consumers themselves.



- c) Include a brief description of the training the county provided to community planning participants regarding the specific purposes and MHSA requirements for INN Projects.

Prior to every MHSA community planning meeting, the meeting facilitator will conduct a brief training on the goals and objectives of the Mental Health Services Act; how funding is allocated to Counties and within San Joaquin County; and the types of program and activities that are funded by MHSA. Additionally the meeting facilitator will also review the regulations and guidelines that direct the planning process and the use of funds. For the INN Community Program Planning Process it is important that stakeholders understand the intention and purpose of the legislature in developing Innovative programs. All meetings to discuss the potential use of the INN funds include an overview of the following key concepts:

- Purpose and Intent of INN funding
- Overview of key terms, including “Unservd,” “Underserved” “Timely” “Access to Services” “Outcomes” “Interagency Collaboration”
- All Innovation projects are described as time limited learning endeavors, that will help answer key research questions, and (if successful) lead to improvements in service delivery.

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3. Primary Purpose

All projects included in the innovative program portion of the county plan shall address one of the following purposes as its primary purpose:

- (A) Increase access to underserved groups, which may include providing access through the provision of permanent supportive housing.
- (B) Increase the quality of services, including measurable outcomes.
- (C) Promote interagency and community collaboration.
- (D) Increase access to services, which may include providing access through the provision of permanent supportive housing.

Mental Health Services Act, as Amended April 2017

Insert Primary Purpose

Increase access to underserved groups, which may include providing access through the provision of permanent supportive housing.

4. MHSA Innovation Project Category

All projects included in the innovative program portion of the county plan shall support innovative approaches by doing one of the following:

- (A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention
- (B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.
- (C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in nonmental health contexts or settings.
- (D) Participating in a housing program designed to stabilize a person's living situation while also providing supportive services on site.

Mental Health Services Act, Amended April 2017

Insert MHSA Innovation Project Category

Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention

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5. Population (if applicable)

Include the following section if the INN project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance.

If applicable, describe the population to be served, including demographic information such as age, gender identity, race, ethnicity, sexual orientation, and language used if relevant to the specific Project. If applicable, describe the estimated number of clients expected to be served annually.

CCR, Title 9, Division 1, Chapter 14, Sect. 3930(c)(4)(B)

a) Estimate number of individuals expected to be served annually. How are you estimating this number?

Estimated Numbers to be Served:

- The Assessment and Respite Center will operate as a stand-alone facility offering respite, stabilization and assessment services. The ARC will see approximately 20 individuals a day, based on anticipated staffing and facility capacity, not estimated demand which is believed to exceed this capacity.

Rationale for Anticipated Demand:

- Large numbers of individuals contact BHS regarding mental health services, however the majority that are screened (following a self-referral) do not meet the criteria for specialty mental health services. A six month review of data revealed the following findings:

BHS TASK Call Log, January – June 2017						
	Jan	Feb	Mar	Apr	May	June
Total Calls	233	233	353	398	388	412
Assessments Scheduled	41	36	46	29	49	56
Avg. # per day that are referred elsewhere for mental health services	7.2	7.8	10.4	12.2	11.6	12.8

- A number of partner programs report a likely high demand for mental health respite, stabilization, assessment and linkages to treatment services, though few were able to estimate the unmet demand for services that could potentially be addressed by the ARC:
 - Stockton Shelter for the Homeless serves approximately 300 individuals each night, including youth, seniors, veterans, and families. In planning meetings, the Shelters CEO stated that many of the individuals served by the shelter are looking for assistance. CMC currently provides routine health care services at the shelter on a weekly basis.

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Access to mental health services is reported to be in high demand, particularly amongst women of color¹⁴.

- Stockton Police Department has assigned bike officers to patrol the Downtown Stockton pedestrian, retail, and entertainment areas. Stockton Police estimate that they have daily encounters with many individuals that could benefit from behavioral health assessment respite, stabilization and treatment services¹⁵.
- San Joaquin County Sheriff books an estimated 100 individuals into the County Jail every day. Of these an estimated 40% have a behavioral health concern (primarily substance use disorders). While not all individuals should be diverted to services at the ARC, local law enforcement agencies are concerned that many who are incarcerated would be better served by behavioral health interventions.

b) Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate.

The target population of the ARC is unserved or underserved adults in San Joaquin County in need of a behavioral health assessment and associated stabilization and treatment services.

In general the greatest demand for services is felt amongst individuals that have low or very low incomes; have witnessed or experienced severe violence; have substance use disorders; are homeless or have unstable housing; have been arrested several times in the past year for an infraction that is suspected to be related to an untreated behavioral health concern; do not have a medical home; and are disproportionately individuals from historically underserved and/or disenfranchised communities.

c) Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.

The ARC is intended to provide a mechanism in which there are low-to-no barriers to entry into mental health services. It is anticipated that a very-low barrier approach to mental health services will greatly increase the number of individuals that complete a mental health assessment and are successfully referred into services. There are no eligibility criteria that must be met, though in general the program will target adults. Some individuals would not be a good fit for the ARC, such as those experiencing a true medical or psychiatric emergency and these would be referred to the hospital emergency room or 24-hour crisis services at BHS. Homeless or runaway youth would typically be referred to other systems

¹⁴ Adam Cheshire, CEO of Stockton Shelter for the Homeless, telephone interview on 9/12/17.

¹⁵ As discussed in various conversations with Chief Eric Jones and other Stockton Police Department representatives participating in LAC meetings, Homeless Taskforce Meetings, LEAD implementation meetings, and other planning processes. Similar discussions also occurred with Sheriff Steve Moore and other Sheriff Deputies. All conversations occurred between Jan 2017 - June 2017 as part of the INN Community Program Planning Process.

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of care, and will generally be met by the *Children and Youth Services Mobile Crisis Response Team* shortly after identification. Children that are in the custody of a parent or guardian would be encouraged to engage in mental health screening and assessment services at one of CMC's twelve neighborhood clinics (though an evaluation may be conducted to determine immediate needs).

6. MHSa General Standards

Describe briefly, with specific examples, how the Innovative Project will reflect and be consistent with all relevant Mental Health Services Act General Standards.

The County shall adopt the following standards in planning, implementing, and evaluating the programs and/or services provided with Mental Health Services Act (MHSa) funds. The planning, implementation and evaluation process includes, but is not limited to, the Community Program Planning Process; development of the Three-Year Program and Expenditure Plans and updates; and the manner in which the County delivers services and evaluates service delivery.

- (1) Community Collaboration, as defined in Section 3200.060.
- (2) Cultural Competence, as defined in Section 3200.100.
- (3) Client Driven, as defined in Section 3200.050.
- (4) Family Driven, as defined in Section 3200.120.
- (5) Wellness, Recovery, and Resilience Focused.
- (6) Integrated Service Experiences for clients and their families, as defined in Section 3200.190.

MHSa General Standards CCR, Title 9, Division 1, Chapter 14, Sect. 3320.

a) Community Collaboration

The Assessment and Respite Center was developed with significant community input and is designed as a component of a larger initiative to reduce the incidence of untreated mental illnesses. The majority of clients will receive ongoing mental health services through CMC, though many will be referred to BHS if they are identified as having a serious mental illness. The project will measure whether a new approach to mental health assessment services improves engagement and retention amongst previously unserved or underserved individuals and leads to improved outcomes amongst consumers.

San Joaquin County Behavioral Health Services

Assessment and Respite Center

Program Partners

Lead Agency: Community Medical Centers

Service Partners:

- Community Medical Centers
 - Primary Health Care Services
 - Behavioral Health Care Services
 - Withdrawal Management Center
 - Dentistry
- Stockton Self Help Housing
- St Mary's Dining Hall
 - Food and Clothes Pantry
- Various Community Based Organizations
 - Case Management
 - Advocacy, legal/document procurement services, and cultural/linguistic supports
 - Other Support Services and Wellness Groups

Referral Partners:

- Stockton Shelter for the Homeless
- Homeless Outreach Teams (operated by various partners, including BHS and local law enforcement agencies) that have been trained to conduct a brief mental health screening.
- Various Community Based Organizations

Collaboration Team Meetings:

Behavioral Health Services will convene monthly collaborative team meetings between BHS management and CMC in order to ensure program services are meeting project goals and objectives. Program staff will also meet on a regular (and at least monthly) to discuss individual referrals and program services.

Community Collaborative meetings will be held quarterly through the Homeward Bound Initiative. The Homeward Bound Initiative is the umbrella initiative over several interconnected projects that are serving this target population:

- Homeless Outreach Teams (Whole Person Care Funds granted)
- Withdrawal Management Center (Proposition 47 Funds granted)
- **Assessment and Respite Center** (INN Funding proposed)
- Clinical Mental Health Services (CSS Funding allocated)
- Progressive Housing (INN Funding proposed)

Community Collaborative meetings will ensure that the separate projects continue to serve distinct needs along the recovery continuum while coordinating referrals and treatment plans across the continuum.

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b) Cultural Competence

CMC serves over 80,000 patients annually in over 250,000 treatment encounters. The vast majority of patients are from racial and ethnic minority communities and have low incomes. Over the past 40 years CMC has grown with, by and for the communities it serves. Staffing demographics are reflective of the communities it serves. CMC also prides itself on being a “first job” for many community members and understands that in addition to providing community driven health care another component of its mission and vision is to reduce health care disparities by training a new generation of health care professionals which is representative of the communities served. CMC employs over 450 community members, including 125 entry level positions.

