SAN JOAQUIN
COUNTY
Greatness grows here.

San Joaquin County
Behavioral Health Services

Mental Health Services Act (MHSA)

DRAFT 2025-2026 Annual Update to the Three-Year Program and Expenditure Plan FY 2023-26

March 17, 2025

30 Day Public Comment Period

SAN JOAQUIN COUNTY

MHSA FISCAL ACCOUNTABILITY CERTIFICATION

County/City: SAN JOAQUIN COUNTY

☐ Three-Year Program and Expenditure Plan

X **Annual Update**

☐ Annual Revenue and Expenditure Report

Local Mental Health Director		**County Assistant Auditor-Controller / City Financial Officer**	
Name:	Genevieve G. Valentine, LMFT	Name:	Jeffery Woltkamp
Telephone Number:	209-468-8750	Telephone Number:	209-468-3925
E-mail:	gvalentine@sjcbhs.org	E-mail:	jwoltkamp@sjgov.org
Local Mental Health Mailing Address:			
1212 N. California St. Stockton CA 95202			

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

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

Genevieve G. Valentine, LMFT, _____ _____
Behavioral Health Director Signature Date

I hereby certify that for the fiscal year ended June 30,2023 the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the fiscal year ended June 30, 2023. I further certify that for the fiscal year ended June 30, 2022, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Jeffery Woltkamp, _____ _____
County Auditor Controller Signature Date

SAN JOAQUIN COUNTY
MHSA COMPLIANCE CERTIFICATION

County/City: SAN JOAQUIN COUNTY

☐ Three-Year Program and Expenditure Plan

X **Annual Update**

Local Mental Health Director		**Program Lead**	
Name:	Genevieve G. Valentine, LMFT	Name:	Cara Dunn
Telephone Number:	209-468-8750	Telephone Number:	209-468-2082
E-mail:	gvalentine@sjcbhs.org	E-mail:	cdunn@sjcbhs.org
Local Mental Health Mailing Address:			
1212 N. California St. Stockton CA 95202			

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

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

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

All documents in the attached Annual Update to the Three-Year Program and Expenditure Plan are true and correct.

Genevieve G. Valentine, LMFT, _____ _____

Behavioral Health Director Signature Date

Table of Contents

I. Introduction

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

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

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

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

All MHSA component plans must address the needs of children and transitional age youth (TAY) with serious emotional disturbances or mental illnesses and adults and older adults with serious mental illnesses. It must also address cultural competency and the needs of those previously unserved or underserved.

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

This Annual Update to the MHSA Program and Expenditure Plan for the period of FY 2023-24, FY 2024-25, and FY 2025-2026 was developed and approved by the San Joaquin County Board of Supervisors on _____.

All San Joaquin County MHSA Plans are available for review at www.sjcbhs.org.

MHSA Program Priorities

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

Mission Statement

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

Vision Statement

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

Planning Priorities

II. Community Program Planning and Stakeholder Process

Community Program Planning Process

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

Quantitative Analysis (Program period July 2023 – June 2024):

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

Community Discussions July 2024-November 2024:

4. MHSA Showcase
    - October 10, 2024 – MHSA Programs - Public Showcase, Stakeholder and Community Engagement Survey

5. Behavioral Health Advisory Board (BHAB)
    - July 17, 2024
        - Announcement to BHAB of Planning Dates for the 2025-2026 MHSA Annual Update – Feedback from BHAB on areas in San Joaquin County to focus

6. Public Forums – Community Planning & Stakeholder Feedback Presentations
    - August 20, 2024 – MHSA Community Planning – Tracy, CA (Tracy Community Center)
    - August 22, 2024 – MHSA Community Planning – Lodi, CA (Lodi Public Library)
    - August 27, 2024 – MHSA Community Planning – (Spanish Session) – Stockton, CA - El Concilio (Zoom Meeting)
    - August 28, 2024 - MHSA Community Planning (General Community Zoom Call)
    - August 29, 2024 – MHSA Community Planning – (Spanish Session) – Stockton, CA – Catholic Charities
    - September 9, 2024 – MHSA Community Planning (MHSA Consortium Zoom Call)
    - September 10, 2024 – MHSA Community Planning (General Community Zoom Call)
    - September 11, 2024 – MHSA Community Planning – French Camp, CA (Westen Ranch Library)
    - October 15, 2024 – MHSA Community Planning – Manteca, CA (Manteca Senior Center)

- October 16, 2024 – MHSA Community Planning - BHS Behavioral Health Advisory Board
- November 13, 2024 – Community Stakeholder Feedback Presentation - MHSA Consortium (Zoom Meeting)
- November 19, 2024 – Community Stakeholder Feedback Presentation - Cultural Competency Committee
- November 20, 2024 – Community Stakeholder Feedback Presentation - BHS Behavioral Health Board
- November 21, 2024 – Community Stakeholder Feedback Presentation - BHS Leadership (BHS Managers Meeting)
- November 22, 2024 – Community Stakeholder Feedback Presentation – Consumer Advisory Council

Targeted Discussions:

7. Consumer Focus Groups
- August 6, 2024 - Co-hosted by the Wellness Center
- October 8, 2024 - Co-hosted by the Martin Gipson Socialization Center

Consumer and Stakeholder Surveys:

8. 2024-25 MHSA Consumer and Stakeholder Surveys

Assessment of Mental Health Needs

County Demographics and County's Underserved/Unserved Populations

San Joaquin County, located in California's Central Valley, is a vibrant community with just over 783,000 individuals, with a diverse population. English is spoken by more than half of all residents, just over 180,000 residents are estimated to speak Spanish as their first language. Tagalog, Chinese, Khmer, and Vietnamese are also spoken by large components of the population. 41% of the county population is predominantly centrally situated in Stockton, the largest city in the county. Cities like Lodi, Tracy, and Manteca make up an additional 31% of the county population, while the remaining smaller cities of Ripon, Lathrop, and Escalon make up 7% of the county population. Unincorporated areas of San Joaquin County make up 21% of the remaining balance. San Joaquin County's gender ratio is 99 men to 100 women (99:100) or .99, equal to the California State average of 99:100.

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

Age Distribution	Percent of Population
0-19	29.9%
20-54	46.1%
55-64	11.2%
65 and over	12.8%

*Source: San Joaquin Council of Governments

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

Population Served

BHS provides mental health services and substance use disorder treatment to nearly 19,000 consumers annually. In general, program access is reflective of the diverse population of San Joaquin County, with a roughly even division of male and female clients. An analysis of services provided in 2023-24 demonstrates the program participation compared to the county population.

Behavioral Health Services Provided in 2023-24

Services Provided by Age	Number of Clients*	Percent of Clients
Children	3,673	19%
Transitional Age Youth	3,328	17%
Adults	10,218	54%
Older Adults	1,891	10%
Total	**19,114**	**100%**

*Source: BHS Client Services Data

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

Services Provided by Race/Ethnicity	County Population by Race/Ethnicity**	Percent of County Population	Clients Served*	Percent of Clients
White	206,520	26%	5,561	29%
Latino	348,403	44%	5,374	28%
African American	58,943	7%	2,721	14%
Asian	135,434	17%	1,339	7%
Multi-Race/Other	33,191	4%	3,707	19%
Native American	3,225	.4%	362	2%
Pacific Islander	5,016	.6%	53	0.3%
Total	**790,742**	**100%**	**19,114**	**100%**

*Source: BHS Client Services Data
**Source: https://www.dof.ca.gov/Forecasting/Demographics/Projections

The diversity of clients served is similar to the distribution in prior years. African Americans are disproportionately over-represented amongst consumers compared to their proportion of the general population (14% of participants, though comprising 7% of the population of the County). Native Americans are also over-represented within the service continuum (3% of clients are Native American). Latinos are enrolled in mental health treatment services at rates lower than expected, compared to their proportion of the general population (28% of clients versus 44% of the population). Asian clients are also underrepresented by 10%.

Services Provided by City	County Population by City**	Percent of County Population	Clients Served*	Percent of Clients
Stockton	317,204	40%	12,025	63%
Lodi	66,492	8%	1,586	8%
Tracy	96,609	12%	1,332	7%
Manteca	90,917	12%	1,254	7%
Lathrop	37,033	5%	418	2%
Ripon	15,741	2%	194	1%
Escalon	7,249	1%	173	1%
Balance of County	160,163	20%	2,132	11%
Total	**791,408**	**100%**	**19,114**	**100%**

*Source: BHS Client Services Data
**Source: Estimates-E1 | Department of Finance (ca.gov)

The majority of clients are residents of the City of Stockton. Stockton is the County seat of government and the largest city in the region, accounting for 40% of the County population. The majority of services and supports for individuals receiving public benefits, including mental health, are located in Stockton, with Lodi, Tracy, Manteca, and Lathrop rounding out the top five.

Stakeholder Involvement:

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

Discussion Group Input and Stakeholder Feedback

San Joaquin County provided two outlets of community planning and stakeholder engagement; in person meetings and zoom meetings. The hybrid model allowed for a robust opportunity to engage with community and stakeholder members throughout the County.

Community Program Planning for 2024-25:

Behavioral Health Advisory Board (BHAB) Agenda Items

At the July 2024 Behavioral Health Board meeting, the MHSA Coordinator announced that the MHSA Plan's community program planning process would begin in August 2024. He shared the methodology and timeline for the annual planning process, which informed the Plan's 2025-2026 Annual Update to the 2023-26 Program and Expenditure Plan. The BHAB also provided recommendations on geographic areas to focus within San Joaquin County for the community program planning process. Promotional flyers with details for both consumer and community discussion groups were distributed to the Board electronically.

Community Stakeholder and Consumer Discussion Groups

There were 17 community discussion groups convened between August 2024 – November 2024, two of which specifically targeted adult consumers and family members. Two of the 17 community discussion groups were held in a Behavioral Health Advisory Board meeting so stakeholders could present their input directly to members of the Board.

All community discussion groups began with a training and overview of the MHSA, a summary of its five components, and the intent and purpose of the different components including:

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

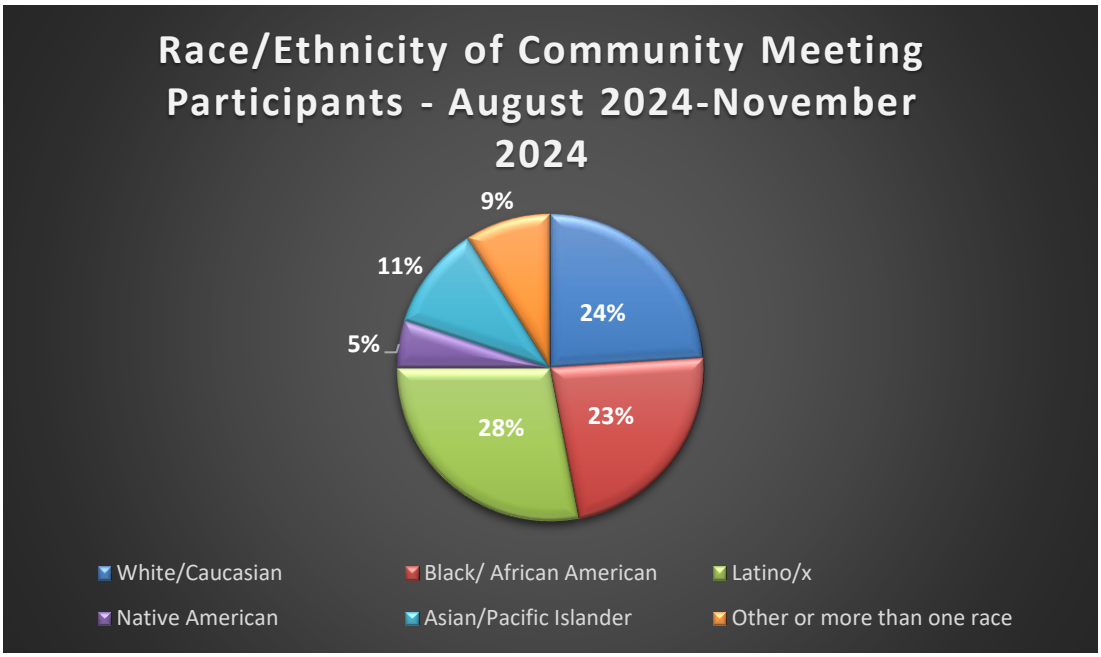
Stakeholder participation was tracked through Sign-In Sheets, zoom chat and completed anonymous demographic Survey Monkey links. Stakeholder participants were demographically diverse and included

representatives of unserved and underserved populations, according to the surveys. The community discussion and focus groups had participation by over 200 individuals, nearly 90% of whom self-identified as a consumer of public mental health services or as a family member of a consumer. The majority of participants identified as adults ages 26-59, 18% were older adults over 59 years of age, and 14% were transitional age youth ages 18-25.

Community discussion groups were also attended by individuals representing the following groups:

- Consumer Advocates/Family Members
- Substance use disorder treatment providers
- Community-based organizations (Behavioral Health & Non-Behavioral Health Providers)
- Children and family services
- Law Enforcement
- Veteran's services
- Senior services
- Housing providers
- Hospital & Health care providers
- Public Health
- County mental health and substance use disorder department staff

A diverse range of individuals from racial and ethnic backgrounds attended community stakeholder discussions and focus groups. Similar to the County's demographic breakdown and those BHS provides services to, no one racial or ethnic group comprised a majority of participants. Latino/x and African American participants were moderately represented in meetings to express immediate needs in the community, compared to the County population.