CMCs cultural competence is also demonstrated by its commitment to serving individuals and families in diverse, low income communities such as the Channel Clinic in Downtown Stockton and the Dorothy L. Jones Clinic in South Stockton. CMC also has extensive experience conducting outreach to individuals who are homeless, have substance use disorders, and/or mental health concerns. As primary care physicians they have, since 2001, operated Care Link, offering free medical care to homeless individuals and families in San Joaquin County. The program provides weekly medical outreach services at area shelters, on the streets, under bridges or at other locations where the homeless congregate. These outreach activities serve as an initial point of contact with most patients, and as relationships are developed these sites act as a link to clinic mental health and based primary care services.

c) Client Driven

The unique needs of individuals and families have driven CMC’s approach to patient care for over forty years. CMC began in the 1960’s as a volunteer effort of the San Joaquin Medical Society, the San Joaquin Local Health District and the Community Action Council. Local physicians, nurses, dentists and community activists who recognized the lack of health and social services programs formed service teams to address the needs of migrant farm workers and their families. The providers went out to the fields and worked from their cars to deliver medical care, to supply food and clothing and to link families with available services. In 1967, the San Joaquin Medical Society received state and federal funding to support the development of two small facilities, as well as mobile clinics to provide services throughout the county.

Today, CMC operates a robust community health education program to ensure that individuals and families are making their own best decisions regarding life style choices and health care services. Individual client based health education includes providing information, guidance and support with the management and prevention of chronic conditions. CMC also engages peer navigators, to help patients talk through their concerns and develop their own wellness plans. One-on-one sessions and classes are also available for free for all clients.

Finally, CMC works with all clients to help ensure that payment is not a barrier to care and each individual can access the health care services that they need. Medi-Cal enrollment and renewal

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assistance targeting uninsured Medi-Cal eligible residents occurs in partnership with San Joaquin County Human Services Agency. Special outreach efforts are made with homeless individuals and families to ensure that all persons can receive needed treatment services. Health case managers are also available for individuals with chronic health conditions who need extra support in managing their recovery.

d) Family Driven

All care provided by CMC is family focused. Individuals assessed through the ARC will be engaged into a health care system that also includes primary health care, preventive services, and dentistry. Services are also family focused – according to Adam Cheshire, CEO of the Stockton Shelter for the Homeless, the largest anticipated demand for services from shelter clients may be from women with minor children. According to Mr. Cheshire, the profile of women in the shelter is of very low-income women, with children, who are unemployed or earning very low wages and who can no longer afford rental rates in San Joaquin County. These women often have trauma related symptomology due to past violence or abuse and may also have substance use disorders. Families that appear at the shelter are typically looking for support in getting out of a bad situation, reports Mr. Cheshire and they are ready to engage in a broad therapeutic intervention for themselves and their children if services are offered.

CMC has developed a range of services and supports to strengthen the well-being of families. In addition to individual counseling and trauma informed treatment services for parents, CMC offers a range of services for children including well child check-ups, immunizations, and dentistry. Family planning, OB-GYN, and support groups are also available. Finally, CMC hosts a special supplemental nutrition program for pregnant & postpartum women, infants and children up to age 5 who are at nutritional risk.

Children’s mental health is also available through BHS, local school districts, and other children and youth serving agencies. San Joaquin County has a robust children’s system of care. PEI funds over \$5 million in community programs delivering trauma informed therapeutic interventions for children and youth in schools and community locations; as well as family therapy, mentoring for at-risk youth, and parenting classes.

e) Wellness, Recovery, and Resilience Focused

The ARC will be reflective of CMC and BHS’s joint commitment to culturally competent, client and family driven services. In addition CMC is pleased to partner with BHS in expanding and enhancing San Joaquin County’s mental health service delivery system. The new ARC will further a joint commitment to consumer wellness, recovery, and resilience. The ARC will:

- Enable more individuals to access mental health treatment services prior to the development of a serious mental illness. The overarching goal is to reduce the number of individuals whose behavioral health concerns are untreated, and lead to a preventable law enforcement contact, mental health crisis, or hospital emergency room visit. Enabling more individuals to access services is critical to this endeavor.

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- Provide a range of supportive respite and stabilization services to aid recovery efforts. Recovery from a chronic health condition is much more complex when there are other conditions affecting health and wellbeing. The ARC takes a holistic view of wellbeing that includes housing and substance use disorder treatment services as necessary components of the treatment plan. These resources are typically outside of the control of a health care organization, however through related initiatives (Withdrawal Management and Progressive Housing) the ARC will be able to link clients to a broad spectrum of recovery supports, including: primary health care services, mental health treatment, substance use disorder treatment services, and housing under one assessment system, that will ultimately be dispersed through all BHS and CMC Clinics.

f) Integrated Service Experiences for clients and their families
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The ARC will be the front gate to an integrated service experience for individuals and their families. Over time the policies and protocols developed through this partnership will significantly enhance the mental health system of care in San Joaquin County. It will create a uniform assessment process to access mild, moderate and serious mental illness treatment services. It will create a range of communication and coordination policies between the two largest providers of mental health services in the County so that individuals can move up and down the treatment spectrum as needed. Finally it will strengthen the partnership between behavioral health and primary care practitioners through a range of small interactions such as psychiatric consultations and joint trainings. The ARC will offer an integrated service experience for clients and strengthen the integration of primary and behavioral health care at all levels.

7. Continuity of Care for Individuals with Serious Mental Illnesses

If applicable, provide a description of how the County plans to protect and provide continuity for individuals with serious mental illness who are receiving services from the Innovative Project after the end of implementation with Innovation Funds.

The Assessment and Respite Center is designed as a five year pilot project to test the success of a new model of conducting mental health assessments and linking clients to services. As such the following design considerations will help ensure continuity of care for individuals with serious mental illness who receive program services.

1. Access to Treatment: All clients who are assessed as needing mental health services will be referred to existing treatment services. Upon project termination, mental health treatment services shall continue to be offered to all individuals with serious mental illnesses.
2. Access to Stabilization Services: Stabilization services are pilot components of this project. If they are successful they may be continued through ongoing funding – potentially prevention and early intervention funding or through other county resources or philanthropy.
3. Continuing provision of Assessment and Respite Services through FQHC: INN funds will test a new model of conducting assessment, but they will secondarily help BHS and CMC create joint

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policies and procedures for a shared assessment and seamless referral to services. Upon completion of the pilot project, successful program policies will be adopted throughout CMC's twelve neighborhood health centers located in San Joaquin County, greatly expanding the front door to mental health services within the County.

8. Compliance Standards for INN Project Evaluation

The evaluation shall be culturally competent and must include meaningful involvement by diverse community stakeholders.

a) Describe the County's plan to ensure the *Cultural Competency* of the evaluation.

Targeted actions will be made to ensure that consumers are represented in all phases of the evaluation design and implementation phase. The evaluation team will work with program partners (BHS, CMC, and other community based organizations) to identify consumers who have lived experience to provide guidance on the development of the evaluation plan and the proposed strategies for collecting information directly from project participants.

Evaluation tools will also be vetted with Community Collaborative stakeholder group. Furthermore, all evaluation activities will be linked to a participant demographic form, which will gather information about participants' age, sexual orientation, gender identity, race/ethnicity, etc. in order to better understand whether there are disparities that are revealed through the evaluation. Any disparities uncovered will be shared with BHS, CMC, and the Community Collaborative in order to develop program course corrections to increase participation and service delivery across diverse populations.

b) Describe the County's plan to include *Meaningful Stakeholder Involvement* in the evaluation.

In order to ensure meaningful stakeholder participation in the evaluation activities, the UC Davis BHCE will rely on a workgroup formed from the Community Collaborative to support evaluation design and implementation activities. Stakeholders engaged in the Community Collaborative may include County staff, providers, consumers, and consumers' families. The *Evaluation Workgroup* will play a critical role for informing overall evaluation design, tool development, and implementation.

Evaluation findings will be communicated to stakeholders, and stakeholders will have the opportunity to contribute to their interpretation and provide input on reports. UC Davis BHCE will also provide training and technical assistance to the *Evaluation Workgroup* throughout the project to support meaningful stakeholder participation.

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9. Continuity of Project Without INN Funds

After completion of the evaluation pursuant to section 3915 (i.e. when the evaluation questions are answered), the County, with meaningful involvement of stakeholders, shall decide whether and how Innovative Projects or elements of Innovative Projects, will be continued and incorporated into the local mental health delivery system and with what other funding sources, if funding is required.

- a) Provide a description of how the County will decide whether and how to continue the Innovative Project, or elements of the Project, without Innovation Funds.

Determination of whether and how to continue the ARC project will be made by BHS, with input from the Community Collaborative. All decisions are subject to the approval of the San Joaquin County Board of Supervisors.

In order for the project to continue beyond the scope of the INN funds a budget recommendation for continued program funding must be received by BHS from the Community Collaborative no later than January 31, 2022 in order to include financing for the transition plan and ongoing sustainability into County-wide budget for any services beyond the project termination in December 31, 2022.

Determination of continuation will be based on a number of factors:

1. Success: At a minimum the project must show some success. Program participants must have increased their access to and utilization of mental health services. Participants must demonstrate positive outcomes, at least comparable with other programs and indicate a strong level of satisfaction with the program. The program must be cost effective, sustainable, and implemented in accordance with the program design and intention.
2. Cost and available financing: There is a possibility that some of the costs associated with stabilization services may be absorbed by PEI funding if results are promising. Currently MHSA regulations allow PEI allocations to pay for local promising or evidence based practices. More research is needed to determine which components of the project are the most effective interventions to encourage ongoing engagement with the assessment process and lead to a successful connection to treatment services.
3. Partnership commitment: Ultimately this project is also a test of a multi-agency community collaboration. The end of five years will determine if the project has been a success, and if community partners are committed to continuing the project or if a new model has emerged from the process.

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10. Communication and Dissemination Plan

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

a) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?

BHS will work with the MHSOAC and its program partners to disseminate information regarding the ARC Innovation Program to local stakeholders and other counties. In general, communication pertaining to the availability of evaluation findings or the publication of research studies will occur through the following steps:

- 1) BHS, CMC, and the UC Davis Behavioral Health Center of Excellence will issue a joint press release and post the report on their respective web sites.
- 2) BHS will simultaneously send the evaluation report to the MHSOAC for posting to statewide bulletins.
- 3) BHS, CMC, UC Davis, and MHSOAC will further use a range of social media outlets to announce findings and direct subscribers to the report.

b) How will program participants or other stakeholders be involved in communication efforts?

The Community Collaborative group, with input from BHS, CMC, UC Davis, and the MHSOAC, will ultimately be responsible for finalizing the plan to communicate results and lessons learned from the Assessment and Respite Center Innovation Project. In addition to the strategies discussed above, the Community Collaborative may also consider whether they want to host a *Learning Community* or prepare a *Conference Presentation*.

Learning Communities

San Joaquin County hosts periodic Learning Communities to address topics of interest to a wide variety of local stakeholders. Learning Communities are typically half-day sessions to discuss project activities and lessons learned. During the Start-up phase a Learning Community is used to announce the program intention and to solicit the support and engagement of potential program partners and community allies. During Implementation, Learning Communities are valuable opportunities for program participants and stakeholders to review best practices, discuss program activities, and make recommendations for program improvements. Towards the end of a project Learning Communities are an opportunity to convey findings, determine the level of stakeholder support for on-going sustainability, and to plan for program termination and the transition of clients into other services and supports (as needed if the program is not recommended for continuation in some fashion).

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Conference Presentations

Conference presentations, poster boards, and exhibits may also be used to communicate project results to a statewide audience of Behavioral Health Directors, Primary Care Providers, and other interested stakeholders. As feasible, program participants should be part of the conference proceedings in order to offer a “lived experience” perspective on what aspects of the program worked and what challenges still need to be addressed.

c) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

1. Mental Health Assessment
2. Co-occurring Disorders
3. Pre-contemplation in mental health
4. Barriers to mental health treatment
5. Social determinants of mental health

11. Timeline

An Innovative Project shall have an end date that is not more than five years from the start date of the Innovative Project. The County designates the timeframe to complete the Innovative Project based on the complexity of the evaluation and the approach to be evaluated.

- Specify Total Timeframe _____ 5 Yrs. 0 Mo.
- Anticipated Start and End Date _____ Jan 2018 Start Dec 2022 End

Include a timeline that specifies key milestones for development and refinement of the approach; ongoing assessment and final evaluation of the Innovative Project; decision-making, including meaningful involvement of stakeholders, about whether and how to continue a successful Innovative Project or parts of the project; and communication of the results and lessons learned with a focus of dissemination of successful Innovative Projects.

a) Provide a project timeline that specifies key activities and milestones.

See Timeline below.

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INN Project Timeline					
Launch & Startup	INN Project Period				Evaluation & Dissemination
<p>Start-Up Activities</p> <ul style="list-style-type: none"> • MHSOAC Approval • Contract Negotiations • Board of Supervisors Approval • Hire staff and begin cross training in existing clinics • Establish Quarterly Collaborative Meetings • Establish subcommittees to develop joint protocols regarding: <ul style="list-style-type: none"> ○ Program referrals and screening processes ○ Integrated and coordinated service expectations ○ On-site partner activities • Enter into lease agreement for ARC facility • Develop Evaluation Plan <ul style="list-style-type: none"> ○ Develop research protocols ○ Consumer input/review of evaluation plan ○ IRB approval of the evaluation plan 	<p>PHASE 1: Pilot test protocols</p> <ul style="list-style-type: none"> • Continue build-out of facility • Plan soft launch for opening by 1/19 • Select clinic locations for pilot testing of BHS & CMC referral policies • Develop internal CMC referral policies • Train BHS TASK, ACCESS, MCRT and Crisis Staff on referral processes • Revise protocols as needed and develop referral policies for housing and withdrawal management services <p>Evaluation</p> <ul style="list-style-type: none"> • Establish evaluation sub-committee • Convene Learning Community • Begin baseline data collection 	<p>PHASE 2: Start-up Full Operations</p> <ul style="list-style-type: none"> • Begin FY with full operations in new ARC facility. • Implement new client tracking and data sharing protocols for clients using stabilization services. • Train additional partners (eg shelters, Stockton PD bike Patrol Officers, etc.) • Work with CVLIHC, SSHH, BHS, and Housing Authority to refine and strengthen housing referrals <p>Evaluation</p> <ul style="list-style-type: none"> • Establish data sharing protocols with UC Davis between health and justice partners • Complete secure project database • Present summary of initial activities to broad group of county partners and stakeholders 	<p>PHASE 3: Revise Operations and Referrals</p> <ul style="list-style-type: none"> • Determine additional programming needs and develop fund development plan. • Expand partnership group to be inclusive of more community based services and supports, such as case management, mentoring, job readiness, and sober living homes. • Review service utilization, capacity, and protocols to determine readiness/ capacity for referrals from additional partners <p>Evaluation</p> <ul style="list-style-type: none"> • Complete evaluation report of Lessons Learned / Recommendations from the Start-up period by 11/15/2020. • Modify policies and procedures as appropriate. • Revise evaluation tools and protocols as appropriate 	<p>PHASE 4: Establish Routine Operations</p> <ul style="list-style-type: none"> • All program operations are implemented as planned. • All partners are trained in screening and referral to ARC protocols <p>Evaluation</p> <ul style="list-style-type: none"> • Conclude consumer data collection. • Complete evaluation report of Preliminary Outcomes • Convene Learning Community <p>Sustainability</p> <ul style="list-style-type: none"> • Develop Client and Program Sustainability Plan <ul style="list-style-type: none"> ○ Document actual financial model ○ Convene key partners to review costs and program needs ○ Identify partner or other funding for program continuity • Budget recommendation is made for continued program funding in FY 22/23 	<p>Project Conclusion</p> <ul style="list-style-type: none"> • Final evaluation reports are completed <ul style="list-style-type: none"> ○ Final Outcomes Report ○ Cost / Benefit Analysis • Findings are presented to community partners and stakeholders • Reports are submitted to the MHSOAC and posted for Public Review. Press Release is sent to local news outlets of project completion. • UC Davis and BHS staff present findings in at least one conference convened by MHSOAC, DHCS, or CIBHS.
1/1/18 – 6/30/18	7/1/18 – 6/30/19	7/1/19 – 6/30/20	7/1/20 – 6/30/21	7/1/21 – 6/30/22	7/1/22 – 12/31/22

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- b) Provide a brief explanation of how the project's timeframe will allow sufficient time for project implementation, operations, evaluation, determination of continuation, and communication of results and lessons learned.

The project time frame is five years, terminating in December 2022. As discussed in the table above the following benchmarks must occur within the stated time periods:

Start-up and Implementation: January 2018 – June 2018

- MHSOAC approval is received
- Contracts are executed
- Initial leases are procured
- New staff are hired and cross-trained in existing clinics
- Operating policies and referral protocols are developed
- Evaluation Plan is due June 1, 2018 (Major Deliverable # 1)

Operations and Evaluation: July 2018 – June 2022

- Client assessments begin
- Evaluation data collection begins
- Lessons Learned Evaluation Report is due November 15, 2020 (Major Deliverable # 2)
- Community Collaborative reviews program Design and makes revisions for implementation in FY 21/22

Determination of Continuation: July 2021 – June 2022

- Preliminary Outcomes Report is due July 15, 2021 (Major Deliverable # 3)
- Community Collaborative develops sustainability plan, due November 15, 2021
- Recommendation of Program Continuation is given to BHS Director by January 31, 2022
- BHS makes determination of ongoing funding and presents plan by June 30, 2022
- Notice of continuation or termination of the project is issued by July 15, 2022.

Communication of Results and Lessons Learned: July 2018 – December 2022

- Determination of Communication Strategy is made by the Community Collaborative, with a written plan due by September 2018, discussing recommendations for:
 - Learning Communities
 - Conference Presentations
 - Other methods of stakeholder communication throughout the duration of the Progressive Housing Innovation Project
- Final Outcome report is due November 15, 2022 (Major Deliverable # 4)

Press Release and Project Brief are distributed by December 31, 2022.

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Part III. Budget

1. Budget Narrative

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project.

Expenditures

1) Personnel Costs (BHS)

Several BHS personnel will work on this project. The likely staff assigned to this project include:

- Program Manager: *Classification* Mental Health Clinician III, or higher
- Case Manager/s: *Classification* Mental Health Specialist II
- Peer Partner/s: *Classification* Mental Health Outreach Worker

The Salary and Benefits will be contributed in-kind.

2) Operating Costs

None.

3) Non Recurring Costs

Non-recurring costs include the one-time purchase of equipment, furnishings, and materials needed to open the new ARC. These costs will be incurred by the contracted program partner and are described below.

4) Consultant Contracts

BHS will contract with UC Davis Behavioral Health Center for Excellence to conduct the comprehensive program evaluation. Project Deliverables and Scope of Work to be determined.

Budget amounts allocated for program evaluation will include:

- \$49,500, for the period of Jan 2018- June 2018, for Evaluation Design
- \$99,000, annually for FY 2018/19, 2019/20, 2020/21 and 2021/22, for ongoing research, evaluation and technical assistance.
- \$49,500, for the period of July 2022 – Dec 2022 to complete evaluation reports and distribute findings
See Evaluation, Item 8, below.

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5) Contracted Service Provider

BHS will contract with Community Medical Centers to operate and manage the Assessment and Respite Center. Costs associated with program operations include program staff, facility lease, direct and indirect program costs. Non-recurring costs include the purchase of furnishings (exam room beds, waiting room chairs, tables, nursing stations, etc.) and equipment (computer equipment, telecommunications systems, medical devices). Other costs associated with the facility renovation and modifications may be incurred as one-time costs or pro-rated into the lease agreement. Budget considerations are described below. The budget includes a 2% cost of living adjustment for personal costs, annually. The narrative below explains the cost model that has been used to derive the project budget. Actual allocations may be adjusted according during the planning and implementation phases.