Survey Input and Stakeholder Feedback

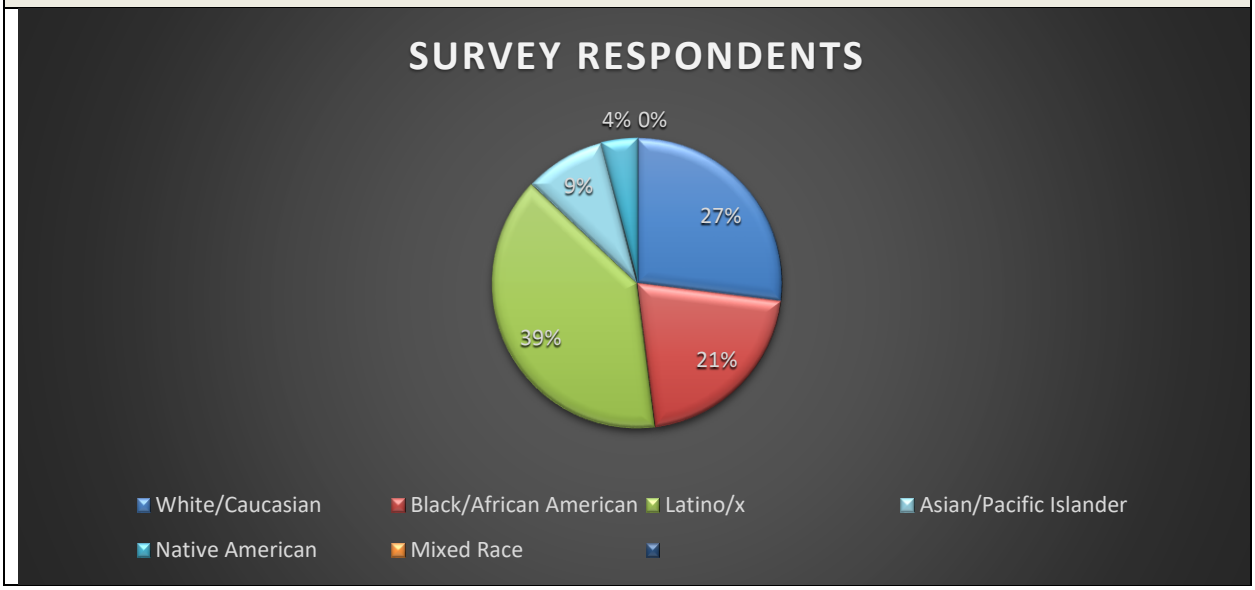
In October 2024 BHS distributed electronic and paper surveys to consumers, family members, and stakeholders to learn more about the perspectives, needs, and lives of clients served through mental health programs. Surveys were completed online and in person with multiple-choice answers and responses were tallied through Survey Monkey reports. There were 263 surveys completed. Survey instruments can be reviewed in the Appendix.

BHS consumers and their family members reported mid-to-high levels of satisfaction with the services provided to address mental health and/or substance use disorders, with 96% of respondents reporting that they would recommend BHS services to others. According to respondents, BHS Informational materials such as flyers, brochures and website need to be updated. A large majority of respondents reported that the BHS Lobby and reception areas are friendly and welcoming from a cultural and linguistic perspective. Respondents agreed strongly with statements regarding staff courtesy and professionalism, respect for cultural heritage, and their capacity to explain things in an easily understood manner.

In the interest of learning more about individuals who use mental health services, survey respondents were asked to anonymously self-report additional demographic information. The objective was to have a more nuanced understanding of the clients and respondents from the data collected in standardized BHS intake forms. The respondent data revealed a deeper understanding of client demographics, criminal justice experiences, and their living situations that were previously unknown.

Survey respondents were diverse and identified as: White/Caucasian (28%), Latino/x (39%), African American (21%), Asian/Pacific Islander (9%), Native American (4%), and Mixed Race (1%)

Self-Reported Race and Ethnicity of Stakeholder Survey Respondents
MHSA 2024-25 Consumer and Stakeholder Surveys



Self-Reported Age/Gender of Stakeholder Survey Respondents

Age Range	Percent
18-25	6.5%
26-59	81%
60 and over	12%
Prefer not to say	.5%

Gender	Percent
Male	24%
Female	67%
Transgender	1%
Non-Binary	3%
Prefer not to say	4%

The 263 respondents surveyed represent the broad diversity of stakeholders in the community and consumers served by BHS. 32% of respondents identify as someone who is receiving, or who needs, mental health treatment services. Consistent with the general population, 12% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQIA).

Community Mental Health Issues

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

Strengthening services and supports for children, youth and their families remains a major concern in San Joaquin County Stakeholders continue to assert that more needs to be done to support and strengthen families, particularly those where risk factors for mental illness are present. In several of the Community Discussion and Focus groups, stakeholders discussed the importance of prevention and earlier interventions, and education for children and families with expansion of services for PEI Services for skill building for parents and guardians.

- Parental involvement – Bridge between school, caregiver capacity, family stressors, integration of home and case management
- Needs to address generational and cultural gaps between parents and children around mental health diagnosis.
- Stakeholders expressed a need for education and training for all family/caregivers to recognize signs and symptoms of mental health concerns and possibly expanding MH Services in afterschool programs.

Recommendations to Strengthen Services for Children and Youth:

- Provide Youth Mental Health First Aid Training for the community and schools.
- Provide Family Services for African American, Asian/Pacific Islander and Latino Community to educate parents on signs and symptoms of mental illness and stigma reduction with an emphasis on cultural consideration.
- Provide funding for older generation guardians and caregivers skill building programs.
- Fully support California Youth Behavioral Health Initiative (CYBHI) to enhance school-based intervention services for local schools.

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

Stakeholders expressed the most concern for transition age youth (TAY) who have aged out of the foster care system, are college-age, or are from communities that are historically unserved or underserved by mental health services. Aside from a few specialty treatment programs, most interventions target either children and youth, or adults. Despite these gaps, stakeholders remain optimistic that current resources can be leveraged in a better way to serve transitional age youth.

- Focused efforts to ensure that TAY programming includes enhancing life skills and suicide prevention education.
- TAY Workforce development and training opportunities, specifically for Peer Support Specialist within the TAY Community.

- TAY focused crisis housing and permanent housing to prevent homelessness.
- TAY needs community activities to enhance social skills.

Recommendations to Strengthen Services for Transition Age Youth

- Provide workforce development and training opportunities through community providers to build vocational opportunities for Transitional Age Youth
- Develop programming with Community Based Organizations to enhance Access and linkage efforts with focus on vulnerable communities that represent the TAY Population.

Key Issues for Adults

Consumers and stakeholders discussed the challenges of being homeless while recovering from a mental illness, and the need to develop more housing for people with mental illnesses. Consumers and stakeholders expressed the lack of Mental health Information in public and community settings. Peers continue to be an integral part of the collaborative team approach for treatment teams.

- Individuals with mental illnesses, and co-occurring disorders that are homeless lack wrap-round services and specialized housing case management.
- Housing options continue to be scarce for adults. Homeless individuals need more outreach/engagement and a clear pathway to housing options with intensive treatment for MH and SUD Challenges.
- Promoting MH Services around the county is important in educating the public on MH and SUD services.
- Lack of groups and group therapy on main campus for adults.

Recommendations to Strengthen Services for Adults

- BHS should continue to strengthen the housing continuum for people with serious mental illnesses by expanding opportunities for housing options.
- BHS should promote MH Services and Warm Line number in all public communities (libraries, city hall, county buildings) – focused on culturally appropriate and community integrated messaging.
- BHS should tap into the public libraries and local community centers throughout the County to educate community on MH Services
- BHS should utilize peer specialists to enhance treatment and support options further supporting recovery efforts for consumers and family members.
- BHS should expand group and group therapy throughout several locations outside of the main campus to provide group services readily available to the community.
- BHS should consider utilizing community centers to provide community driven/culturally appropriate education for communities of color, LGBTQIA, and Asian communities – exploring opportunities to enhance and develop support groups throughout the county.

Key Issues for Older Adults

Older adults with mild to moderate mental health concerns remain at risk for untreated depression and suicide ideation. More articulation is needed with senior and older adult service providers to offer interventions for older adults that have escalating behavioral health challenges. More public information and education about the risk of suicide in adults and older adults is needed; particularly focusing on adult men who are at the highest risk for suicide in San Joaquin County. Stakeholders encouraged more behavioral health services co-located at county community centers that provide senior activities, services, and support throughout the County.

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

Recommendations to Strengthen Services for Older Adults:

- BHS Older Adult Services should provide meaningful alternatives such as a "day program" for daily living that combats depression and isolation including more socialization activities and more activities that prevent memory deterioration or loss of cognitive functioning.
- Broaden suicide prevention efforts to target the older adult community. Include targeted prevention information for middle age and older adult men. Address handguns and firearm safety when living with loved ones experiencing depression.

III. Public Review of the 2025-26 Annual Update to the 2023-26 MHSA Three Year Program and Expenditure Plan

Dates of the 30 day Review

The public is invited and encouraged to review and submit input to the draft MHSA Plan from March 17, 2025, to April 16, 2025.

Methods of Circulation

The draft MHSA Plan is posted for review on the San Joaquin County Behavioral Health Services website at https://www.sjcbhs.org/MHSA/mhsaplan.aspx.

Comments can be accepted via e-mail at mhsacomments@sjcbhs.org or by U.S. Postal Service at:

MHSA Coordinator
San Joaquin County Behavioral Health Services Administration
3127 Transworld Dr. Ste 150
Stockton, CA 95206

E-mail notices were sent to the BHS MHSA e-mail list which has been continuously maintained since MHSA planning began in 2006. Contracted providers were asked to post notifications in their public program areas, indicating that the 2025-2026 MHSA draft annual update to the 2023-26 MHSA Three Year Plan was available for review.

Public Hearing

A public hearing will be held on April 16, 2025, in conjunction with a regularly scheduled Behavioral Health Board Meeting:

Meeting Date/Time/Location
Wednesday, April 16, 2025 – 5pm-7pm

San Joaquin County Behavioral Health Services
Behavioral Health Advisory Board – Conference Rooms A-C
1212 N. California St.
Stockton, CA 95202

Public Hearing will begin with a brief presentation of the 2025-26 MHSA Annual Update and the community planning process used to inform the Plan. The presentation will also include highlights of changes created throughout the plan. The presentation concluded with a comment period allowing attendees to provide direct feedback on the plan.

A copy of the public presentation will be included in the appendix.

Public Comments:

- TBD

Additional feedback provided during the 30-day period outside of the public hearing can be found in the appendix.

Comments and feedback shared during the 30-day public comment period are an important part of the community planning and stakeholder feedback process. Planning is ongoing and many comments received during this period may be incorporated into ongoing implementation and will help guide future planning efforts.

Changes made to the 2025-2026 MHSA Annual Update during the 30-day public review period and reflected in the final draft

- TBD

IV. MHSA Component Funding for FY 2025-26

MHSA Component Worksheets describe the total planned expenditures for Fiscal Years 2025-26

1. Summary Worksheet
2. Community Services and Support Worksheet
3. Prevention and Early Intervention Worksheet
4. Innovation Worksheet
5. Workforce Education and Training Worksheet
6. Capital Facilities and Technological Needs Worksheet

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: San Joaquin

Date: 3/13/25

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
E. Estimated FY2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	16,845,671	33,579,944	12,319,183	(79,101)	2,846,158	
2. Estimated New FY2025/26 Funding	42,010,330	10,502,580	2,763,840			
3. Transfer in FY2025/26	(5,992,297)			500,000	5,492,297	
4. Access Local Prudent Reserve in FY2025/26						0
5. Estimated Available Funding for FY2025/26	52,863,704	44,082,524	15,083,023	420,899	8,338,455	
F. Estimated FY2025/26 Expenditures	90,290,962	14,426,756	1,547,947	967,730	8,338,455	
G. Estimated FY2025/26 Unspent Fund Balance	(37,427,258)	29,655,768	13,535,076	(546,830)	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2024	6,939,866
2. Contributions to the Local Prudent Reserve in FY 2023/24	0
3. Distributions from the Local Prudent Reserve in FY 2023/24	0
4. Estimated Local Prudent Reserve Balance on June 30, 2024	6,939,866
5. Contributions to the Local Prudent Reserve in FY 2024/25	3,278,862
6. Distributions from the Local Prudent Reserve in FY 2024/25	0
7. Estimated Local Prudent Reserve Balance on June 30, 2025	10,218,728
8. Contributions to the Local Prudent Reserve in FY 2025/26	0
9. Distributions from the Local Prudent Reserve in FY 2025/26	0
10. Estimated Local Prudent Reserve Balance on June 30, 2026	10,218,728

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

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Joaquin Date: 3/13/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children and Youth FSP	14,677,622	9,561,748	5,084,974			30,900
2. Transitional Age Youth FSP	857,595	438,069	400,426			19,100
3. TAY Intensive Care Coordination and Intensive Home Based Services FSP	6,500,000	6,500,000	0			
4. Adult FSP	11,202,602	7,004,753	3,921,399			276,450
5. Older Adult FSP	1,554,810	1,095,735	428,375			30,700
6. Community Corrections FSP	2,387,479	1,841,808	488,231			57,440
7. InSPIRE FSP	1,007,813	702,725	295,588			9,500
8. Intensive Adult FSP	2,640,000	1,718,152	889,248			32,600
9. Intensive Justice Response FSP	1,932,500	972,772	924,328			35,400
10. High-Risk Transition Team	1,280,000	1,018,000	229,000			33,000
11. Adult Residential Treatment Services	5,353,528	3,959,626	1,254,512			139,390
12. Housing Stabilization FSP Services	1,650,000	1,650,000	0			
Non-FSP Programs						
13. Mental Health Outreach and Engagement	687,236	687,236	0			
14. Mobile Crisis Support Team	2,983,057	2,822,357	140,000			20,700
15. Peer Navigation	315,000	285,000	25,000			5,000
16. Wellness Center	1,837,555	1,837,555	0			
17. Project Based Housing	3,600,000	3,600,000	0			
18. Employment Recovery Services	431,413	431,413	0			
19. Community Behavioral intervention Services	918,000	630,562	251,438			36,000
20. Housing Coordination Services	18,174,560	17,965,203	188,757			20,600
21. Crisis Services Expansion	8,653,139	4,409,359	3,943,891			299,889
22. Co-Occuring Disorder Program	700,000	509,425	190,575			0
23. TAY Outpatient Care	750,001	545,813	204,188			
24. Justice Decriminalization Foresnsics Restart	1,240,406	1,077,906	162,500			
25. System Development Expansion	4,805,737	4,604,737	201,000			
CSS Administration	14,421,008	14,421,008				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	110,561,061	90,290,962	19,223,430	0	0	1,046,669
FSP Programs as Percent of Total	53.1%					

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Joaquin Date: 3/13/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention Programs for Children, Youth & Families						
1. Skill Building for Parents and Guardians	1,662,502	1,662,502				
2. Prevention for Children 0-5	600,000	600,000				
3. Mentoring for Transitional Age Youth	815,346	815,346				
4. Coping and Resiliency Education Services	2,292,606	1,804,218	488,388			
Early Intervention Programs for Children and Youth						
5. Early Interventions to Treat Psychosis	1,801,349	746,569	1,001,780			53,000
Early intervention Programs for Adults and Older Adults						
6. Community Trauma Services for Adults	2,700,000	2,160,000	540,000			
7. Prevention and Early Intervention for Older Adults	1,171,000	550,000	621,000			
8 Misdemeanor IST Diversion- Early Intervention (MIST)	500,000	500,000				
Access and Linkage to Treatment Program						
9. Whole Person Care	1,782,034	1,282,034	500,000			
Outreach for Increasing Recognition of the Early Signs of Mental Illness						
10. Increasing Recognition of Mental Illnesses	75,000	75,000				
Stigma and Discrimination Reduction Program						
11. Information and Education Campaign	500,000	500,000				
Suicide Prevention Program						
12. Suicide Prevention with Schools	725,076	725,076				
13. Suicide Prevention and Education in the Community	500,000	500,000				
PEI Administration	2,268,737	2,268,737				
PEI Assigned Funds	0					
Funds assigned to CalMHSA	237,274	237,274				
Total PEI Program Estimated Expenditures	17,630,924	14,426,756	3,151,168	0	0	53,000

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Joaquin Date: 3/13/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. CalMHSA Semi-Statewide EHR Innovation Project	1,346,041	1,346,041				
INN Administration	201,906	201,906				
Total INN Program Estimated Expenditures	1,547,947	1,547,947	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Joaquin Date: 3/13/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	682,904	682,904				
2. Internship and Financial Assistance	158,600	158,600				
WET Administration	126,226	126,226				
Total WET Program Estimated Expenditures	967,730	967,730	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Joaquin Date: 3/13/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Facility Renovations	1,500,000	1,500,000				
2. Facility Repair and Upgrades	5,511,700	5,511,700				
CFTN Programs - Technolgical Needs Projects						
3. Technology Equipment and Software	500,000	500,000				
CFTN Administration	826,755	826,755				
Total CFTN Program Estimated Expenditures	8,338,455	8,338,455	0	0	0	0

V. Community Services and Supports

Essential Purpose of Community Services and Supports Component Funds

The Mental Health Services Act (MHSA) allocates funding for Community Services and Supports (CSS) programs that provide treatment and interventions with individuals with serious mental health illnesses who meet the criteria for specialty mental health care services.

"Community Services and Supports" means the component of the Three-Year Program and Expenditure Plans that refers to service delivery systems for mental health services and supports for children and youth, transition age youth, adults, and older adults. These services and supports are similar to those found in Welfare and Institutions Code Sections 5800 et. seq. (Adult and Older Adult Systems of Care) and 5850 et. seq. (Children's System of Care). *CA Code of Regulations §3200.080*

In San Joaquin County CSS funding will support:

1) Full-Service Partnership Programs – to provide all of the mental health services and supports necessary to an individual who is unserved, underserved, and experiencing homelessness, justice involvement, or other indicator of severe unmet need (see eligibility criteria below.)

2) Outreach and Engagement Programs – to provide outreach and engagement to people who may need specialty mental health services but are not currently receiving the care they need or are only receiving episodic or crisis mental health services.

3) General System Development Programs- to improve the overall amount, availability, and quality of mental health services and supports for individuals who receive specialty mental health care services.

The Mental Health Services Act is intended to expand and enhance mental health services to reduce the long-term adverse impacts on individuals and families resulting from untreated serious mental illness. The Community Services and Supports component of the Act, improves *outreach and engagement* to ensure that more individuals are successfully engaged in specialty mental health care services to reduce the incidence of untreated serious mental illness; *full service partnership programs* improve the quality and intensity of specialty mental health services for the most seriously ill and gravely disabled individuals that are experiencing negative outcomes associated with incarceration, homelessness, and prolonged suffering; and *system development projects* expand and enhance the entire specialty mental health system of care to better address the needs of all individuals diagnosed with serious mental illnesses or serious emotional disorders.

Full-Service Partnership Program Regulations

BHS provides a range of community-based specialty mental health services to support consumers and family members. Individuals with a mental health diagnosis may be served at various levels within the continuum of care depending upon their treatment needs. Full-Service Partnership Programs are offered to consumers who require the highest level of treatment interventions to achieve their recovery goals and who meet the Full-Service Partnership eligibility criteria.

"Full-Service Partnership Service Category" means the service category of the Community Services and Supports component of the Three-Year Program and Expenditure Plans, under which the County, in collaboration with the client, and when appropriate the client's family, plans for and provides the full spectrum of community services so that children and youth, transition age youth, adults and older adults can achieve the identified goals. *CA Code of Regulations §3200.140*

"Full Spectrum of Community Services" means the mental health and non-mental health services and supports necessary to address the needs of the client, and when appropriate the client's family, in order to advance the client's goals and achieve outcomes that support the client's recovery, wellness and resilience. *CA Code of Regulations §3200.150*

FSP Eligibility Criteria

All individuals referred to and receiving FSP Program Services must meet the eligibility criteria for enrollment in a FSP as described by state statute, regulation, and local priority needs. Individuals enrolled in an FSP program will be reassessed every six months to ensure eligibility criteria remain current. Individuals that no longer meet the eligibility criteria and have stabilized in their treatment plan will be transitioned to more appropriate mental health services.

Criteria 1: Eligibility for Public Mental Health Services (WIC § 5600.3)

All individuals enrolled in a Full-Service Partnership program must meet the criteria for specialty mental health services as defined by the California Welfare and Institutions Code.

Children and Youth (0-17)	Adults (18 and older)

Have a primary diagnosis of a mental disorder which results in behavior inappropriate to the child's age, and
• As a result, has substantial impairment, and
  ○ Is at risk of removal from the home, *or*
  ○ The mental disorder has been present for more than 6 months and is likely to continue for more than a year if untreated.
 	
OR
 	
The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.
	Have a primary diagnosis of a serious mental disorder which is severe in degree, persistent in duration, and which may cause behavioral functioning that interferes with daily living.
	• Mental disorder, diagnosed and as identified in Diagnostic and Statistical Manual of Mental Disorders.
	• As a result of the mental disorder, the person has substantial functional impairments
	• As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.
	
	OR
	Adults who are at risk of requiring acute psychiatric inpatient care, residential treatment, or an outpatient crisis intervention.

Criteria 2: Designated as Underserved or Unserved (CCR §3200.300 and 3200.310)

Individuals enrolled in a Full-Service Partnership program must meet the MHSA definition of an individual who is underserved or unserved by mental health services, as described in the California Code of Regulations.

Underserved	Unserved
"Underserved" means clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness and/or resilience. When appropriate, it includes clients whose family members are not receiving sufficient services to support the client's recovery, wellness and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out of home placement or other serious consequences; members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services; and those in rural areas, Native American rancherias and/ or reservations who are not receiving sufficient services.	**"Unserved"** means those individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved.

Criteria 3: MHSA Criteria for Full Service Partnership Category (CCR § 3620.05)

Individuals enrolled in a Full-Service Partnership programs must meet the MHSA eligibility criteria for enrollment.

- All children and youth identified at risk and seriously emotionally disturbed (SED) as a result of a mental health diagnosis, are eligible for enrollment in a Full-Service Partnership Program.
- All others, (including Transitional Age Youth, Adults, and Older Adults) must meet the following additional criteria:

Transitional Age Youth (Ages 16-25)	Adults (Ages 26-59)	Older Adults (Ages 60 and Older)
TAYS are unserved or underserved and one of the following: • Homeless or at risk of being homeless. • Aging out of the child and youth mental health system. • Aging out of the child welfare systems • Aging out of the juvenile justice system. • Involved in the criminal justice system. • At risk of involuntary hospitalization or institutionalization. Have experienced a first episode of serious mental illness.	(1) Adults are unserved and one of the following: • Homeless or at risk of becoming homeless. • Involved in the criminal justice system. • Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment. OR (2) Adults are underserved and at risk of one of the following: • Homelessness. • Involvement in the criminal justice system. • Institutionalization.	Older Adults are unserved experiencing, or underserved and at risk of, one of the following: • Homelessness. • Institutionalization. • Nursing home or out-of-home care. • Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment. • Involvement in the criminal justice system.

Criteria 4: San Joaquin County Priority Service Needs

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

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

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

Full-Service Partnership Program Implementation in San Joaquin County

FSP Component Services

The foundation of San Joaquin County's FSP Program is the provision of a full spectrum of community supports and services (e.g. housing, employment, education, mobile crisis response, peer support, and substance abuse treatment services) to sustain and stabilize individual consumers within their recovery process. FSP Programs have a high staff to consumer ratio, and a team approach that is predicated upon the partnership between the consumer, the mental health clinical team, and family or peer partners in recovery.

BHS will operate five FSP Programs and four intensive FSP programs for very high-risk individuals who are extremely reluctant to engage in mental health services, at imminent risk of institutionalization, and/or have a history of repeated contact with law enforcement for serious offenses.

<u>Standard FSP Programs</u>

- Children and Youth FSP
- Transitional Age Youth FSP
- Adult FSP
- Older Adult FSP
- Community Corrections FSP

<u>Enhanced FSP Programs</u>

- InSPIRE:
  for individuals with serious mental illnesses who are extremely reluctant to engage in services
- Intensive Adult:
  for individuals with serious mental illnesses who are at imminent risk of institutionalization
- Intensive Justice Response:
  for individuals with serious mental illnesses who commit serious offenses and are justice-involved
- High Risk Transition Team:
  for individuals with serious mental illness transitioning from institutionalization to other services

BHS also operates several programs that are designed for the exclusive use of FSP clients including: *FSP Housing Empowerment Services* (available for eligible FSP Clients ages 18 and over) and long-term *Adult Residential Treatment Services* for FSP clients and FSP eligible clients that require enhanced engagement or specialty services to avoid institutionalization and stabilize in treatment services.

Accessibility and Cultural Competence

Equal Access:

FSP program services are available to all individuals that meet the clinical eligibility criteria for specialty mental health care and full-service partnership programming without regard to the person's race, color, national origin, socio-economic status, disability, age, gender identification, sexual orientation, or religion. All program partners are required to take reasonable steps to ensure that organizational behaviors, practices, attitudes, and policies respect and respond to the cultural diversity of the communities and clients served.

Linguistic Competence:

FSP program services are delivered in a manner which factors in the language needs, health literacy, culture, and diversity of the population that is served. Information and materials are available in multiple languages and trained mental health translators are assigned as needed to ensure comprehension and understanding by the clinical team of the client's recovery goals and agreement or adherence to the treatment plan. All program partners are required to provide meaningful access to their programs by persons with limited English proficiency.

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

- African American consumers
- Asian / Pacific Islander consumers, including services in:
    - *Cambodian / Khmer*
    - *Hmong, Laotian, Mien*
    - *Vietnamese*
- Latino/Hispanic consumers, including services in
    - *Spanish*
- Lesbian, gay, bisexual and transgender consumers
- Middle Eastern consumers
- Native American consumers

BHS is continually striving to improve cultural competence and access to diverse communities. All partners are expected to provide meaningful linguistic access to program services and to address cultural and linguistic competency within their organization.

Full-Service Partnership Program Services

FSP Engagement:

- *Enthusiastic Engagement: Individuals* with serious mental illnesses that do not respond to engagement services as usual may be referred to the InSPIRE FSP team. Enthusiastic engagement refers to a program strategy that supports daily attempts at contact and finding creative pathways to treatment services for hesitant or reluctant clients. This is an Enhanced FSP program with a limited case load. Following successful engagement clients are transitioned to an appropriate FSP program for ongoing treatment and supports.

- *Transition to Treatment: Individuals* that are treated within the BHS crisis continuum (Crisis Services, Crisis Stabilization Unit, or Psychiatric Health Facility) are discharged with a transition to treatment plan that includes a scheduled follow-up appointment and linkage to routine services. Peer navigators are also a part of the transition to treatment process following a crisis episode and may be a component of the discharge plan.

FSP Assessment and Referral Process:

- *Assessment:* Prior to receiving treatment services for a serious mental illness, all individuals must undergo a complete psychosocial assessment to evaluate their mental health and social wellbeing. The assessment examines clinical needs, perception of self, and ability to function in the community. The assessment process may also include an assessment of substance use disorders. The assessment is typically completed by a Mental Health Clinician through a scheduled appointment or as a component of a crisis evaluation – though in some (limited) instances it may be completed by a psychiatrist or psychologist.

- *Referral to Care:* Based on the assessment, the Clinician will develop a preliminary treatment plan and make a referral to the appropriate level of care. Depending on the findings of the assessment this may be a referral to a primary care physician or health plan to address a mild-moderate mental health concern; a referral to an outpatient clinic to enter into routine treatment services; or a referral to either standard or enhanced FSP services, per the MHSA eligibility criteria reviewed above *and* the purpose and capacity of the FSP program to address individual treatment needs.

FSP Enrollment into a Treatment Team

- *FSP Treatment and Support Team: Individuals* enrolled in an FSP program will have a treatment team that includes a clinician, nursing or medical staff, case manager, and frequently a peer or parent partner with lived experience in recovery is part of the team. FSP treatment teams provide targeted clinical interventions and case management and work with community-based partners to offer a full range of wraparound services and supports.

- *Orientation to FSP Services:* FSP program staff will evaluate the needs and orient the eligible consumer to the program philosophy and process; providing enough information so that the consumer can make an informed choice regarding enrollment. This process is used to explore the natural supports individuals have to build into recovery efforts, including family and community supports, and to further understand treatment needs. Clinicians will conduct comprehensive clinical assessments to make recommendations for treatment and service interventions which are outlined in the Client Treatment Plan.

- *Partnership Assessment Form: The* Partnership Assessment Form (PAF) is completed once, when a partnership is established within an FSP program. The PAF is a comprehensive intake that establishes history and baseline data in the following areas: residential, education, employment, sources of financial support, legal issues, emergency interventions, health status, substance abuse, and other special age and dependency related concerns.

- *Enhanced FSP Treatment Team:* All services described above, and additionally; Individuals enrolled in one of the Enhanced FSP Programs will be engaged by a larger treatment team that may additionally include an alcohol and drug counselor; and a housing, rehabilitation, or vocational specialist as part of the team. There is a low ratio of clients to treatment team staff; ideally 10:1, but not less than 15:1. The treatment team also has 24-hour responsibility responding to a psychiatric crisis and will respond at the time of any hospital admission.

FSP Treatment and Recovery Plan

- *(TAY, Adult, and Older Adult) Client Treatment Plan*: Plans describe the treatment modalities and services recommended to support recovery. Planning may occur in one or more sessions and will be completed within 60 days of enrollment. Plans include a *Strength Assessment* that highlights the interests, activities and natural supports available to the consumer and the core areas of life, or domains, (e.g. housing or personal relationships) they wish to focus on through treatment. Clients will be evaluated by a psychiatrist to review and discuss medications as a component of the treatment plans. Client Treatment Plans will be updated every six months.