5.1 Personnel

<u>Position</u>	<u>FTE</u>	<u>Base Salary</u>	<u>Responsibilities on this Project</u>
<u>Program Manager</u>	1	\$ 90,000	The Substance Abuse Program Manager coordinates substance abuse programs or related administrative and support programs.
<u>PA/ NP</u>	1	\$ 152,000	Physician's Assistant/Nurse Practitioner will provide direct medical care to patients.
<u>LCSW</u>	2	\$ 119,000	The Licensed Clinical Social Worker is responsible for the development, implementation and evaluation of case management services and counseling, and facilitation of support groups for clients with health related issues.
<u>LVN</u>	6	\$ 51,209	The Licensed Vocational Nurse is responsible for providing skilled nursing care to patients by practicing within and to the top of their scope of practice in collaboration with and under the direction of MDs, PAs, NPs and RNs.
<u>Medical Assistants</u>	6	\$ 36,649	The Medical Assistant works as a part of the Care Team with the licensed clinical staff and others to provide medical care to patients.
<u>AOD Counselors</u>	2	\$ 51,209	Under general supervision, performs casework and counseling within substance abuse programs; coordinates services or component programs; and other related work.
<u>Peer Support Counselors</u>	6	\$ 36,649	Under supervision, performs group and individual counseling services within substance abuse programs and other related work.
<u>Patient Navigator</u>	2	\$ 39,811	The Patient Navigator is responsible for assisting the Program Manager in coordinating substance abuse programs and care with clients and their families.

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	2017/18 (6 mo.)	2018/19	2019/20	2020/21	2021/22	2022/23 (6 mo.)	Total (60 mo.)
Program Manager (1)	\$45,000	\$91,800	\$93,636	\$95,509	\$97,419	\$49,684	\$473,048
PA/ NP (1)	0	\$155,040	\$158,141	\$161,304	\$164,530	\$83,910	\$722,925
LCSW (2)	0	\$242,760	\$247,615	\$252,567	\$257,619	\$131,385	\$1,131,948
Licensed Vocational Nurse (6)	0	\$313,399	\$319,667	\$326,060	\$332,581	\$169,616	\$1,461,325
Medical Assistants (6)	0	\$224,292	\$228,778	\$233,354	\$238,021	\$121,390	\$1,045,833
AOD Counselors (2)	0	\$104,466	\$106,555	\$108,686	\$110,861	\$56,539	\$487,109
Peer Support Counselors (6)	0	\$224,292	\$228,778	\$233,354	\$238,021	\$121,391	\$1,045,833
Patient Navigator (2)	0	\$81,214	\$82,839	\$84,495	\$86,185	\$43,954	\$378,689
Benefits 25%	\$11,250	\$359,317	\$366,504	\$373,834	\$381,309	\$194,469	\$1,686,677
Total Personnel Costs by Year (increases 2% annually)	\$ 56,250	\$ 1,796,580	\$ 1,832,512	\$ 1,869,163	\$ 1,906,544	\$972,339	\$8,433,388

5.2 Other Direct Costs

Direct Costs are inclusive of all costs associated with general and ongoing operations:

- Rent (with improvements)
- Utilities
- Maintenance
- Medical Supplies
- Medications / Pharmacy
- Client Food
- Office Supplies

	2017/18 (6 mo.)	2018/19	2019/20	2020/21	2021/22	2022/23 (6 mo.)	Total (60 mo.)
Lease with Improvements	-	99,988.00	99,988.00	99,988.00	99,988.00	49,994.00	449,946
Office Supplies	2,400.00	4,800.00	4,800.00	4,800.00	4,800.00	4,800.00	26,400
Utilities	-	12,000.00	12,000.00	12,000.00	12,000.00	12,000.00	60,000
Maintenance	-	10,800.00	10,800.00	10,800.00	10,800.00	10,800.00	54,000
Medical Supplies	-	30,000.00	30,000.00	30,000.00	30,000.00	30,000.00	150,000
Medications / Pharmacy	-	7,200.00	7,200.00	7,200.00	7,200.00	7,200.00	36,000
Client Food	-	3,600.00	3,600.00	3,600.00	3,600.00	3,600.00	18,000
Total Annual Costs	2,400	168,388	168,388	168,388	168,388	118,394	794,346

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Non-recurring costs are inclusive of all one-time purchases of furnishings, medical equipment, and computer or telecommunications equipment necessary to start-up operations of the ARC.

Non-Recurring Costs / Fixed Assets	2017/18
<i>Computers and Medical Equipment</i>	
Medical beds, etc.	108,149
Computer Equipment	100,000
<i>Furnishings / Office Set-up</i>	
Waiting room chairs, etc.	20,796
Total	\$ 228,945

	2017/18 (6 mo.)	2018/19	2019/20	2020/21	2021/22	2022/23 (6 mo.)	Total (60 mo.)
Total Direct Costs	231,345	168,388	168,388	168,388	168,388	118,394	\$ 1,023,291

5.3 Indirect Costs

Indirect Costs are calculated at 15% of Community Medical Centers Direct Costs (Personnel + Other Direct Costs).

	2017/18 (6 mo.)	2018/19	2019/20	2020/21	2021/22	2022/23 (6 mo.)	Total (60 mo.)
Indirect Costs	8,438	269,487	274,877	280,374	285,982	145,851	\$1,265,009

5.4 Total Operating Costs

Total operating costs are the estimated total costs for operating the ARC. Actual INN expenditures will be lower, based on revenue generated by the anticipated service expansion which will occur at CMC as new clients are assessed and enrolled into clinical services and supports including mild-moderate mental health treatment services and primary health care services. See section below for a summary of the potential revenue anticipated for the project.

	2017/18 (6 mo.)	2018/19	2019/20	2020/21	2021/22	2022/23 (6 mo.)	Total (60 mo.)
Total Operating Costs	\$ 296,033	\$ 2,234,455	\$2,275,777	\$2,317,925	\$2,360,914	\$ 1,236,584	\$ 10,721,688

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5.5 Anticipated Revenue

The Assessment and Respite Center is anticipated to generate revenue by increasing the number of patients served by CMC that utilize reimbursable clinic services including any services provided by a nurse, physician, or licensed clinical social worker.

No revenue is anticipated in the first 18-months of the project, during the start-up and implementation phase. By the second year, (FY 19/20) some revenue will begin to be generated and applied to program costs. See anticipated revenue below.

Anticipated Revenue: Community Medical Centers	2020/21	2020/21	2021/22	2022/23	Total 60 Months
	Year 2	Year 3	Year 4	Year 5	
FQHC Reimbursements	\$112,500	\$337,500	\$907,500	\$836,584	\$2,194,084
Other Payment (Medicare, etc.)	\$75,000	\$150,000	\$225,000	\$400,000	\$850,000
Total Revenue Received	187,500	487,500	1,132,500	1,236,584	3,044,084

A measure of the project success will be if sufficient revenue can be generated through the engagement of new clients into services, such that ARC activities are self-sustaining over time. The project goal is that INN project funds allocated to Community Medical Centers for contracted program services dwindle each year, with a target goal of CMC being able to sustain most activities within the ARC following 60 months of start-up support from BHS through INN funds.

5.6 Total INN Allocation to Contracted Service Provider

The total allocation of INN funds to Community Medical Centers will be calculated based on the difference between operating expenditures (see 5.3) and anticipated revenue (see 5.4). Revenue generated will offset costs, lowering the annual allocation each year.

See chart below.

	2017/18 (6 mo.)	2018/19	2019/20	2020/21	2021/22	2022/23 (6 mo.)	Total (60 mo.)
ARC Costs	\$ 296,033	\$ 2,234,455	\$2,275,777	\$2,317,925	\$2,360,914	\$ 1,236,584	\$ 10,721,688
ARC Revenue			187,500	487,500	1,132,500	1,236,584	3,044,084
ARC INN	\$296,033	\$2,234,455	\$2,088,277	\$1,830,425	\$1,228,414	\$0	\$7,677,604

Total operating costs associated with the ARC over the 60 month project period: \$10,721,688
 Total revenue generated that will be offset against costs over the project period: - \$3,044,084
Total INN funds to be spent on the ARC over the project period: \$ 7,677,604

**San Joaquin County Behavioral Health Services
Assessment and Respite Center**

6) Other Expenditures

None

7) Evaluation

See above. Evaluation funds are allocated to the Evaluation Contractor.

BHS will negotiate the scope of work and actual annual allocation upon project approval.

2017/18 (6 mo.)	2018/19	2019/20	2020/21	2021/22	2022/23 (6 mo.)	Total (60 mo.)
\$ 49,500	\$ 99,000	\$ 99,000	\$ 99,000	\$ 99,000	\$ 49,500	\$ 495,000

8) Total Costs to Implement Program and use of INN Funds

The total amount incurred for the administration of this program, inclusive of all costs, is indicated below.

INN Use of Funds	2017/18 (6 mo.)	2018/19	2019/20	2020/21	2021/22	2022/23 (6 mo.)	Total (60 mo.)
Community Medical Centers to operate ARC Program	\$296,033	\$2,234,455	\$2,088,277	\$1,830,425	\$1,228,414	\$0	\$7,677,604
UC Davis BHCE to evaluate ARC Program	\$ 49,500	\$ 99,000	\$ 99,000	\$ 99,000	\$ 99,000	\$ 49,500	\$ 495,000
TOTAL PROJECT COSTS	\$345,533	\$2,333,455	\$2,187,277	\$1,929,425	\$1,327,414	\$49,500	\$8,172,604

**San Joaquin County Behavioral Health Services
Assessment and Respite Center**

2. Budget by Fiscal Year and Specific Budget Category

See Budget Tables.

3. Budget Context, if applicable

a) Provide a brief description of the broader project or initiative to which the Innovation is a component of.