- *(Children and Youth) Dynamic Problem List (formally* Client Treatment Plan): For youth in treatment in a FSP, a dynamic problem list describes the treatment modalities and services recommended to support recovery. Planning may occur in one or more sessions and is driven by the Child Family Team and CANS results. The CANS includes a strengths section that highlights interests, activities, natural supports and internal characteristics that the CFT can use to support the client on their path to wellness. The CANS also identifies areas of need that can be the focus of treatment. Client Treatment Plans are updated at least annually.

- *Wellness Recovery Action Plan (WRAP): Adult* Consumers will work with peer partners to develop their own WRAP plans with strategies to decrease and prevent intrusive or troubling thoughts and to increase positive activities and quality of life. WRAP plans are consumer-directed, and empowerment focused.

Clinical and Service Interventions:

- *Psychiatric Assessment and Medication Management: FSP* Consumers will meet with a prescribing practitioner to determine appropriate medications and will be followed by a nurse or psychiatric technician to ensure that the prescribed medications are having the desired effects. Follow-up visits with the psychiatrist or prescribing practitioner will be scheduled as needed to refine or adjust prescriptions. Additionally, case management services may include daily or weekly reminders to take medications as prescribed.

- *Clinical Team Case Management:* FSP Consumers are enrolled into a clinical team that provides intensive home or community-based case management. The frequency of contact is directed by consumer needs and level of care. With most FSP programs clients are seen 1-3 times a week. Within enhanced FSP programs clients have 3-6 contacts per week. Case Management services include:
    - Treatment planning and monitoring of treatment progress
    - Individualized services and supports
    - Group services and supports
    - Referrals and linkages to health care services, public benefit programs, housing, legal assistance, etc.

- *Individual interventions:* FSP consumers receive individualized interventions from a clinician. BHS clinicians are trained in several modalities. Consumers work with clinicians that have training in the modality that best meets their treatment needs. Individual therapeutic approaches to support consumers may include:
    - Cognitive Behavioral Therapies, including for psychosis
    - Trauma Focused Cognitive Behavioral Therapy
    - Parent Child Interactive Therapy

- *Cognitive Behavioral and Skill-Building Groups: FSP* consumers will additionally participate in group skill building and treatment activities. Group activities are intended to further refine, reflect, and practice the behaviors and thinking patterns identified within the WRAP and treatment plans. Consumers with co-occurring disorders will also be screened for substance use disorder treatment services, including residential or outpatient treatment services. A range of evidence-based treatment and support groups may be offered, including, but not limited to:

    - Aggression Replacement Training

- Anger Management for Individuals with Co-occurring Disorders
- Chronic Disease Self-Management Skills
- Dialectical Behavior Therapy
- Seeking Safety (a trauma-informed, cognitive behavioral treatment)
- Matrix (a cognitive behavioral substance use disorders)
- Cognitive Behavioral Interventions for substance use disorders
- Various peer and consumer-driven support groups

- *Additional Clinical Supports:*
  - Community Behavioral Intervention Services are available to adult and older adult FSP clients who are having a hard time managing behaviors and impulses and have experienced a severe loss of functioning. The services are based on the principles of *Applied Behavioral Analysis* and intended to address specific behaviors to support long-lasting functional change.
  - Intensive Home-Based Services and Intensive Care Coordination are available for children, youth, and their families for any children or youth who meet Specialty Mental Health Services, and who would benefit from those services.
  - Substance Use Disorder Treatment Services are available through the Substance Abuse Services Division and include a range of outpatient, intensive outpatient, and residential treatment programs. BHS also contracts with qualified community partners to provide medication assisted treatment for individuals with co-occurring disorders.

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

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

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

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

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

Monitoring Treatment Progress

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

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

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

Transition to Community or Specialty Mental Health Services

- *Transition Planning:* Transition planning is intended to help consumers "step-down" from the highly intensive services of the full-service partnership program into specialty and/or community based mental health services. Indicators that a consumer is ready to step down include, increase stability in housing; increase functionality as indicated by attainment of

treatment goals; completion of therapeutic interventions and readiness as determined by the FSP clinical team; and client's ability to move successfully to a lower level of care.

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

- *Post FSP Services*: FSP consumers stepping down from an FSP program will be linked with a Peer Specialist. Peer Specialist workers will ensure that individuals who have stabilized in treatment services will remain stable by providing regular follow-up services to ensure satisfaction and engagement with new treatment services and continued stability in the community for a period of up to six months following discharge from an FSP.

    - CYS Post FSP Services: CYS FSP Consumers step down from an FSP program via a warm handoff when appropriate. The FSP team introduces the consumer to their new treatment team. Often this introduction takes place during a Child Family Team Meeting. The FSP does not close out services until the consumer is fully engaged in the step-down program.

Community Services and Supports Funded Programs

Full Service Partnerships

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

Outreach & Engagement

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

General System Development

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

22. Co-Occuring Disorder Program

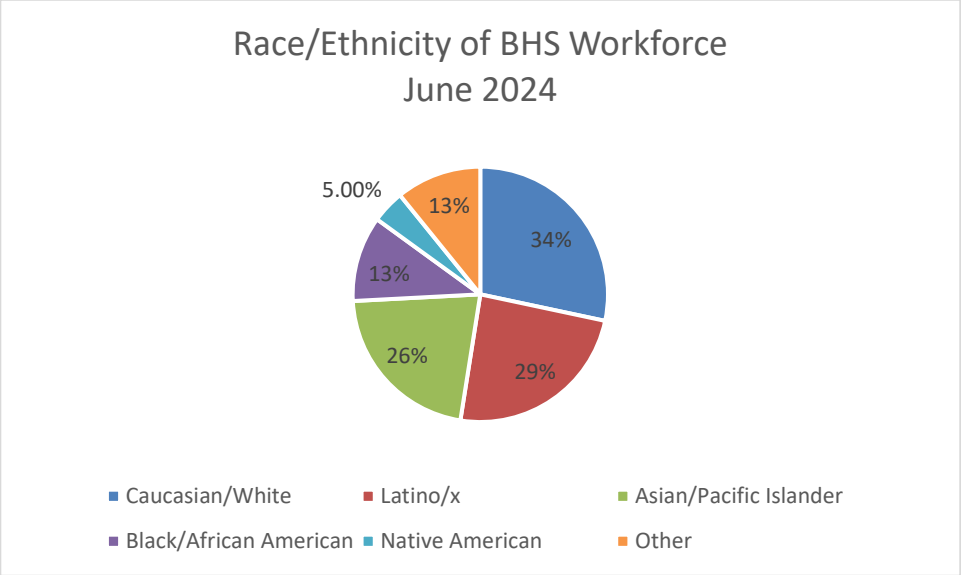
23. TAY Outpatient Care

24. System Development Expansion

Capacity to Implement CSS Programs

Over 1,000 mental health services staff and partner staff work throughout the county to deliver mental health services to over 17,000 individuals with serious mental illness (a 17:1 ratio of clients to partners and staff). BHS employs the largest proportion of the workforce (N=737) or 74% of the workforce. Other network providers and community-based organizations account for the remaining portion of the workforce.

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



BHS works hard to recruit and retain a diverse workforce. Compared to the general population the BHS workforce is relatively diverse, and somewhat reflective of the residents of San Joaquin County. Data shows that Hispanic/Latino individuals are under-represented in the workforce, comprising 29% of the workforce, compared to 41% of the county population and 46% of Medi-Cal Beneficiaries, however in the recent year, Hispanic/Latino individuals have become slightly higher in representation than their Caucasian/White counterparts.

Further details about language capacity and cultural competency at BHS are in the Cultural Competency Plan, located in the Appendix. The Cultural Competency Plan provides more insight on the strengths and limitations of the workforce to serve a diverse population and describes the ongoing activities and strategies to strengthen the workforce and meet community needs.

CSS FSP Program Work Plans

Funding is allocated towards nine FSP programs that are implemented by 22 different clinical teams comprised of psychiatrists, clinicians, case managers, peer partners, nurses, psychiatric technicians, and others. Annually, over 2,000 individuals receive services within San Joaquin's FSP programs. FSP program participants may also participate in one or more specialty programs to receive additional services and supports beyond those usually provided by an FSP team.

	Unique Count of Clients Served in FY 23-24
Full Service Partnership Programs	
1. Children and Youth FSP (5 Teams)	619
2. Transitional Age Youth (TAY) FSP (2 Teams)	74
3. Adult FSP (7 Teams)	541
4. Older Adult FSP (1 Team)	94
5. Community Corrections FSP (1 Team)	688
6. InSPIRE FSP (1 Team)	36
7. Intensive Adult FSP (2 Teams)	172
8. Intensive Justice Response FSP (2 Teams)	179
9. High Risk Transition Team FSP (1 Team)	84
TOTAL CLIENTS ENROLLED IN FSP PROGRAMS	**2,487**

CSS Project 1: Children and Youth FSP

Project Description

The Children and Youth Services FSP programs provide intensive and comprehensive mental health services to children and youth who have not yet received services necessary to address impairments; reduce risk of suicide, violence, or self-harm; or stabilize children and youth within their own environments (see FSP Enrollment Criteria 1, page 34). Full-Service Partnership program interventions are targeted for children and youth who are: (1) juvenile justice involved, or (2) engaged with the Child Welfare System, or (3) diagnosed with a serious mental illness or severe emotional disturbance that necessitates service interventions beyond the scope of traditional specialty mental health care.

Target Populations

1. **Dependency Population:** FSP programs serve children and youth that are in the dependency system. All children and youth that meet California's Pathways to Wellbeing and Intensive Care Coordination requirements are eligible for FSP services.
2. **Children and Youth:** FSP programs serve children and youth that have a severe emotional disorder and /or a diagnosed serious mental illness that require a full spectrum of services and supports to meet recovery goals.

Project Components

There are four FSP teams working with children and youth.

FSPs for Children and Youth in the Dependency System

1. Dependency FSP Team

The vast majority of children and youth served by this FSP are simultaneously involved with the juvenile justice system or the child welfare system, or both. The purpose of the Dependency FSP team is to provide an intensive level of engagement and stabilization services while working in a cross-system, cross-agency team environment that more effectively and efficiently addresses concurrent and complex child, youth, and family needs. Trained clinical staff provide trauma-informed, evidence-based services and supports to include individual therapy and group therapy, Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) anchored in the principles and values of the Core Practice Model.

The Child and Family Team (CFT) meeting along with the CANS will be used to address emerging issues, provide integrated and coordinated interventions, and refine and inform the plan and services as needed.

2. MHSA Pathways FSP Team

This FSP serves children and youth with the highest and most acute treatment needs that meet criteria for sub-class services. Youth receive community-based Intensive Care Coordination (ICC) in compliance with State mandates, and Intensive Home-Based Services (IHBS) per State Medi-Cal regulations. ICC includes the practice of teaming with the child/youth, family, child welfare social worker, probation officer, mental health worker, and other supports through the use of CANS informed Child and Family Team (CFT) meetings. Contracted staff are CANS certified and skilled in the use of methods of team facilitation in order to ensure effective engagement and inclusion of the child/youth and family.

3. Therapeutic Foster Care (TFC) Team

The TFC team provides a short-term, intensive, highly coordinated, trauma-informed, and individualized intervention via the TFC Resource Parent. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. Children in this program also receive ICC and other medically necessary SMHS, as set forth in the client plan. TFC service provision is guided by a Child and Family Team (CFT). The TFC Resource Parent works under the supervision of the TFC agency and under the direction of a Licensed Mental Health Professional (LPHA) or a Waivered or Registered Mental Health Professional (WRMP) employed by the TFC agency. To ensure continuity of care the TFC agency can continue to serve the youth when they are stepped down from a TFC placement and even if the youth transitions out of foster care.

4. Short Term Residential Therapeutic Programs (STRTP)

STRTP's offer the highest level of care for at-risk youth in the foster and juvenile justice system. STRTP's are an out of home placement. Services include 24-hour supervision and an intensive, trauma informed, treatment program. The focus of treatment is to help youth and families build skills to manage challenging behaviors, restore permanent family connections and strengthen community ties through a continuum of interventions. SMHS are guided by a Child and Family Team (CFT).

FSPs for non-dependent Children and Youth

5. BHS Child and Youth (CYS) FSP Team

This team provides intensive clinical treatment services for children and youth that are at risk for and/or presenting with delinquency, violence, substance use, conduct disorder, oppositional defiant disorder, disruptive behavior disorder, mood disturbances, anxiety symptoms, or trauma. Intensive Care Coordination (ICC) will include the practice of teaming with the child/youth, family, mental health worker, and other formal and natural supports through the use of CANS informed Child and Family Teams (CFT). All services will be driven by the CFT and may include therapy, Intensive Home Based Services (IHBS) and Intensive Care Coordination (ICC). Therapy, in conjunction with intensive care

coordination (ICC) and intensive home based services (IHBS), will be provided by a mental health clinician and paraprofessionals. The length of stay is 6-12 months. Services will be based on Wraparound principles and will utilize a Child and Family Team Meeting to monitor progress and engage with and support the family.

Whatever It Takes Funds will be utilized to assist FSP clients to meet the recovery needs of FSP clients within this FSP Program

Documentation of Achievement in performance outcomes:

BHS Internal FSP Program

Over the past two years there has been a consistent increase in the number of children/youth who received Intensive Home Based Services (IHBS), by approximately 143%.

Victor Community Support Services

- 100% of FY23-24 first offered prescriber appointments meeting the 15-business day.
- Objective Q4 admits being offered first follow-up treatment within 10 business days, but investigation found that 23 of 25 (92%) received a follow-up service within 10 business days of their first service, including each non-transfer admits (2 of 2, 100%).
- Objective 4 was met with 83% of members for FY having a timely finalized assessment template.
- More than 89% of clients in Q4 months had at least one service every 30 days.
- Objective 7 was met on the dashboard, with 0% in the quarter 4 having a crisis episode.
- Objective 8 was met on the dashboard, with 100% for the FY (and 0% needing a psychiatric hospitalization in Q4) having service within 7 days of psychiatric hospitalization discharge.
- Objective 9 was met on the dashboard for the FY, with under 1% of clients being admitted to the JJC.
- Objective 10 was met on the dashboard, showing under 15% of notes were late in each month in Q4.
- VCSS investigation showed this to be met, with 83 of 97 (86%) of eligible clients having a CANS in the last six months.
- 97% of client social workers were provided with written documentation as to the status of progress on their client treatment plans.

Challenges or barriers:

BHS Internal FSP Program

Challenges remain with the new EHR, and limited data utility related to the ICC/IHBS Screener and Referral form. When this form was in our previous EHR, we were able to pull data such as number of referrals, outcome of referrals, and timeliness of referral follow ups. We were also

able to track staff compliance with completion of the screening form at required times such as at intake, every 6 months and after a crisis visit or psychiatric hospital stay. The lack of reports in the current EHR limits clinical management on cases which can impact timely completion of screeners and assessments. Transportation, availability of families, and reluctance to have service providers in the home impacts ability to increase services. Hiring clinical staff continues to be a barrier. The program has been able to use both locum clinicians and masters level students through our agreements with local colleges.