This INN program operates within a broader Homeward Bound Initiative. The Homeward Bound initiative targets individuals with serious mental illnesses that are homeless or at risk of homelessness. It is also presumed that the majority of individuals within this target population will also have co-occurring substance use disorders. The Homeward Bound Initiative consists of five interrelated program components that, collectively, are designed to increase access to treatment services for this chronically unserved and underserved population. The five components include:

<p>Outreach & Engagement <i>Identify potential clients, and conduct a brief screening to determine the likeliness of mental illness</i></p>	<p>Homeless Outreach Teams Mobile Crisis Response Team Community Outreach Partners</p>
<p>Stabilization <i>Address urgent stabilization needs (housing and substance withdrawal) prior to completing the assessment</i></p>	<p>Withdrawal Management Center Pre-Contemplation Home</p>
<p>Assessment & Access to Care <i>Conduct a multi-phase assessment process with brief treatment interventions to address high-risk behavior and options for care.</i></p>	<p>Assessment and Respite Center¹⁶</p>
<p>Whole Person Treatment Model <i>Provide integrated housing and clinical services in a program designed to increase housing stability and recovery.</i></p>	<p>Progressive Housing Clinical Treatment Services through BHS, CMC, and other community care providers</p>
<p>Linkage Additional Community Supports <i>Create a seamless referral process to wrap existing services and supports around consumers as best fits their needs and interests including substance use recovery and peer supports.</i></p>	<p>Substance Use Treatment Programs Wellness Centers</p>

¹⁶ Bold project are those projects for which INN funding will be applied upon approval by the MHSOAC. All other programs are currently funded.

San Joaquin County Behavioral Health Services Assessment and Respite Center

- b) Provide the total amount of funding that will be used and the extent to which non-MHSA funds are being leveraged. List additional funding sources, the amounts anticipated to be leveraged, and provide a brief description of the funding source.

Leveraged Programs

All projects within the Homeward Bound Initiative have their own program budgets and will be managed and operated independently from the ARC Project.

Federal Funding

After five years CMC anticipates that assessment services will result in more patients enrolled in routine care services than would otherwise be engaged. A financial sustainability goal is to generate enough revenue from reimbursable patient services to cover some of the costs associated with the range of non-reimbursable services offered through the ARC. The extent to which additional revenue is generated over the course of the five year project, and can contribute to program operations, will be considered in the program evaluation and will guide the decision over continued operations following the conclusion of the INN period.

**San Joaquin County Behavioral Health Services
Assessment and Respite Center**

A. New Innovative Project Budget By FISCAL YEAR (FY)*								
EXPENDITURES								
PERSONNEL COSTs (salaries, wages, benefits)		FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total
1.	Salaries							
2.	Direct Costs							
3.	Indirect Costs							
4.	Total Personnel Costs							
OPERATING COSTs		FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total
5.	Direct Costs							
6.	Indirect Costs							
7.	Total Operating Costs							
NON RECURRING COSTS (equipment, technology)								
8.								
9.								
10.	Total Non-recurring costs							
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total
11.	Direct Costs	\$ 49,500	\$ 99,000	\$ 99,000	\$ 99,000	\$ 99,000	\$ 49,500	\$ 495,000
12.	Indirect Costs							
13.	Total Consultant Costs	\$ 49,500	\$ 99,000	\$ 99,000	\$ 99,000	\$ 99,000	\$ 49,500	\$ 495,000

	Contracted Service Provider (Name: Community Medical Centers)	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total
14.	Personnel (Salary + Benefits)	\$ 56,250	\$ 1,796,580	\$ 1,832,512	\$ 1,869,163	\$ 1,906,544	\$ 972,339	\$ 8,433,388
15.	Other Direct costs	231,345	168,388	168,388	168,388	168,388	118,394	\$ 1,023,291
16.	Indirect Costs	8,438	269,487	274,877	280,374	285,982	145,851	\$ 1,265,009
17.	Total Operating Costs	\$ 296,033	\$ 2,234,455	\$ 2,275,777	\$ 2,317,925	\$ 2,360,914	\$ 1,236,584	\$ 10,721,688

**San Joaquin County Behavioral Health Services
Assessment and Respite Center**

New Innovative Project Budget By FISCAL YEAR (continued)							
EXPENDITURES							
OTHER EXPENDITURES (please explain in budget narrative)	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total
18.							
19.							
20. Total Other expenditures							

BUDGET TOTALS							
Personnel (line 4)							
Direct Costs (add lines 5, 11, and 17 from above)	\$345,533	\$2,333,455	\$2,374,777	\$2,416,925	\$2,459,914	\$1,286,084	\$11,216,688
Indirect Costs (add lines 3, 6 and 12 from above)							
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET	\$345,533	\$2,333,455	\$2,374,777	\$2,416,925	\$2,459,914	\$1,286,084	\$11,216,688

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

**San Joaquin County Behavioral Health Services
Assessment and Respite Center**

A. Expenditures By Funding Source and FISCAL YEAR (FY)								
Operations:								
A.	Estimated total mental health expenditures for Operations for the entire duration of this INN Project by FY & the following funding sources:	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total
1.	Innovative MHSA Funds	\$296,033	\$2,234,455	\$2,088,277	\$1,830,425	\$1,228,414	\$0	\$7,677,604
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding* (revenue received)			\$187,500	\$487,500	\$1,132,500	1,236,584	\$3,044,084
6.	Total Program Costs	\$ 296,033	\$2,234,455	\$2,275,777	\$2,317,925	\$2,360,914	\$1,236,584	\$10,721,688
Evaluation:								
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total
1.	Innovative MHSA Funds	\$ 49,500	\$ 99,000	\$ 99,000	\$ 99,000	\$ 99,000	\$ 49,500	\$ 495,000
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding*							
6.	Total Evaluation Costs	\$ 49,500	\$ 99,000	\$ 99,000	\$ 99,000	\$ 99,000	\$ 49,500	\$ 495,000
TOTAL:								
C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	Total
1.	Innovative MHSA Funds (Line A1+B1)	\$345,533	\$2,333,455	\$2,187,277	\$1,929,425	\$1,327,414	\$49,500	\$8,172,604
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding* (Revenue received)			187,500	487,500	1,132,500	1,236,584	3,044,084
6.	Total Project Expenditures	\$ 345,533	\$2,333,455	\$2,374,777	\$2,416,925	\$2,459,914	\$1,286,084	\$11,216,688
*If "Other funding" is included, please explain: Revenue procured by contracted provider for FQHC reimbursable services.								

San Joaquin County Behavioral Health Services Assessment and Respite Center

4. Budget Assurances

- a) Documentation that the source of INN funds is 5% of the County's PEI allocation and 5% of the CSS allocation.

San Joaquin County is providing assurance that our INN funds are within the 5% of our total MHSA allocation.

- b) Documentation that the Annual Mental Health Services Act Revenue and Expenditure Report was submitted by December 31, following the end of the fiscal year.

San Joaquin County has not submitted our 2015-16 Mental Health Services Act Revenue and Expenditure Report. It will be completed and submitted on or before September 30, 2017.

**San Joaquin County Behavioral Health Services
Assessment and Respite Center**

Appendix

Certifications

1. Board of Supervisors Resolution
2. Certification of Regulatory Compliance
3. Certification of Fiscal Compliance

NOTE: All certifications will be inserted following the public hearing on September 20, 2017.

Community Program Planning Process

4. Survey Instrument
5. Paper Survey Distribution and Return Count
6. Email Invitation to Targeted Roundtable Discussions
7. Sample Meeting Flyer
8. Demographic Form
9. Assessment and Respite Center Project Presentation
10. Homeward Bound Project Presentation
11. Progressive Housing Project Presentation

**San Joaquin County Behavioral Health Services
Assessment and Respite Center**

1. Board of Supervisors Resolution

This Page deliberately left blank on September 19, 2017

Insert Resolution Here before final submission to MHSOAC

**San Joaquin County Behavioral Health Services
Assessment and Respite Center**

2. San Joaquin County Compliance Certification

County/City:

- Innovation Plan
- Annual Update

Local Mental Health Director

Program Lead

Name:

Name:

Telephone Number:

Telephone Number:

E-mail:

E-mail:

Local Mental Health Mailing Address:

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 [REDACTED].

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.

NAME, _____
Mental Health Director Signature

_____ Date

San Joaquin County Behavioral Health Services (BHS)

2017 MHSA 3-Year Program Plan: Stakeholder Input Survey

Please answer the following questions to provide feedback on mental health services in San Joaquin County. Your responses will help us understand what works well and how we can improve services. Thank you!

Q1 Are you a consumer or family member of someone receiving mental health services at BHS?

Yes, I am a consumer

Yes, I am a family member.....

Yes, I am both a consumer and a family member

No, I am neither a consumer or a family member Go to Question 3 if you are neither a consumer or family member

Q2 If you are a consumer or a family member, what mental health clinic do you or your family member mostly receive services at?

Children and Youth Services

TCC/SEARS

Tracy

BACOP

CATS, Team A, B, C or D ...

Lodi

La Familia

GOALS

Forensic.....

Other

Please enter the name of the other clinic location:

Q3 Please rate your satisfaction with the following aspects of our services:

	Poor	Fair	Very Good	Excellent	Don't Know
The location of our services.	<input type="checkbox"/>				
Informational flyers and pamphlets	<input type="checkbox"/>				
Access to information on our website	<input type="checkbox"/>				
The length of time it takes to get an appointment	<input type="checkbox"/>				
The professionalism of our staff	<input type="checkbox"/>				
The cultural sensitivity of our services	<input type="checkbox"/>				
The thoroughness of our services	<input type="checkbox"/>				

Q4 Would you recommend our services to someone who needs help for a mental health concern?

Yes

No

Maybe

Don't Know

BHS is also interested in ensuring that program activities fill unmet needs and work with those who need help the most.

Q5 Which of the following services do we need more of?

	Right Amount	Need a little more	Need alot more	Don't Know
Mental health clinic services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crisis services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respite services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer drop-in, wellness, or socialization services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services to get basic needs met (food, clothing, hygiene products)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation to appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Help finding the right health care provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q6 Do we need more services for the following populations?