Victor Community Support Services

Challenges in quarter 1 were referrals being made to SB 163 Wraparound at the same time as Pathways. There were also challenges with social workers not having the correct contract information for caregivers. There were also barriers with families not wanting services because of the time that would need to devoted to Pathway services.

Challenges in quarter 2 were inconsistent referrals and referrals that had already been referred to other programs. Referrals continued to contain the wrong information causing challenges. Caregivers were being overwhelmed with services or not understanding why the clients were getting services since they did not see a need. This delayed the process of services and assessments at times because there is no reply from the caregiver.

Challenges in quarters 3 and 4 were primarily from the changing of teams on cases as new staff were onboarding and outgoing staff were handing off the cases

Clients Served within the Children and Youth FSP Program

Client Demographics

Children and Youth FSP Program 2023-2024 N= 619		
	Number	**Percent**
Total by Age Group Served		
▪ Children and Youth	385	62%
▪ Transitional Age Youth	234	38%
Gender Identity		
▪ Female	365	59%
▪ Male	253	41%
Race/Ethnicity		
▪ African American	144	20%
▪ Asian / Pacific Islander	18	3%
▪ Hispanic/Latino	259	26%
▪ Native American	7	1%
▪ White/Caucasian	153	25%
▪ Other / Not-Identified	214	34%
▪ Multiracial	42	7%
Linguistic Group		
▪ English	410	66%
▪ Spanish	14	2%
▪ Other non-English	195	32%

Cost per Client

Number Served	**Total Expenditures**
619	$6,789,784
Average Annual Cost	**Average Monthly Cost**
$10,462	**$872**

Client Projections

Clients Served/Projected			
2023-24	**2024-25**	**2025-26**	**Age Group**
619	655	691	Combined
385	405	426	Children & Youth
234	250	265	TAY

****2026-27 Unprojected due to transition to BHSA and Integrated Plan**

CSS Project 2: Transitional Age Youth (TAY) FSP

Project Description

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

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

Target Population 1: Exiting or Former Foster Care Youth

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

Target Population 2: Transitional Age Youth

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

Documentation of Achievement in performance outcomes:

The TAY FSP program in the Adult System of Care currently serves 43 members, providing case management, linkage, rehabilitation, and therapy services. The TAY FSP program provides two TAY Coping Skills Groups and continues to look to add additional groups based on member needs. The TAY FSP team attended several training courses to increase their knowledge and skills to better serve members.

Challenges or barriers:

The TAY FSP team continues to experience challenges related to staffing. There continues to be limited housing resources combined with the lack of financial resources for this age group. Many of the TAY FSP youth do not have reliable transportation to participate in additional MH services such as groups.

Strategies:

The Adult Outpatient Services team cross-trains staff to provide support to programs needing staff coverage to support TAY members. The TAY team continues to utilize CHOICE funding and other community housing programs for temporary shelter until more stable placement can be secured. The TAY FSP team continues to assist with transportation needs of their members and the team has a designated staff providing transportation to groups and other services.

Project Components:

There are two FSP teams working with Transitional Age Youth.

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

Client Demographics

Transitional Age Youth FSP Program 2023-2024 N=74		
	Number	**Percent**
Total by Age Group Served		
▪ Adult	13	18%
▪ Transitional Age Youth	61	82%
Gender Identity		
▪ Female	33	45%
▪ Male	41	55%
Race/Ethnicity		
▪ African American	14	19%
▪ Asian / Pacific Islander	8	11%
▪ Hispanic/Latino	25	34%
▪ Multiracial/Other	5	7%
▪ White/Caucasian	21	28%
Linguistic Group		
▪ English	60	81%
▪ Spanish	3	4%
▪ Other, Asian	1	1%
▪ Other non-English	10	14%

Cost per Client

Number Served	**Total Expenditures**
74	$488,351
Average Annual Cost	**Average Monthly Cost**
$6,599	**$550**

Client Projections

Clients Served/Projected			
2023-24	**2024-25**	**2025-26**	**Age Group**
74	80	85	Combined
13	13	13	Adult
61	67	72	TAY

****2026-27 Unprojected due to transition to BHSA and Integrated Plan**

CSS Project 3: TAY Intensive Care Coordination and Intensive Home-Based Services FSP

Project Description

Per Information Notice 16-004, Behavioral Health Services is obligated to provide Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) through the Early & Periodic Screening, Diagnosis, & Treatment (EPSDT) benefit to all youth under the age of 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for these services.

Intensive Care Coordination (ICC), Child Family Team Facilitation (CFT), and Intensive Home-Based Interventions Services (IHBS) will be provided to San Joaquin County Medi-Cal Beneficiaries ages 16 through 20 who meet criteria for services. The services will be culturally competent and will be delivered in compliance with the Core Practice Model Guideline issued by the Department of Health Care Services (DHCS). The overarching objective is to provide intensive mental health services, medication services, and skill-based interventions to develop or enhance functional skills to improve self-care and self-regulation by intervening to decrease or replace non-functional behavior that interferes with daily living tasks. A multi-disciplinary team serves to work intensively with individuals with severe mental health issues to assist them with remaining in their community while reducing the need for residential or inpatient placements. All treatment, care and support services are provided in a context that is youth centered, family-focused, strength based, culturally competent and responsive to each youth's psychosocial, developmental, and treatment care needs. Services will be based on Wraparound principles and will utilize a Child and Family Team Meeting to monitor progress and engage with and support the family.

Target Population

This program provides a full spectrum of services and supports for transition aged youth ages 16 through 20 that demonstrate more intensive needs who meet established eligibility criteria.

Project Components

1. **Child and Family Team (CFT) Meetings:** The CFT is responsible for the identification and inventory of family strengths, for conducting a comprehensive culturally relevant life domain needs analysis, and for monitoring and accountability. All services will be strength based, individualized, and will include services youth feel they need from both behavioral health and their community in order to be successful. The CFT's role is to include natural supports in defining and reaching identified goals for the youth. All services will be driven by the CFT and may include, therapy, Intensive Home-Based Services (IHBS) and Intensive Care Coordination (ICC).
2. **Intensive Care Coordination (ICC):** Intensive Care Coordination is a targeted case management service that facilitates assessment of care planning for, and coordination of, services- including urgent services. It includes the practice of teaming with the child/youth, family, mental health worker, and other formal and natural supports with CANS informed Child and Family Teams

(CFT). An ICC coordinator must be designated and will serve as the single point of accountability to:

a. Ensure that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, youth driven, and culturally and linguistically relevant manner and that services and supports are guided by the needs of the youth;

b. Facilitate a collaborative relationship among the youth, his/her natural supports and involved child-serving systems;

c. Identify the youth's strengths and needs and assist the natural supports in understanding/meeting strengths and needs identified;

d. Help establish the Child and Family Team (CFT) made up of formal and natural supports to provide ongoing support;

e. Organize and match care across providers and child-serving systems to allow the youth to be served in his/her home and or community

3. **Intensive Home-Based Mental Health Services (IHBS):** Intensive Home-Based Services are clinical services provided in the youth's home and/or community. Services are provided to youth who have returned or are returning home from out-of-home care or psychiatric hospitalization and require intensive community-based services, are at imminent risk of placement due to mental health issues, emotional disturbance, or substance abuse, or have involvement with one or more child -serving systems. Services are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a youth's functioning and are aimed at helping the youth build skills necessary for successful functioning in the home and community.

Whatever It Takes Funds will be utilized to assist FSP clients to meet the recovery and housing needs of FSP clients within this FSP Program

Documentation of Achievement in performance outcomes:

Services to begin FY 2024-2025

Challenges or barriers:

Services to begin FY 2024-2025

CSS Project 4: Adult FSP

Project Description

Adult FSP services are available throughout the county for any adult with serious mental illness who meets the criteria for FSP enrollment, with priority enrollment given to individuals who are currently homeless, involved with the criminal justice system, frequent users of crisis or emergency services, or are at-risk of placement in an institution.

Target Population

- *Adults 26-59,* with serious and persistent mental illnesses that have not otherwise stabilized their recovery through specialty mental health services, and who are unserved or underserved, and experiencing at least one of the following (*see eligibility criteria p. 34-36*):
    - Involvement with the criminal justice system
    - Homeless or at imminent risk of homelessness
    - Frequent emergency room or crisis contacts to treat mental illness.
    - At risk of institutionalization

Project Components

There are a variety of FSP teams working with Adults who have serious mental illnesses.

1. **Intensive FSP Program**
   BHS has three intensive FSP teams to serve adults with serious mental illnesses who require additional intensive wrap-around services and supports in order to engage and stabilize clients into standard FSP programs. The Intensive FSP teams are described as CSS Projects #7,#8, and #9 in order to better define and account for the specialized services provided by these teams.

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

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

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

Starting in FY 2023-24, BHS will begin to contract with community-based organizations to provide culturally appropriate and community driven FSP services for the following Standard FSPs:

- Black Awareness and Community Outreach FSP Program – Fully Contracted with Mary Magdalene Community Services as of 2023-24.
- La Familia FSP Team – Will be RFP'd in the 2024-25 fiscal year

Housing Empowerment Services and Whatever It Takes Funds will be utilized to assist FSP clients to meet the recovery and housing needs of FSP clients within this FSP Program

Documentation of Achievement in performance outcomes:

We have merged two Adult FSP programs and created one team to have more staff available to serve our members. Our Black Awareness and Community Outreach FSP was contracted with Mary Magdalene Community Services to provide culturally appropriate and community driven FSP services for our African American members.

Challenges or barriers:

The lack of housing resources for our members continues to be our main challenge. Housing for members with no income, emergency placements as well as appropriate facilities for members with medical conditions has been a challenge. Board and Care facilities continue to close, which further impacts placements for members who require this level of care.

Strategies –

Continue to work with identifying housing programs and resources in the community that can assist our members' housing needs. Continue to develop collaborative relationships with our BHS housing team to assist in identifying appropriate housing resources for our FSP members.

Clients Served within the Adult FSP Program

Client Demographics

Adult FSP Program 2023-2024 N= 541		
	Number	**Percent**
Total by Age Group Served		
▪ Transitional Age Youth	20	4%
▪ Adults	482	89%
▪ Older Adults	39	7%
Gender Identity		
▪ Female	226	42%
▪ Male	314	58%
Race/Ethnicity		
▪ African American	126	23%
▪ Asian / Pacific Islander	55	10%
▪ Hispanic/Latino	95	18%
▪ Native American	30	6%
▪ White/Caucasian	174	32%
▪ Other / Multiracial	56	10%
Linguistic Group		
▪ English	418	87%
▪ Spanish	14	3%
▪ Asian/Pacific Islander	6	1%
▪ Indo European	1	1%
▪ Other non-English	48	9%

Cost per Client

Number Served	**Total Expenditures**
541	$3,206,603
Average Annual Cost	**Average Monthly Cost**
$5,788	**482**

Client Projections

Clients Served/Projected			
2023-24	**2024-25**	**2025-26**	**Age Group**
541	747	807	Combined
20	20	20	TAY
482	647	697	Adults
59	80	90	Older Adults

**2026-27 Unprojected due to transition to BHSA and Integrated Plan

CSS Project 5: Older Adult FSP

Project Description

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

Target Population

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

Project Components

- There is one FSP team working with Older Adults who have serious mental illnesses.

Housing Empowerment Services and Whatever It Takes Funds will be utilized to assist FSP clients to meet the recovery and housing needs of FSP clients within this FSP Program

Documentation of Achievement in performance outcomes:

Older adult services currently serve 343 clients with seven Case managers and of those are 64 Full-Service Partnership clients.

Successes

Older adult services have successfully maintained minimal client hospitalizations/rehospitalization.
Maintained relationship and comradery among OAS staff and better communication with other teams (Warm hand Off, Case reviews and consultations).
Improved on our Rehab Services and services provided in the community/Field
Increased access to linkages to other treatment programs
Outreach for increased recognition of Older Adult Services

Challenges or barriers:

Lack of availability of appropriate housing for older adults on all levels (independent/ residential care facilities/ long term care (SNF's), Assisted Living facilities etc.
Closure of B/C homes housing OAS client requiring immediate relocation in and or out of County
Housing challenges (all levels/types)
Securing an appropriate level of care for Older Adults with Comorbidity (Medical issues and substance use issues)
Challenges with Transition of care to PCP

Strategies

Increase availability for appropriate housing, utilization of other funding sources to supplement clients housing needs.
Cohesiveness and communication between teams for continuity of client care and services.
Encourage Outreach and Engagement and promote the need for older adults services.
Increased referrals
Increased advocacy to PCP's regarding continuity of care Services
Fully staff with one outstanding position.
Encourage and promote wellness activities.

Clients Served within the Older Adult FSP Program

Client Demographics

Older Adult FSP Program 2023-2024 N= 97		
	Number	**Percent**
Total by Age Group Served		
▪ Older Adults	94	97%
▪ Adults	3	3%
Gender Identity		
▪ Female	53	55%
▪ Male	44	45%
Race/Ethnicity		
▪ African American	25	26%
▪ Asian / Pacific Islander	1	1%
▪ Hispanic/Latino	9	9%
▪ Native American	7	7%
▪ White/Caucasian	49	51%
▪ Other / Not-Identified	1	1%
▪ Multiracial	5	5%
Linguistic Group		
▪ English	79	81%
▪ Spanish	4	14%
▪ Other non-English	4	4%

Cost per Client

Number Served	**Total Expenditures**
97	$529,867
Average Annual Cost	**Average Monthly Cost**
$5,463	**$455**

Client Projections

Clients Served/Projected			
2023-24	**2024-25**	**2025-26**	**Age Group**
94	125	145	Older Adults
3	3	3	Adults

**2026-27 Unprojected due to transition to BHSA and Integrated Plan

CSS Project 6: Community Corrections Forensic FSP

Project Description

BHS's Justice and Community Integration Division works in partnership with San Joaquin County Jail, Correctional Health Services, the Collaborative Court System, the Probation Department, and other justice agencies, to provide a full spectrum of mental health services to consumers who are engaged by the criminal justice system. Unit staff work in collaboration with the justice system to reduce the criminalization of the mentally ill. Services include assessment, identification, outreach, support, linkage, and interagency collaboration in the courtroom and to supervising Probation Officers to help ensure a successful reentry and transition into the community for justice-involved individuals. Program activities align with the objectives of the Stepping Up Initiative, a national program for reducing incarcerations for people with serious mental illnesses. FSP programming is available for clients that meet the State's eligibility criteria and are among the following target populations.

Target Population 1: Re-entry Population

- *Justice-involved Adults 18 and over,* with serious and persistent mental illnesses who are being treated by Correctional Health Services within the San Joaquin County Jail and are within 30 days of release into the community.

Target Population 2: Forensic or Court Diversion Population

- *Justice-involved Adults 18 and over,* with a diagnosed mental illness or co-occurring substance use disorder, who are participating in problem-solving, collaborative courts in San Joaquin County or other formal diversion program.

Project Components

There are several FSP teams working with justice-involved adults who have serious mental illnesses.

1. **Intensive FSP**
   BHS contracts with two community partners to provide intensive FSP programming using an Assertive Community Treatment program model to engage justice-involved clients with a historic reluctance to engage in treatment services. The Intensive FSP program for justice-involved individuals with serious mental illnesses is described as CSS Project#9 in order to better define and account for the specialized services provided by these teams.

2. **Standard FSP**
   Forensic FSP Team
   Contracted FSP Services for Misdemeanor ISD Diversion

Housing Empowerment Services and Whatever It Takes Funds will be utilized to assist FSP clients to meet the recovery and housing needs of FSP clients within this FSP Program.

Documentation of Achievement in performance outcomes:

Last year the Forensics FSP Teams served 330 clients, and we expect this number to slightly rise for 2024-2025 and are estimated to serve 350 clients. During this reporting timeframe we successfully facilitated 4 different rehabilitation groups running at the forensics clinic- men's group rehabilitation, MATRIX, Seeking Safety, and a coed Skill building group. In August of 2023 we had our first behavioral health outreach worker become peer certified.

During this time, 9551 services were provided to our clients- 1080 psychiatric services, 3578 case management, 181 comprehensive assessments, screened 486 members for services, 416 individual and group therapy sessions, 1465 group and individual rehabilitation, 1409 plan development, and 959 non-billable services.

Challenges or barriers and strategies:

During this reported time a barrier that arose for management and the program was hiring various new staff at one time. This presented hardship both for the clients and new staff in delivery of services. A strategy to minimize impact on services was to have regular in-service training on programming procedures and team building activities to establish rapport within the team.

In the development and expansion of justice services within SJCBHS, an influx of clients was transferred from another BHS division to Forensics FSP. To mitigate impact, each client was assigned a case manager upon intake to not have a break in services.

A continued barrier of obtaining adjunct benefits/services- SSI/CalFresh/payeeship/ birth certificate/ Social Security card etc. is challenging as the process requires follow up that is difficult for intensive clients, especially homeless and those who have no phones. Some improvement has been made after placing clients in temporary housing-hotels via choice funding. Rapport building interventions were administered to help clients stay engaged in services. "Out of the box" interventions such as community food boxes were also given to clients upon placement, followed by next day contact.

Our last continued barrier has been a lack of presence by the probation department in Mental Health Court. The current judge and administration have been in support of having the San Joaquin Probation Department present in court for collaboration and support of the members, but due to lack of staffing a probation officer has not been available. Continued conversations with San Joaquin Probation Department are ongoing to build a supportive collaborative relationship.

Clients Served within the Community Corrections FSP Program

Client Demographics

Community Corrections FSP Program 2023-2024 N=688		
	Number	**Percent**
Total by Age Group Served		
▪ Transitional Age Youth	75	11%
▪ Adults	580	84%
▪ Older Adults	33	5%
Gender Identity		
▪ Female	183	27%
▪ Male	494	72%
Race/Ethnicity		
▪ African American	161	23%
▪ Asian / Pacific Islander	31	5%
▪ Hispanic/Latino	182	26%
▪ Native American	15	2%
▪ White/Caucasian	179	26%
▪ Other / Not Identified	38	6%
▪ Multiracial	27	4%
Linguistic Group		
▪ English	460	67%
▪ Spanish	19	3%
▪ Other non-English	208	30%
▪ Asian/Pacific Island	1	1%

Cost per Client

Number Served	**Total Expenditures**
688	$1,216,177
Average Annual Cost	**Average Monthly Cost**
$1,768	**$147**

Client Projections

Clients Served/Projected			
2023-24	**2024-25**	**2025-226**	**Age Group**
688	722	758	Combined
75	78	82	TAY
580	609	639	Adults
33	35	37	Older Adults

**2026-27 Unprojected due to transition to BHSA and Integrated Plan

CSS Project 7: InSPIRE FSP

Project Description

The Innovative Support Program in Recovery and Engagement (InSPIRE) program serves adults 18 and older who are hesitant or resistant to engaging in mental health treatment and are involved in the justice system or at risk of justice involvement.

In FY 24/25 The Inspire FSP is expanded to serve clients involved in Care Court Process.

Senate Bill (SB) 1338 (Umberg, Chapter 319, Statutes of 2022) established the Community Assistance, Recovery, and Empowerment (CARE) Act, which provides community-based behavioral health services and supports to Californians living with untreated schizophrenia spectrum or other psychotic disorders through a new civil court process. The CARE Act is intended to serve as an upstream intervention for individuals experiencing severe impairment to prevent avoidable psychiatric hospitalizations, incarcerations, and Lanterman-Petris-Short Mental Health Conservatorships.

The CARE Process will provide earlier action, support, and accountability for both CARE clients, and the local governments responsible for providing behavioral health services to these individuals. The CARE Act authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan that may include treatment, housing resources, and other services.

The CARE Act creates a new pathway to deliver mental health and substance use disorder services to the most severely impaired Californians who too often suffer from homelessness or incarceration without treatment. The CARE Act moves care and support upstream, providing the most vulnerable Californians with access to critical behavioral health services, housing and support.

InSPIRE strives to find additional pathways to mental health services for hesitant or reluctant clients to improve individual well-being and create a safer community. A key element of InSPIRE is Enthusiastic Engagement.

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

Target Population

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

Project Components

- There is one InSPIRE FSP team. - This team provides *Intensive FSP* services for adult clients who may be involved in the Care Court process.

Housing Empowerment Services and Whatever It Takes Funds will be utilized to assist FSP clients to meet the recovery and housing needs of FSP clients within this FSP Program

Documentation of Achievement in performance outcomes:

During FY 2023/2024, InSPIRE transitioned staff and members to the Justice and Community Integration Division of Behavioral Health Services. During that time, members without a history or risk of justice involvement were slowly transitioned, depending on their individual needs, to other BHS programs suited to address their treatment goals. During that time, InSPIRE served 35 members.

In addition to this transition and providing treatment to a challenging population, the InSPIRE team began participating in many collaborative meetings with community stakeholders and justice partners and participated in trainings offered by DHCS and HMA in preparation for their role in the CARE Act process which will commence December 1, 2024.

Challenges or barriers and strategies:

Staff turnover and continued staff vacancies have been a challenge in this FY. Staff vacancies have included Clinicians, Case Managers and Peer Support staff. Currently, InSPIRE is down three Behavioral Health Outreach Workers and one Mental Health Clinician Supervisor. However, the Clinician and Case Manager positions are now fully staffed.

Clients Served within the InSPIRE FSP Program

Client Demographics

InSPIRE FSP Program 2023-2024 N=36		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	34	94%
▪ Older Adults	1	3%
▪ TAY	1	3%
Gender Identity		
▪ Female	8	22%
▪ Male	28	78%
Race/Ethnicity		
▪ African American	9	25%
▪ Asian / Pacific Islander	2	6%
▪ Hispanic/Latino	7	19%
▪ Native American	2	6%
▪ White/Caucasian	8	22%
▪ Other / Not-Identified	7	19%
▪ Multiracial	2	6%
Linguistic Group		
▪ English	31	86%
▪ Spanish	0	0%
▪ Other non-English	4	11%

Cost per Client

Number Served	**Total Expenditures**
36	$454,069
Average Annual Cost	**Average Monthly Cost**
$12,613	**$1,051**

Client Projections

Clients Served/Projected			
2023-24	**2024-25**	**2025-26**	**Age Group**
36	39	41	Combined
34	34	34	Adult
1	3	5	Older Adults
1	2	2	TAY

**2026-27 Unprojected due to transition to BHSA and Integrated Plan

CSS Project 8: Intensive Adult FSP

This Intensive Adult FSP will work with adult consumers, aged 18 and older, with serious and persistent mental illnesses or co-occurring substance use disorders that are at risk for institutionalization. Intensive Adult FSP Program services will use an Assertive Community Treatment (ACT) Model to provide team-based services that produce positive outcomes and reduce the need for hospitalization or institutionalization.

ACT is an evidence-based program designed to support community living for individuals with the most severe functional impairments associated with serious mental illnesses. The ACT model utilizes a multi-disciplinary team, which is available around the clock, to deliver a wide range of services in a person's home or community setting. Additional information regarding Assertive Community Treatment can be found through:

- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345
  - https://store.samhsa.gov/shin/content/SMA08-4345/EvaluatingYourProgram-ACT.pdf
  - https://www.centerforebp.case.edu/client-files/pdf/act-dacts.pdf (Fidelity Criteria)

Target population

- *Adults,* between the ages of 18-59 (some exceptions) who have a serious mental illness and are substantially deteriorating, gravely disabled, or unable to care for themselves. The target population for the program is consumers who are at risk of acute or long-term locked facility placement and/or have had multiple failed transitions from locked facilities to lower level of care. Intensive Adult FSP clients may pose a serious risk to themselves or others, may have co-occurring disorders, and/ or may have other chronic health concerns.

Project Components

- There will be two Intensive Adult FSP teams.
- Teams provide *Intensive FSP* services for adults.

Housing Empowerment Services and Whatever It Takes Funds will be utilized to assist FSP clients to meet the recovery and housing needs of FSP clients within this FSP Program

Documentation of Achievement in performance outcomes:

Telecare – Connect 1
9% of transfer clients who were engaged within 3 business days of receiving the referral.
58% of clients received housing assistance during the reporting period.

98% of clients engaged in meaningful life activities such as volunteer work, prosocial activities, education, and employment as indicated in their individual client plan.
Turning Point - Esperanza

50% of transfer clients who were engaged within 3 business days of receiving the referral.
83% of clients who received housing assistance
63% of clients will be engaged in meaningful life activities such as volunteer work, prosocial activities, education, and employment as indicated in their individual client plan

Challenges or barriers:

Telecare – Connect 1
SmartCare continues to be a challenge. Charge reporting lacks unique identifiers, creating tremendous difficulties to track services. One of our biggest challenges is the length of time it takes to grant access to SmartCare for new staff. This impacts our abilities to provide high quality services while remaining financially stable. A lack of local Board and Care Homes has forced our higher-cute members to be placed out of the county, which has impeded our ability to provide frequent, face-to-face services. The Public Defender assigned to the LPS calendar continues to treat everyone in the court, including the member, her client, with hostility. BHS and this team have brought these demeanor issues to the Public Defender's supervisor with no effect.

Turning Point - Esperanza
Both programs have not met the outcome related to positive discharges to a lower level of care although Esperanza improved in Q4. TPCP has identified challenges related to an increase in acuity and substance use that has impacted our members successful discharge rate. We have also identified that more members are referred without active case management at BHS and no address or phone number, which adds challenges related to initial engagement and effective treatment.

Even though both programs attempt to meet goal expectations, Esperanza and Justicia programs strive to work towards meeting the requirements in the following categories. (3) 80% of clients will engage in meaningful life activities. Even though some members reported engaging in meaningful activities, others chose to not engage or have not identified participating in meaningful activities. We continue to support our staff in listening and engaging with members to identify meaningful activities they may be participating in already or would like to bring into their lives. (4.) 85% of members will have zero homeless day. Although Esperanza was close with 74.2%. A barrier that members of both Esperanza and Justicia face, is that San Joaquin County has a limited amount of affordable housing. Substance use and abuse also appear to contribute to this outcome as well as we have a number of members that refuse housing options especially shared housing and temporary housing and choose to remain homeless. However, 85% of Esperanza members and 80% members have achieved housing stability in this reporting period which is an increase from last quarter.

Clients Served within the Intensive Adult FSP Program

Client Demographics

Intensive Adult FSP Program 2023-2024 N= 172		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	152	88%
▪ Older Adults	14	8%
▪ Transitional Aged Youth	6	3%
Gender Identity		
▪ Female	66	38%
▪ Male	106	62%
Race/Ethnicity		
▪ African American	38	22%
▪ Asian / Pacific Islander	18	10%
▪ Hispanic/Latino	32	19%
▪ Native American	7	4%
▪ White/Caucasian	61	35%
▪ Other / Not-Identified	6	3%
▪ Multiracial	9	5%
Linguistic Group		
▪ English	164	95%
▪ Spanish	0	0
▪ Other, Asian	2	1%
▪ Other non-English	6	3%

Cost per Client

Number Served	**Total Expenditures**
172	$2,531,650
Average Annual Cost	**Average Monthly Cost**
$14,719	**$1,227**

Client Projections

Clients Served/Projected			
2023-24	**2024-25**	**2025-26**	**Age Group**
172	172	172	Combined
152	152	152	Adult
14	14	14	Older Adults
6	6	6	TAY

**2026-27 Unprojected due to transition to BHSA and Integrated Plan

CSS Project 9: Intensive Justice Response FSP

This Intensive Justice Response FSP will work with adult consumers, aged 18 and older, with serious and persistent mental illnesses that have co-occurring substance use disorders. Intensive Justice Response FSP Program services will use an Assertive Community Treatment (ACT) Model to provide team-based services that produce positive outcomes and reduce re-offending.

This program will provide a range of mental health treatment services within the ACT model, including case management and cognitive behavioral interventions to address criminogenic thinking with an emphasis on antisocial behaviors, antisocial personality, antisocial cognition, and antisocial associations; and lifting up protective factors associated with family, meaningful activities, or social connections. Other anticipated program services include substance use disorder treatment services; housing support services; and Re-entry coaching and support.

Additional information regarding Assertive Community Treatment can be found through:

- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345
  - https://store.samhsa.gov/shin/content/SMA08-4345/EvaluatingYourProgram-ACT.pdf
  - https://www.centerforebp.case.edu/client-files/pdf/act-dacts.pdf (Fidelity Criteria)

Target population

- *Adults,* between the ages of 18-59 who have a serious mental illness. The target population for this project is adults, between the ages of 18-59 who have a serious mental illness; may pose a serious risk to themselves or others; have a history of reluctance to engage in traditional mental health treatment services; and have a history of repeated contact with law enforcement with multiple involuntary holds (CA Penal Code §5150). Some participants may have more serious offense histories, including violent crimes.