	Right Amount	Need a little more	Need alot more	Don't Know
Homeless individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individuals with frequent mental health crises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individuals with frequent visits to the emergency room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individuals with frequent arrests for mental health related behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individuals with both mental health and substance use disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individuals at-risk of institutional care for a mental health illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q7 Are there any other services or populations that we should be prioritizing?

We would like to know a little bit more about you so we can understand the needs and experiences of different types of people.

Q8 Please indicate your age range:

- Under 18
- 18-25
- 26-59
- 60 and older

Q9 What is your gender:

- Female
- Male
- Other, Both, Transgender

Q10 Please indicate the primary language spoken in your home:

- English
 - Spanish
 - Other
- If other please specify:

Q11 What is your race / ethnicity (check all that apply)

- | | |
|---|--|
| White/Caucasian <input type="checkbox"/> | Asian or Pacific Islander <input type="checkbox"/> |
| Black/African American <input type="checkbox"/> | American Indian, Native American, First Nations <input type="checkbox"/> |
| Hispanic/Latino <input type="checkbox"/> | Other <input type="checkbox"/> |
- If other please specify:

Q12 Do you work with an agency that currently provides mental health or substance use treatment services in San Joaquin County

- Yes No Don't Know

Q13 Do you have any other recommendations on how we can improve program services?

Thank you so much for taking the time to let us know what you think!

2017 MHSA 3-Year Program Plan: Stakeholder Input Survey

2017 Substance Use Disorder Treatment Services: Client Input Survey

Distribution List

Clinic or Program Name	Date Received	Date Returned	Number Returned
CATS Team A		3/27	18
CATS Team B		3/27	5
CATS Team C		3/20	18
CATS Team D		3/27	2
CYS Clinic		3/20	45
Forensic Clinic		3/20	31
Crisis Clinic		3/20	28
BACOP Clinic		3/20	13
La Familia Clinic		3/20	30
GOALS Clinic		3/28	56
TCC / SEARS Clinic		3/21	27
Manteca Clinic		3/28	11
Lodi Clinic		3/27	13
Tracy Clinic		3/27	10
The Wellness Center		3/27	46
Martin Gipson Socialization Center		3/20	37

CDCC		3/17	71
Recovery House		3/6	30
Family Ties		3/9	24
ADAP		3/7	4
Central Intake		3/7	2
New Directions		3/28	66
CYS Tracy		3/28	11
CYS Manteca		3/28	11

Email invitation for: MHSA - Homelessness—Strategy Roundtable # 1

Subject line: IMPORTANT—MHSA Strategy Roundtable Invite

Dear Community Partner,
San Joaquin Behavioral Health Services is hosting a Strategy Roundtable Discussion on the issue of providing mental services to homeless individuals in San Joaquin County.

At this meeting we will:

- Identify the most pressing needs
- Brainstorm potential strategies
- Discuss resources and opportunities

The meeting will be held on Wednesday January 11, from 10am – noon at San Joaquin County Behavioral Health Services, 1212 N. California Street, Stockton, Conference Room A.

Please RSVP to this email address as soon as possible.

Note, in order to have a successful discussion, this meeting is by invitation only. If you have any questions, please contact Kayce Rane, 925-876-0760 or kaycerane@ranecd.com

Thank you very much!

Sincerely,

Behavioral Health Services

Invitees:

Frances Hutchins / Cara Dunn

Billy Olpin

Members of the San Joaquin County Homelessness Task Force

All LAC

Email invitation for: MHSA Housing Services—Strategy Roundtable # 2

Subject line: IMPORTANT—MHSA Strategy Roundtable Invite

Dear Community Partner,

San Joaquin Behavioral Health Services is hosting a Strategy Roundtable Discussion on the issue of providing housing services for individuals with mental health illnesses, a substance use disorder, and/or are re-entering the community from jail or prison.

At this meeting we will:

- Identify the most pressing needs
- Brainstorm potential strategies
- Discuss resources and opportunities

The meeting will be held on Wednesday January 11, from 3:00 – 5:00pm at San Joaquin County Behavioral Health Services, 1212 N. California Street, Stockton, Conference Room A.

Please RSVP to this email address as soon as possible.

Note, in order to have a successful discussion, this meeting is by invitation only. If you have any questions, please contact Kayce Rane, 925-876-0760 or kaycerane@ranecd.com

Thank you very much!

Sincerely,

Behavioral Health Services

Invitees:

Frances Hutchins / Cara Dunn

Billy Olpin

Cindy Morishigue

MHSA Housing Providers, AOD continuum partners, and sober living partners

All LAC

Email invitation for: Prop 47 Diversion and Reentry —Strategy Roundtable # 1

Subject line: IMPORTANT—Prop 47 Diversion and Reentry Strategy Roundtable Invite

Dear Community Partner,

San Joaquin Behavioral Health Services is hosting a Strategy Roundtable Discussion on the issue **diversion and re-entry services and supports** for individuals arrested, convicted or incarcerated for non-violent and non-serious offenses in order to prevent recidivism and support successful reentry into the community.

At this meeting we will:

- Identify the most pressing needs
- Brainstorm potential strategies
- Discuss resources and opportunities

The meeting will be held on Wednesday January 18, from 10am – noon at San Joaquin County Behavioral Health Services, 1212 N. California Street, Stockton, Conference Room A.

Please RSVP to this email address as soon as possible.

Note, in order to have a successful discussion, this meeting is by invitation only. If you have any questions, please contact Kayce Rane, 925-876-0760 or kaycerane@ranecd.com

Thank you very much!

Sincerely,

Behavioral Health Services

Invitees:

Frances Hutchins / Cara Dunn

Billy Olpin

Friends Outside

Partners in the San Joaquin County Assessment Center

San Joaquin County Court Partners

All LAC

Email invitation for: Prop 47 Behavioral Health Treatment Services —Strategy Roundtable # 2

Subject line: IMPORTANT—Prop 47 Mental Health and Substance Use Disorder Treatment Services Strategy Roundtable Invite

Dear Community Partner,

San Joaquin Behavioral Health Services is hosting a Strategy Roundtable Discussion to identify the needs and opportunities to provide **mental health and substance use disorder treatment services** for individuals arrested, convicted or incarcerated for non-violent and non-serious offenses in order to prevent recidivism and support successful reentry into the community.

At this meeting we will:

- Identify the most pressing needs
- Brainstorm potential strategies
- Discuss resources and opportunities

The meeting will be held on Thursday, January 19 from 10am – noon at San Joaquin County Behavioral Health Services, 1212 N. California Street, Stockton, Conference Room A.

Please RSVP to this email address as soon as possible.

Note, in order to have a successful discussion, this meeting is by invitation only. If you have any questions, please contact Kayce Rane, 925-876-0760 or kaycerane@ranecd.com

Thank you very much!

Sincerely,

Behavioral Health Services

Invitees:

Frances Hutchins / Cara Dunn

Billy Olpin

Cindy Morishige

Donna Bickham

FSP partner programs

Mental health treatment organizational providers (St. Joseph? Community Medical Centers?)

All LAC

Email invitation for: Behavioral Health Treatment Continuum of Care —Strategy Roundtable # 1

Subject line: IMPORTANT—MHSA Mental Health Treatment Services Strategy Roundtable Invite

Dear Community Partner,
San Joaquin Behavioral Health Services is hosting a Strategy Roundtable Discussion to identify the needs and opportunities to develop a broad spectrum of public and private mental health treatment services in San Joaquin that are designed to serve individuals and families within the full spectrum of mental health treatment needs.

At this meeting we will:

- Identify the most pressing needs
- Brainstorm potential strategies
- Discuss resources and opportunities

The meeting will be held on Thursday, January 19 from 3:00 – 5:00pm at San Joaquin County Behavioral Health Services, 1212 N. California Street, Stockton, Conference Room A.

Please RSVP to this email address as soon as possible.

Note, in order to have a successful discussion, this meeting is by invitation only. If you have any questions, please contact Kayce Rane, 925-876-0760 or kaycerane@ranecd.com

Thank you very much!

Sincerely,

Behavioral Health Services

Invitees:

Frances Hutchins / Cara Dunn

Cindy Morishige

Donna Bickham

Jacqui Coulter

FSP partner programs

CYS contracted mental health partners

Residential program partners

Mental health treatment organizational providers (St. Joseph? Community Medical Centers?)

Health Plan of San Joaquin

Email invitation for: Behavioral Health Treatment Continuum of Care —Strategy Roundtable #2

Subject line: IMPORTANT— Provider Partners Strategy Roundtable Invite

Dear Community Partner,

San Joaquin Behavioral Health Services is hosting a Strategy Roundtable Discussion to identify the needs and opportunities to strengthen the capacity of community partners to provide mental health and substance use treatment services by becoming a licensed and certified organizational provider.

At this meeting we will:

- Current Regulations
- Identify the most pressing needs
- Brainstorm potential strategies
- Discuss resources and opportunities

The meeting will be held on Wednesday, January 25 from 3:00 – 5:00pm at San Joaquin County Behavioral Health Services, 1212 N. California Street, Stockton, Conference Room A.

Please RSVP to this email address as soon as possible.

Note, in order to have a successful discussion, this meeting is by invitation only. If you have any questions, please contact Kayce Rane, 925-876-0760 or kaycerane@ranecd.com

Thank you very much!

Sincerely,

Behavioral Health Services

Invitees:

Frances Hutchins / Cara Dunn

Billy Olpin

Donna Bickham

FSP partner programs

SAS partner programs

Health Plan of San Joaquin



San Joaquin County Behavioral Health Services

Transforming Mental Health Services

Mental Health Services Act 3-Year Program and Expenditure Plan MHSa Program Partners for Contracted Services

A new MHSa Three Year Program and Expenditure Plan for FY 2017-18, 2018-19, and 2019-20 is due to the Mental Health Services Oversight and Accountability Commission in June, 2017.