Project Components

- There are two Intensive Justice Response FSP teams.
- Teams provide *Intensive FSP* services for adults.

Housing Empowerment Services and Whatever It Takes Funds will be utilized to assist FSP clients to meet the recovery and housing needs of FSP clients within this FSP Program

Documentation of Achievement in performance outcomes:

Telecare – Connect 2
20% of transfer clients who were engaged within 3 business days of receiving the referral.
56% of clients received housing assistance during the reporting period.
96% of clients engaged in meaningful life activities such as volunteer work, prosocial activities, education, and employment as indicated in their individual client plan.

Turning Point – Justicia
48% of transfer clients who were engaged within 3 business days of receiving the referral.
81% of clients who received housing assistance
46% of clients will be engaged in meaningful life activities such as volunteer work, prosocial activities, education, and employment as indicated in their individual client plan

Challenges or barriers:

Telecare – Connect 2
SmartCare continues to be a challenge. Charge reporting lacks unique identifiers, creating tremendous difficulties to track services. One of our biggest challenges is the length of time it takes to grant access to SmartCare for new staff. This impacts on our abilities to provide high quality services while remaining financially stable. A lack of local Board and Care Homes has forced our higher-cute members to be placed out of the county, which has impeded our ability to provide frequent, face-to-face services. The Public Defender assigned to the LPS calendar continues to treat everyone in the court, including the member, her client, with hostility. BHS and this team have brought these demeanor issues to the Public Defender's supervisor with no effect.

Turning Point - Justicia
Both programs have not met the outcome related to positive discharges to a lower level of care although Esperanza improved in Q4. TPCP has identified challenges related to an increase in acuity and substance use that has impacted our members successful discharge rate. We have also identified that more members are referred without active case management at BHS and no address or phone number, which adds challenges related to initial engagement and effective treatment.

Even though both programs attempt to meet goal expectations, Esperanza and Justicia programs strive to work towards meeting the requirements in the following categories. (3) 80% of clients will engage in meaningful life activities. Even though some members reported engaging in meaningful activities, others chose to not engage or have not identified participating in meaningful activities. We continue to support our staff in listening and engaging with members to identify meaningful activities they may be participating in already or would like to bring into their lives. (4.) 85% of members will have zero homeless days. Although Esperanza was close with 74.2%. A barrier that members of both Esperanza and Justicia face, is that San Joaquin County has a limited amount of affordable housing. Substance use and abuse also appear to contribute to this outcome as well as we have a number of members that refuse housing options especially shared housing and temporary housing and choose to remain homeless. However, 85% of Esperanza members and 80% members have achieved housing stability in this reporting period which is an increase from last quarter.

Clients Served within the Intensive Justice Response FSP Program

Client Demographics

Intensive Justice Response FSP Program 2023-2024 N=179		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	160	89%
▪ Older Adults	11	6%
▪ Transitional Aged Youth	8	4%
Gender Identity		
▪ Female	54	30%
▪ Male	125	70%
Race/Ethnicity		
▪ African American	57	32%
▪ Asian / Pacific Islander	5	3%
▪ Hispanic/Latino	35	20%
▪ Native American	8	4%
▪ White/Caucasian	54	30%
▪ Other / Not-Identified	13	7%
▪ Multiracial	6	3%
Linguistic Group		
▪ English	164	92%
▪ Spanish	4	2%
▪ Other non-English	11	6%

Cost per Client

Number Served	**Total Expenditures**
179	$1,668,976
Average Annual Cost	**Average Monthly Cost**
$9,324	**$777**

Client Projections

Clients Served/Projected			
2023-24	**2024-25**	**2025-26**	**Age Group**
179	179	179	Combined
160	160	260	Adult
11	11	11	Older Adults
8	8	8	TAY

**2026-27 Unprojected due to transition to BHSA and Integrated Plan

CSS Project 10: High-Risk Transition Team FSP

Project Description

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

Target Population

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

Program Components

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

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

- Provide 24/7 “on-call” services for clients in crisis.

Housing Empowerment Services and Whatever It Takes Funds will be utilized to assist FSP clients to meet the recovery and housing needs of FSP clients within this FSP Program

Documentation of Achievement in performance outcomes:

Telecare – Connect 3
18% of transfer clients who were engaged within 3 business days of receiving the referral.
60% of clients received housing assistance during the reporting period.
98% of clients engaged in meaningful life activities such as volunteer work, prosocial activities, education, and employment as indicated in their individual client plan.

Challenges or barriers:

Telecare – Connect 3
SmartCare continues to be a challenge. Charge reporting lacks unique identifiers, creating tremendous difficulties to track services. One of our biggest challenges is the length of time it takes to grant access to SmartCare for new staff. This impacts our abilities to provide high quality services while remaining financially stable. A lack of local Board and Care Homes has forced our higher-cute members to be placed out of the county, which has impeded our ability to provide frequent, face-to-face services. The Public Defender assigned to the LPS calendar continues to treat everyone in the court, including the member, her client, with hostility. BHS and this team have brought these demeanor issues to the Public Defender’s supervisor with no effect.

Client Demographics

High Risk Transition FSP 2023-2024 N=84		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	68	81%
▪ Older Adults	3	4%
▪ Transitional Aged Youth	13	15%
Gender Identity		
▪ Female	33	39%
▪ Male	51	61%
Race/Ethnicity		
▪ African American	26	31%
▪ Asian / Pacific Islander	7	8%
▪ Hispanic/Latino	23	27%
▪ Native American	2	2%
▪ White/Caucasian	20	24%
▪ Other / Not-Identified	4	3%
▪ Multiracial	2	2%
Linguistic Group		
▪ English	67	80%
▪ Spanish	4	5%
▪ Other, Asian	1	1%
▪ Other non-English	12	14%

Cost per Client

Number Served	**Total Expenditures**
84	$1,042,832
Average Annual Cost	**Average Monthly Cost**
$12,415	**$1,034**

Client Projections

Clients Served/Projected			
2023-24	**2024-25**	**2025-26**	**Age Group**
84	84	84	Combined
68	68	68	Adult
3	3	3	Older Adults
13	13	13	TAY

**2026-27 Unprojected due to transition to BHSA and Integrated Plan

CSS Project 11: FSP Adult Residential Treatment Services

Project Description

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

Target Population

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

Program Requirements

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

The purpose of the program is to facilitate a safe and timely placement or transition from a higher-level care facility to a community home-like setting. ARTS services may also be used to stabilize an individual to prevent placement in a higher level of care.

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

Per state licensing requirements, services will include:

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

Program Components

ARTS shall provide the appropriate level of therapeutic support, staffing and programming for program participants to avoid transitioning to a higher level of care. It is anticipated that residents will move toward a more independent living setting within six months from the date of their admission.

Crisis intervention, treatment plans, and collateral services shall be provided for program participants as follows:

A. Crisis Interventions

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

B. Treatment

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

C. Collateral

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

Clients Served/Projected			
2023-24	2024-25	2025-26	Age Group
Ribbon Cutting occurred April/May 2024 – No reportable data for 23-24			

**2026-27 Unprojected due to transition to BHSA and Integrated Plan

CSS Project 12: Housing Stabilization FSP Services

Community need and project description:

Research demonstrates that Social Determinants of Health (SDOH) influence health equity and outcomes. Some of the risk factors for developing more complex needs and issues within the population who experience both homelessness and SMI/SUD are lack of support, lack of care coordination, lack of trust in the system of care, the need for rapport and a need for building professional and social supports as well as a need for fostering and improving protective factors. These all play a huge role in positive treatment outcomes and measures. Meeting those in need where they reside in our community such as, on the street, in shelters, in encampments and offering them care coordination on all levels such as: basic needs, linkage, engagement, food, clothing, housing support, MH and SUD treatment as well as connecting to PCP treatment is not only a need but also a gap within our community and system of care where SMI/SUD affects at least 30% of those experiencing homelessness and complex issues. This FSP program will Provide intensive small caseloads of clients who have not otherwise been served in our system of care, with care coordination along with case management, screening, linkage, treatment, transportation, and professional support to ensure basic needs are addressed as they navigate all the systems in their lives to ensure they have the tools needed to remain in treatment and improve overall health outcomes and treatment alliance.

Target population: Adults (18-59) and Older Adults (60+) who are experiencing homelessness, at risk of homelessness who are also suspected to have an SMI/SUD who may also have multiple complex issues and struggle within the areas of their lives related to the SDOH who have not been treated in the BHS system of care, those who are underserved or inappropriately served.

- Whole Person Care (PEI Project 9) – Clients referred from the Whole Person Care Project will be prioritized to receive FSP services through the Housing Stabilization FSP Project to alleviate and support untreated mental illness and/or substance use disorders and assist to stabilize high utilization of health care services. (BHS FSP Team)

- Homelessness & Transitional Housing Project– Clients that are receiving navigation and housing supports through Housing Coordination Services (CSS Project 20) will be prioritized to receive FSP services through the Housing Stabilization FSP Project to alleviate and support untreated mental illness and/or substance use disorders as an effort to remain engaged in treatment and provide intensive recovery activities to support clients clinical and housing success. (Internal FSP Team)

Project Components: Provide outreach, engagement, linkage, housing support and housing linkage, mental health and substance abuse linkage and treatment, screening, intensive case management, transportation, follow up, support and comprehensive care coordination with a whole person care lens and spirit of meeting clients where they are and building on their inherent resilience to increase protective factors and improve treatment adherence over the long term. The project will provide this support within the community, for those who have not yet been treated and are unserved/underserved

within our system of care who are leaving institutions, hospitals, jails, are living in encampments, on the street, under bridges or in shelters.

Project Goals: To improve linkage, engagement, and treatment outcomes for the long term of those experiencing homelessness, at risk of homelessness and who also exhibit a complex need in areas of the SDOH who have not been served by our BHS system of care.

Housing Empowerment and Whatever It Takes Funds will be utilized to assist FSP clients to meet the housing and recovery needs of FSP clients within this FSP Program

Clients Served/Projected			
2023-24	**2024-25**	**2025-26**	**2026-27**
Services began in FY 2023-24			

General System Development Programs

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

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

Outreach and Engagement

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

General System Development

- Wellness Center
- Project Based Housing
- Employment Recovery Services
- Community Behavioral Intervention Services
- Housing Coordination Services
- Crisis Services Expansion
- Co-Occuring Disorders Program
- TAY Outpatient Care
- Forensic RESTART Outpatient Program
- System Development Expansion

CSS Project 13: Mental Health Outreach & Engagement

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

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

Target populations

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

Mental Health System Outreach and Engagement

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

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

Documentation of Achievement in performance outcomes

The Family Advocate program was able to assist 167 consumers and/or family members during FY 21/22. This number represents 83.5% of their goal of reaching 200 individuals and/or family members. The program had a decrease in providing services due to the pandemic.

Challenges or barriers:

The pandemic has reduced the number of consumers and/or family members requesting services from the Family Advocate. In addition, the number of opportunities to participate in presentations and informational sessions explaining the program and the program benefits to both the community and BHS staff members were limited due to the pandemic and imposed restrictions. The program anticipates that these challenges will become less problematic as COVID-19 restrictions decrease.

CSS Project 14: Mobile Crisis Support Team

Project Description

Mobile Crisis Support Teams (MCSTs) provide on-site mental health assessment and intervention within the community for individuals experiencing mental health issues and to avert a mental health related crisis. MCST help avert hospitalizations and incarcerations by providing early interventions to individuals who would not otherwise be able to seek help at traditional service locations.

MCSTs transition individuals to appropriate mental health crisis interventions in a timely fashion, reducing dependency on law enforcement and hospital resources. Comprised of a clinician and a peer- or parent-partner, MCSTs provide a warm handoff to services and help educate and introduce individuals and their family to the most appropriate services in a calm and supportive manner.

Target Population

- Individuals who are known to have serious mental illness and are substantially deteriorating or experiencing an urgent mental health concern.

- Individuals who are suspected of having a serious mental illness who may be unconnected to a mental health care team.

Project Components

- BHS operates four mobile crisis support teams.
- Services are available daily (Monday – Sunday), and into the evening hours most days of the week.

Mobile Crisis Support Teams conduct same day and follow-up visits to individuals that are experiencing a mental health crisis and require on-site, or in-home, support and assistance. MCSTs conduct mental health screenings and assessments to determine severity of needs and help transition individuals into routine outpatient care services.

Documentation of Achievement in performance outcomes:

MCST staff have completed all 10 mandatory Mobile Crisis Response trainings, as required by BHIN 23-025. We filled vacant positions, and our occupancy rate had improved through much of 2024. MCST received 1,049 referrals, with 466 coming from law enforcement. MCST detained a total of 193 people in FY 23-24 and co-responded with law enforcement partners in Mobile Evaluation Team operations, on approximately 300 referrals. With the addition of the Mobile Crisis Response Team (1 hour community response), it is expected that MCST referral numbers may decrease in FY 24-25. MCRT services begin 24/7/365 in July of 2024 and as MCRT becomes more widely publicized and utilized, some MCST referrals will naturally flow into the MCRT service model. As such, MCST is now a co-response model where clients already connected to BHS/BHS contractors are referred

internally, using familiar/assigned treatment staff to co-respond with MCST during service provision. This has increased the ability for MCST to engage and build rapport with vulnerable clients, which has in turn increased effective collaboration and better outcomes for clients in crisis.

Challenges or barriers and strategies:

The addition of the Mobile Crisis Response Team has complicated operations and has eliminated staffing gains made in FY 23-24. SJC BHS has been covering MCRT 24/7/365 and utilizing on-call/standby employees to cover from 11:00 pm-7:00 am. There are minimal staff who are able and willing to cover these shifts, and these staff are assigned to full-time daytime schedules as well, which means having to work many hours per week. This has been difficult. Our various law enforcement partners continue to have decreased staffing as well, which has also created challenges when attempting to safely intervene with clients in crisis, who have a history of aggression or propensity to violence. As law enforcement agencies are legally limited when interacting with certain mental health crisis situations, MCRT and MCST also face challenges with how to intervene without law enforcement assistance. If a suicidal client meets criteria for a 5150 hold but refuses to voluntarily leave the premises with MCST/MCRT staff, we struggle to get them into vehicles safely without law enforcement assistance.