BHS is currently conducting a community program planning process to solicit input from consumers, family members and other stakeholders on existing programs and services; opportunities for improvements; and recommended changes or additions to the plan. Please join us for a special discussion of our partner organization to talk about strategies to strengthen the broad continuum of care of community mental health services. The discussion will be inclusive of prevention, early intervention, clinical treatments services, and other support services for consumers with serious mental illnesses.

While not within the scope of the MHSa, we will also be soliciting feedback on the broad continuum of care for individuals that do not meet the clinical criteria for a serious mental illness and will be asking for feedback and suggestions on how we can collectively strengthen the system of care for all individuals and families in San Joaquin County.

Wednesday February 8, 2017

10:00 – 12:00

Conference Room A

1212 N. California Street

Stockton, CA 95202

We are also hosting Community Meetings to generate feedback about existing program services. Please ask your clients to join us at our next Community Meeting:

Thursday, February 9, 2017, from 3:30 – 5:30pm
San Joaquin County Public Health Department – Conference Room
1601 East Hazelton Avenue, Stockton CA 95205

Thank you for your assistance in spreading the word about our upcoming community meeting!

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.

Proposed INN Plan: Assessment and Respite Center

PRESENTATION TO:

SAN JOAQUIN COUNTY
BEHAVIORAL HEALTH BOARD
SEPTEMBER 20, 2017

Presentation

- Overview of Innovation Funding
- BHS Strategic Priorities and Directives
- The Planning Process
- Project Goals
- Project Activities
- Next Steps

Purpose of MHSA Innovation Funds

- **Introduce new mental health practices or approaches**
 - Increase access to mental health services
 - Increase the quality of mental health services
 - Promote interagency and community collaboration
- **Address persistent mental health challenges**
- **Contribute to practice improvements by evaluating and sharing findings from the innovation**

San Joaquin Innovation (INN)

- **Prior INN Projects**
 - Residential Learning Communities
 - ✦ Led to the InSPIRE Project within CATS
 - Adapted Functional Family Therapy
 - ✦ Led to the Family Therapy program within CYS
- **Proposed 2017 INN Projects**
 - Progressive Housing
 - ✦ Reviewed August 16, 2017
 - Assessment and Respite Center
 - ✦ Reviewed September 20, 2017

BHS: Strategic Priorities

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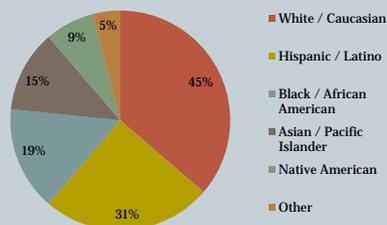
Planning Directives

- **Alignment with San Joaquin County Strategic Priorities by addressing the behavioral health concerns of high-risk unserved individuals:**
 - Homeless
 - Criminal justice involvement
- **Emerging Best Practices in Community Program Planning processes**
 - Use multiple methods of outreach
 - Increase accessibility for individuals who are SED/SMI

INN Community Planning Process (CPP)

- **Engagement Efforts**
 - Community Meetings (8)
 - Focused Partner Discussion Groups (6)
 - Consumer Discussion Groups (3)
 - Client and Stakeholder Surveys (665)
 - ✦ Electronic surveys
 - ✦ Paper surveys

Race/Ethnicity of 2017 Survey Respondents:



50% of responses – Consumer
 20% of responses – Family Member
 40% of responses – Professional

CPP: Key Findings

- High utilization of emergency and crisis mental health services by African Americans
- Low engagement in mental health services by Hispanics
- Homeless individuals represent only a scant portion of those receiving treatment, despite high counts
- Insufficient access to services for those with substance use disorders &/or justice involvement

CPP: Systemic Challenges

- **Systemic challenges impede access to services for unserved and underserved populations**
 - CA has a bifurcated treatment system – with service delivery systems divided between those with serious mental illness and those with mild/moderate mental illnesses.
 - The assessment process is burdensome and emotionally draining and may be a causal factor associated with disproportionalities.
 - The assessment process is not well geared to those who are homeless, intoxicated, or who have other acute concerns that inhibit their readiness to engage in services.

INN Project Goals:

- **Improve access to services for unserved and underserved populations.**
- **Resolve systemic challenges that cause individuals to fall through services system gaps.**

Project Partner



- **Community Medical Centers**
 - Providing neighborhood based health services in San Joaquin County for nearly 50 years.
 - A mission of providing high quality health care services to low-income, indigent, immigrant, and unserved populations wherever they are at.
 - A federally qualified health center offering preventive, primary, and dentistry services with a growing behavioral health practice.
 - Operates twelve health centers in neighborhoods throughout San Joaquin County (Waterloo, Tracy, Lodi, Stockton, etc.)

Assessment and Respite Center (ARC)



- **Improve access to services**
 - Develops a 24/7 drop-in assessment and respite center offering psychosocial assessments, case management, peer counselors, and respite services.
 - Provides clients with a range of respite and stabilization services, including brief therapeutic interventions, housing, withdrawal management.
 - Links clients to ongoing, trauma informed and culturally responsive mental health clinical services for low-income individuals, with mild-moderate mental health concerns.

Assessment and Respite Center (ARC)

- **Resolve systemic gaps**
 - New bi-directional procedures to eliminate the gap in services between “mild-moderate” and “seriously mentally ill”
 - Linkages to stabilization services including withdrawal management and housing
 - Provides a pathway to sustainable treatment through federal reimbursements for mental health services

Innovative Components

- **New approach to screening, assessment, and referral**
 - Incorporates in respite and stabilization services
 - Allows for client direction regarding pace and scope
- **Interagency / Community collaboration**
 - Creates new model to resolve a persistent mental health challenge associated with individuals falling through the cracks by creating a seamless assessment system with no option to “screen-out” for individuals requesting assistance.

Additional Details

- **5 Year Budget:**

- Total ARC Operating Costs \$10,721,688
- Revenue (starting year 3) -\$ 3,044,084
- Total INN allocation to CMC \$ 7,677,604
- Budget Goal
 - ✦ By end of 60 months most project activities are sustained through FQHC reimbursements

- **Evaluation**

- UC Davis Behavioral Health Center for Excellence
 - ✦ Total 5 year Budget allocation \$495,000

Next Steps

- **Assessment and Respite Center**

- Public Hearing, October 18, 2017
- Board of Supervisors, November 2017
- MHSOAC, January 2018

- **Ongoing MHSA Planning**

- Annual Update Planning – Starts January 2018
- Annual Update to be complete by May 2018

Questions



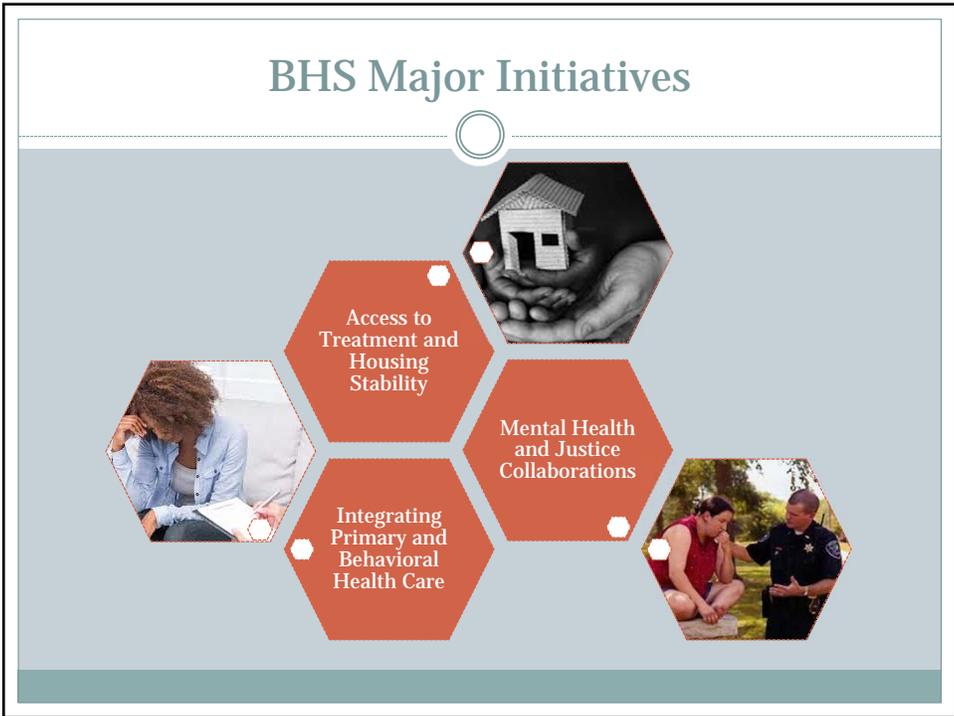
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2017 - 2020 Mental Health Services Act Plan

SAN JOAQUIN COUNTY
BEHAVIORAL HEALTH SERVICES

HOMeward BOUND
&
OUR PROPOSED APPROACH TO SYSTEM
STRENGTHENING



Planning Directives

- Re-examine what is working, incorporate emerging best practices, and strengthen outcomes for consumers.
- Develop collaborative programs that leverage multiple funding sources.
- Broaden the behavioral health system of care and add more partners to the mental health and substance use disorder treatment system.

Meeting Objectives

- Discuss the merits of potential project initiatives under consideration.
- Provide feedback on FSP and PEI program strengths and challenges.
- Rank order priority funding areas for consideration.
- Provide input on other areas of interest or concern.

MHSA Overview

- **MHSA Program Feedback**
 - FSP – 5 Full Service Partnership Programs
 - ✦ Children and Youth, Transitional Age Youth
 - ✦ Adults, Older Adults, Justice Consumers
 - ✦ Includes outreach, engagement, and wrap-around support services
 - PEI – Prevention and Early Intervention
 - ✦ Suicide prevention in schools, mentoring for high risk youth, parenting classes, assessment and linkages at JJC
 - ✦ Trauma informed treatment for children in schools and with CWS, and treatment of youth with emerging psychosis,

Discussion # 1

- **PEI and FSP Project Review**
 - PEI – prevention and early intervention. Most programs target high-risk children, youth, and families.
 - FSP – Full Service Partnership Program. Program services are reserved for those with serious mental illnesses and the highest level of functional impairment.
- **Activity Instructions**
 - Complete the program feedback survey for PEI or FSP program services.
 - In groups discuss the strengths and challenges identified.
 - Develop a recommendation to improve programming.
- Handout MHSA Program Survey

Organized Delivery System Overview

- **1115 Waiver**
 - A pilot-project of the State of California
 - Designed to test a process to increase the effectiveness of substance use disorder treatment.
 - Counties must submit an application to “opt-in”
 - Adopts the American Society of Addiction Medicine (ASAM) criteria for referring clients to treatment
 - Requires providers to become licensed and certified by DHCS
- **Opportunity for San Joaquin**
 - Leverage new funding to pay for substance use treatments
 - Potentially expanding the amount of services available

Prop 47 Overview

- **Safe Neighborhoods and Schools Act**
 - Maximize alternatives for non-serious, non-violent crimes.
 - Funding must be used to provide mental health, substance use disorder treatment, and / or diversion programs.
 - Reduce recidivism of people convicted of non-serious, non-violent offenses and have substance use or mental health problems.
- **Target Population**
 - Serve people who have been arrested, charged with, or convicted of a criminal offense AND have a history of mental health issues or substance use disorders.
- **Other Requirements**
 - 50% of funding must be allocated to non-governmental partners.

Innovation Overview (INN)

- **Intended to create new, effective practices and approaches in the field of mental health.**
 - Novel, creative, and contribute to learning
- **Essential Purposes of Innovation Funding**
 - Increase access to underserved groups
 - Increase quality of life, including better outcomes
 - Promote interagency collaboration
 - Increase access to services

Consumer & Stakeholder Input

- **Housing!!!**
 - Consumers are unstably housed, impacting health, well-being and recovery.
- **Co-occurring Disorders**
 - Appropriate treatment services are difficult to access
 - ✦ There are no residential treatment services designated for individuals with co-occurring mental health disorders.
 - ✦ Only a small portion of substance use disorder treatment staff have been trained in mental health approaches.
- **Case Management**
 - Having an ally and a navigator is essential to access services and to stay accountable and engaged in treatment plan
- **Stigma and Disparities in Access**
 - Many consumers are still not receiving needed services
 - Populations remain reluctant to access services through BHS

INN Concept Ideas

- **Review and Assess Initial Concept Ideas**
 - Supportive Housing for high-acuity consumers with co-occurring disorders with on-site programming and case management
 - ✦ Increase quality of life, including better outcomes
 - Residential Substance Use Treatment Facility for individuals with co-occurring Disorders
 - ✦ Increase access to underserved groups
 - ✦ Increase quality of life, including better outcomes
 - Community Assessment and/or Respite Center – integrated with primary health care services and linkages to case management
 - ✦ Increase access to underserved groups
 - ✦ Increase quality of life, including better outcomes
 - ✦ Promote interagency collaboration
 - ✦ Increase access to services

Activity # 2

- **Activity Instructions:**
 - In groups, review the project summaries.
 - Discuss the pros and cons
 - **Determine validity of concept**
 - Is it needed?
 - Will it serve an essential purpose in Mental Health Services?
 - **Brainstorm Additional Concepts**
- Handout, Discussion Recording Form

Closing Discussion

- **Activity Review**
 - Summary of Feedback
 - Key Findings
- **Next Steps**
 - Provide written comments or meeting feedback
 - Opportunities for Further Participation
- **PLEASE, spread the word.....**

THANK YOU!

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Progressive Housing Innovation Project

{ Presentation to:
San Joaquin County Behavioral Health Board
August 16, 2017

Mental Health Services Act

Innovation

- ∞ Increase access
- ∞ Increase quality
- ∞ Promote collaboration

Overview & Primary Purpose

Individual with co-occurring serious mental illnesses and substance use disorders need a safe and stable place to live in order to engage in treatment services and meet their recovery goals.

Our Vision

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Existing housing options are scarce, expensive, rarely accommodate individuals with co-occurring disorders, and are challenging to develop.

Our Challenge

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Develop a new model of affordable, easy to develop, and recovery oriented housing that can be quickly started by a county mental health departments with limited resources.

Our Need

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Progressive Housing

Introduce a new application to the mental health system of a promising community-driven practice.

Project Objective

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Progressive Housing:
An Adapted Approach to
Housing First

Proposed Project

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A model that places homeless
individuals in a permanent
home*, without preconditions.

* typically scattered site apartments

Housing First

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Designed in New York City with the following design considerations:

- ∅ High Density
- ∅ Access to Public Transportation
- ∅ Rich, Decentralized Service Environment

Implementing Housing First

∅ **Level Housing** to create safe home spaces that align to recovery stages, and cluster individuals at similar stages in their recovery.

∅ **Wellness Environment** with the inclusion of *Consumer Choice Programming* and a *Resident House Manager* with lived experience.

Adaptation

Unserved or Underserved
individuals with severe and
persistent mental illness who
are homeless or at risk of
homelessness

Target Population

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A Linear Approach to Housing First

House Levels align with ASAM stages of recovery:

- ∅ Pre-contemplation house (Assessment phase)
- ∅ Contemplation, Treatment and (Sober) Recovery Houses
- ∅ Graduation House (Post-programming)

The Innovation

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Provide shared housing in three- to five-bedroom houses, with each client having a private bedroom but sharing common areas, chores, and living conditions.

Housing Component

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All clients will receive treatment services by BHS according to their individualized treatment needs, including FSP enrollment, access to substance use services, etc.

Clinical Component

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A Resident House Manager with lived experience

Consumer Choice Programming

Volunteer &/or Vocational opportunities

Consumer Driven

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Very-low barriers to entry

Design model anticipates relapse within the recovery process

Housing Case Manager helps guide consumers towards permanency

Family Driven

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Non – Clinical

Shared Recovery-oriented Home

Consumer Choice Programming and Classes

Housing Permanency Case Plans

Peer-partners in Recovery

∅ WRAP

∅ Home Visits / Peer Support

∅ Transportation to Wellness Center, Martin Gipson, and other Support Groups

Treatment Component

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Other Clinical Services

∅ Outreach Worker assigned to houses

∅ Home Visits by medical and mental health practitioners

∅ Coordination and collaboration between clinical and housing services

Treatment Component

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Is it Feasible?
Is it Effective?
Are Costs Reasonable?
Is Implementation Timely?

Learning Questions

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Lead Partner:
Sacramento Self Help Housing

Collaborative Partners:

- ∅ Homeless Outreach Teams
- ∅ Withdrawal Management Center
- ∅ Assessment and Respite Center
- ∅ Allies and Allies / SOAR Clinical Services
- ∅ Other Community Based Agencies

Implementation Model

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Research Partner: UC Davis – Behavioral
Health Center for Excellence

- ⌘ Feasibility Study
- ⌘ Outcomes Study
- ⌘ Cost Benefit Study

Evaluation

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Projections show INN funds decreasing annually.

Over the four year period of FY 19/20 – 22/23, total
INN funds decrease from \$4.4 million to \$3.9 million

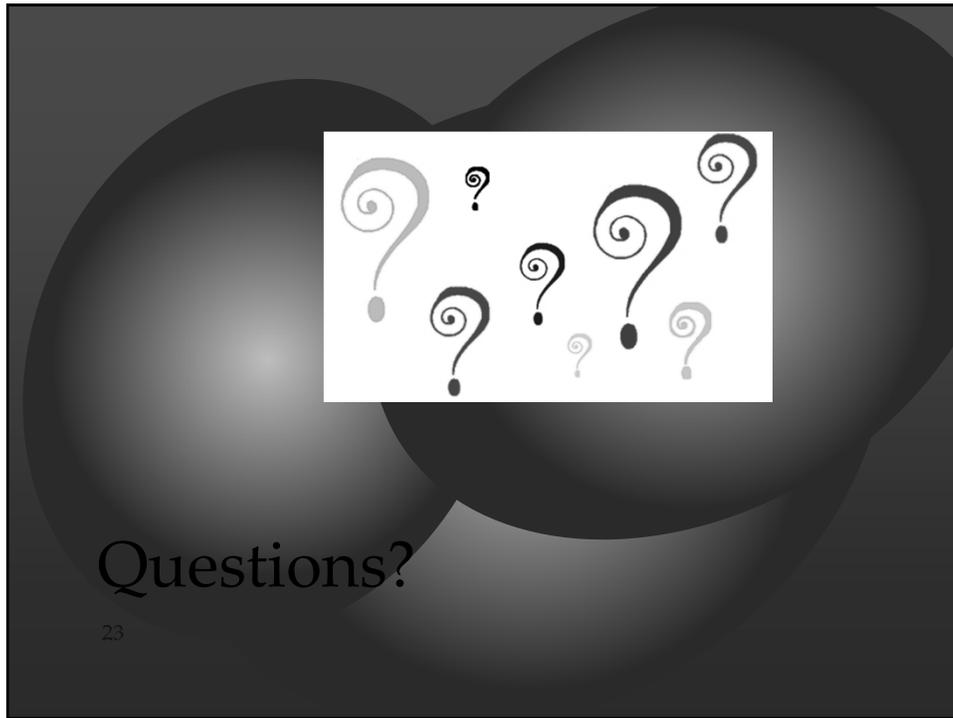
BHS anticipates spending approximately \$1 – 1.75
million on the Progressive Housing project annually,
depending on the number of houses operating.

This accounts for 30% - 40% of total available INN
funds in any given year.

Additional INN projects are in development,
including the Assessment and Respite Center

Budget

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Questions?

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Plan Posting Date: August 18, 2017

30-day public comment period 8/18 – 9/20

Submit comments to:
mhsacomments@sjcbhs.org

Public Hearing: September 20, 2017

Next Steps

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