CSS Project 15: Peer Navigation

Project Description

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

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

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

Project Components

BHS will work with an organizational provider to provide services. The Community partner will hire and train individuals, with lived experience in mental health recovery, to serve as Peer Navigators. Community Partners will use an evidence-based curriculum to train Peer Navigators. Some training activities occur in partnership with BHS, in order to ensure that Peer Navigators are familiar with BHS services. Examples of curriculum include:

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

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

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

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

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

Skills and Competencies:

- Lived experience in mental health recovery.
- Reflective Listening
- Motivational Interviewing
- Wellness Recovery Action Planning (WRAP)
- Strong interpersonal skills

Documentation of Achievement in performance outcomes:

Telecare –

27 consumers avg per quarter served/ 108 total
68 consumers who attended a recommended group or activity during the reporting period.
2000 services provided by Peer Navigators during the year

Challenges or barriers:

Telecare –

Budget issues to maintain support for the program as funding and scopes shift

CSS Project 16: Wellness Center

Project Description

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

Project Goal

The primary objectives for this program will be to:

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

Target Population

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

Project Components

The Wellness Center will provide the following services:

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

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

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

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

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

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

Documentation of Achievement in performance outcomes:

Objective 1: Program will interact with 1200 unduplicated consumers/family members annually. 1637 people interacted with

Objective 2: Contractor will participate in or host 18 events during the fiscal year designed to educate and inform consumers and family members about available services accessible to residents of the South, Central and North County. 65 events

Objective 3: Assist 35 unduplicated consumers in completing a Wellness Recovery Action Plan (WRAP). 31 unduplicated consumers assisted
Objective 4: 8 complete WRAP courses will be hosted during the contract term (approximately 2.33 per year). 7 WRAP courses hosted
Objective 5a: Peer Recovery Coaches will plan, develop and facilitate at least 1200 class sessions/support groups annually. 1703 classes
Objective 5b: 400 unduplicated consumers/family members will participate in at least one individual class session. 709 unduplicated consumers/family members
Objective 6a: Minimum of two staff members will be trained to provide Mental Health First Aid Trainings. 8 staff members trained
Objective 6b: 3 trainings will be given for TWC member and community members. 3 trainings given
Objective 7: Contractor will provide direct assistance to 550 unduplicated consumers/family members in at least one of the following categories: transportation needs, employment needs, obtaining proper clothing, obtaining necessary records/documents, food resources (referrals, information and/or transportation to address food scarcity, e.g., food banks) or housing resources (referrals, information and/or transportation to housing programs to address homelessness and/or improve member's housing circumstances) in the South, Central and North County areas. 770 consumers/family members received assistance
Objective 8: Maintain a roster of at least 10 active, adequately trained volunteers in the South, Central and North County areas. 35 active volunteers
Objective 9: Contractor will convene the PRS Board of Directors a minimum of 4 times. 4 times
Objective 10: Contractor will maintain a roster of at least 7 active members on the PRS Board of Directors. 39 active members
Objective 11: Contractor will receive at a minimum 300 completed surveys (utilizing a tool developed with BHS) from consumers during the contract term. 310 completed surveys received

Challenges or barriers:

In quarter one the uncertainty of the outcome of Prop 1 (formerly SB326) has led us to pause on getting a larger facility in the south county area.

In quarter two while we have hired multiple staff this quarter, we have also experienced attrition due to medical and family issues. One of our Admin Assistant positions is currently vacant. We are looking for a candidate that has basic IT/Computer Maint skills. It has been a challenge in the current economic climate to find qualified candidates to fill positions requiring more advanced skills.

In quarter three we have had more turnover of employees than we would like. There have been a variety of unforeseen reasons that have contributed to this. Scheduling conflicts and staffing issues have contributed to not currently being on pace for the year in terms of the number of WRAP courses completed and WRAP graduates. However, we have a plan in place to ensure we reach our objectives in both areas.

In quarter four we faced several challenges this year, including the loss of a trained WRAP facilitator and several individuals who signed up to take WRAP but did not attend. In addition, SJCBHS postponed the previous facilitator and refresher training. Subsequently, we have identified an online refresher available at a reasonable cost and look forward to the fall facilitator training. We hope to have additional trained

WRAP facilitators in the next 6 months. We are confident and project meeting or exceeding the number of classes and certified graduates in the upcoming fiscal year.

CSS Project 17: Project Based Housing

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

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

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

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

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

Project Components

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

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

   This fund shall be an irrevocable transfer of money from San Joaquin County Behavioral Health Services to the Housing Authority of San Joaquin for the purpose of creating current and future Project Based Housing Programs.

   Previous funded housing projects were completed on March 2022 with a total of 37 housing units completed: exceeding the previous Three Year Program and Expenditure Plan goal of developing 34 units of housing for individuals with serious mental illnesses.

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

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

In 2024-25 BHS partnered with the Housing Authority of San Joaquin to construct Satellite II Project Based Housing to increase the permanent supportive housing continuum for clients that are justice-involved.

In 2025-26 BHS will partner once again with the Housing Authority to construct Edison House, a 32-bed permanent supportive housing for adult clients that are justice-involved to increase of the continuum of housing.

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

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

- Hazardous materials requirements

Project-Based Housing purchased, constructed and/or renovated with General System Development funds shall also:

- Have appropriate fire, disaster, and liability insurance
- Apply for rental or other operating subsidies
- Report any violations to DHCS if a violation is discovered
- Maintain tenant payment records, leasing records, and/or financial information

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

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

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

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

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

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

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

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

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

CSS Project 18: Employment Recovery Services

Project Description

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

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

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

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

Target Population

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

Project Components

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

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

- *Vocational Profiles:* Conduct individualized interviews with each consumer to determine their preferences for type of employment, educational and work experiences, aptitudes and

motivation for employment. Vocational profiles will be consumer driven and based on consumers' choices for services. Vocational assessment will be an ongoing process throughout the consumer's participation in the program.

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

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

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

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

Documentation of Achievement in performance outcomes:

Objective 1: Minimum of 50 unduplicated mental health consumers will be served annually. 46 served
Objective 2: 5% of consumers served will obtain competitive employment. 9% did
Objective 3: 5% of consumers served will attend an educational program. 4% did
Objective 4: 50% of consumers served will demonstrate knowledge of self-sufficiency skills. 50% did
Objective 5: 75% of consumers annually will have their employment skills assessed. 76% did
Objective 6: 50% of consumers annually will have an increase in their employment skills assessment score. 67% did
Objective 7: 50% of consumers served annually will demonstrate knowledge of how employment impacts their benefits. 61% did
Objective 8: The job developer was expected to contact 25 discrete community-based employers on a quarterly basis. 25 were contacted each quarter.

Challenges or barriers:

In quarter one due to an unexpected medical leave of the Employment Director, assigning the task of consumer satisfaction surveys and WRAPs were not completed. This oversight has been corrected, and they will be completed in Q2.

In quarter two due to training of the new staff member and several holidays we are slightly below some of our objective goals, but we plan to conduct more post assessments in the 3rd and 4th quarters.

There were no challenges reported in quarter three and four.

CSS Project 19: Community Behavioral Intervention Services

Project Description

The project will provide behavioral intervention work in the community to consumers who are having a hard time managing behaviors and impulses. The services are based on the foundation and principles of Applied Behavior Analysis and intended to address behaviors or symptoms that jeopardize mental health consumers' recovery, wellness, and quality of life. The interventions are not intended as a "stand alone" service. They will supplement other mental health services provided to consumers.

Project Goal: The *goal of the project is to provide behavioral interventions in order to increase mental health consumers' stability, social functioning, and recovery-focused behaviors.*

The project is intended to promote long-lasting functional change among consumers by decreasing the incidence of dysfunctional and maladaptive behaviors and increasing the incidence of functional and adaptive behaviors. Successful change may result in the following outcomes among participating consumers:

- Prevention of or reductions in psychiatric hospitalizations and re-hospitalizations.
- Reduction in incidences of homelessness, disruption in housing and/or out-of-home placements; and
- Reduction of the stigma and distress experienced by many consumers as a result of maladaptive behaviors.

Target Population

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

Project Components

The contractor will use a behavior analysis model in which procedures are systematically applied to improve socially significant behavior to a meaningful degree. Treatment strategies will be flexible and individualized. In general, treatment strategies will include instruction to increase appropriate alternative behaviors. The treatment methodology will include:

- Individualized goals developed to meet the needs of each consumer;
- Teaching skills that are broken down into manageable, easy-to-learn steps;

- Opportunities for consumers to practice each step.
- Acknowledgement of successes using a tangible reward system; and
- Continuous measurement of individual consumer progress so that treatment may be adjusted as needed.

Additional project components include:

- *Behavior Assessment (Functional Analysis):* Comprehensive assessments of each consumer's behavior will be conducted to determine target behaviors that need to be addressed, the antecedents of those behaviors, and the consequences of maintaining them. The contractor staff is expected to include BHS staff, the consumer, family members and other relevant treatment team members in the behavior assessments. Behavior assessments must be completed within 30 days of the service authorization from BHS.

- *Individual Recovery Plans (Behavior Plans):* Specific and measurable Individual Recovery Plans will be completed within 30 days of the service authorization from BHS. All Individual Recovery Plans will include:

    - Definition of the target behavior;
    - Alternative behaviors to be taught;
    - Intervention strategies and methodologies for teaching alternative behaviors;
    - Methods for collecting data on and measuring target behaviors to ensure they are being reduced; and
    - An emergency management section providing detailed instruction for staff and family members on how to address the target behavior when it reoccurs.

  Individual Recovery Plans will be coordinated with and approved by BHS.

- *Individualized Progress Reports*: Progress reports on the accomplishment of goals for each consumer will be provided to BHS on a schedule as determined by BHS, but no less than monthly. Progress reports will be based on systematic data collection and evaluation of data on each consumer's progress towards their goals.

Documentation of Achievement in performance outcomes:

Objective 3: 90% of targeted behaviors served that inhibit medication compliance will be reduced annually. 90% were
Objective 4: 80% of consumers participating in services will have no or reduced psychiatric re-hospitalizations. 98% did
Objective 6: Minimum of 80% of consumers referred for target behavior affecting potential loss of housing will maintain housing for a period of one year upon completing the intervention. 80% did
Objective 8: Minimum of 90% of treatment goals for enrolled consumers will show an improvement as measured by a data collection and analysis system developed by UOP and approved by BHS. 93% did
Objective 9: Minimum of 50% of consumers enrolled in the program will reduce or eliminate behaviors which impede their ability to seek employment. 95% did
Objective 10: Minimum of 50% of consumers requiring assistance with vocational skills will be referred

to BHS vocational services. 100% were
Objective 11: 90% of consumers who are referred and are appropriate for socialization skills training will have an opportunity to practice socialization in a normal community setting. 100% did
Objective 12: Maximum of 10% of consumers referred to CBIS will be re-referred for the same behavior over a two-year period. 0% were

Challenges or barriers:

Objective 1: Minimum of 200 consumer behaviors will begin the assessment process during the fiscal year. 157 did
Objective 2: Minimum of 180 consumer behaviors will be complete a behavioral assessment (functional analysis) annually. 87 did
Objective 5: 90% of all successfully closed cases will have an individualized Wellness Recovery Action Plan (WRAP). 53% did
Objective 7: Minimum of 80% of consumers served will receive two clinical intensive behavioral intervention service contacts per week, one of which must be face to face. 68% did

CSS Project 20: Housing Coordination Services

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

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

Project Components

Project 1: Housing Referral and Linkage

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

Project 2: Housing-based Case Management

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

Project 3: Housing Stabilization Resources

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

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

Project 4: Homelessness and Transitional Housing Project (formally known as INN Progressive Housing)

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

The Homelessness and Transitional Housing Project is an adaptation of the housing first model, integrating the stages of recovery to create a rehabilitative housing environment. The program uses scattered sites, single family homes, staffed to assist clients with recovery. Each house is designated a level (1-3) that coincides with the level of care provided in that specific home. The levels of care are as follows:

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

The ultimate goal of the program is to stabilize a person's living situation, while simultaneously introducing and providing supportive services (provided by CSS Project #12 - Housing Stabilization FSP Services) to aid the client's eventual transition to independent - permanent housing.

Documentation of Achievement and performance outcomes

The Housing Coordination Program in the Adult System of Care currently serves 111 members in our Homelessness and Transitional housing program (HAT). This program consists of Level 1 and Level 2 which is a shelter and Level 3 which is transitional housing. We currently have 15 homes that are in Level 1 and Level 2, and 5 homes that are in Level 3. We have been able to maintain the low barrier and harm reduction model to help individuals access housing while they receive wrap around services through case management to help them achieve their recovery goals. We currently have four project-based housing in which are partnered with the housing authority, and 3 supportive housing-based models within the community. We have been able to provide a total of 113

permanent housing units for members with these combined models. Park Center is scheduled to be available Fall 2025 and will have an additional 50 units.

Challenges or barriers

Many members who are accepted into BHS HAT program have no income and are in need of gaining independent living skills. We have found that providing intense case management support, linkage to resources, and rehabilitation skills to decrease impairment in residential functioning has helped members acquire the skills needed to transition to independent placements. Many members who are accepted into BHS supportive housing are living independently for the first time. We have found out that providing intense case management services that include daily to weekly contact is imperative to prevent decompensation and maintain a level of functioning for successful transition into independent living. However, case management services are optional for members who are enrolled in BHS services. This creates challenges with treatment compliance and the maintaining of residence.

Strategies

Continue to collaborate with community-based organizations, and community partners to address the need for housing solutions for specialty mental health members. Continuous weekly to bi-weekly meetings to address concerns and mitigate continued risks. Continue to train and educate BHS staff on how to provide clinical case management and rehabilitation interventions to increase member's self-sufficiency.

CSS Project 21: Crisis Services Expansion

Project Description

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

Project Components

Project 1: Capacity Expansion

Prior to the passage of the Mental Health Services Act in November 2004, the BHS Crisis Unit operated M-F from 7am – 11pm. Staffing was limited and waiting times were very long. MHSA funding created a full-service Mental Health Crisis Unit for San Joaquin County that is open 24/7, 365 days a year.

The expanded crisis unit boasts more robust staffing, reducing waiting times. It has a new medication room, eliminating the need to wait for the pharmacy to open for the team to dispense medications. Services are expanded with a new triage unit, ensuring all clients receive a warm welcome and a brief screening within a timely fashion. Enhanced discharge services make it possible for clients to receive aftercare support and a warm connection to continuing services through the Outpatient Clinics. New discharge services include post-crisis or -hospitalization transportation home, and transport to initial outpatient appointments, if necessary.

Project 2: Warm Line

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

Project 3: Crisis Community Response Teams (CCRT)

CCRT clinicians respond to emergency requests from law enforcement for immediate, on-site mental health crisis services, including mental health evaluations for temporary, involuntary psychiatric inpatient care in situations where the mental health consumer is a danger to self, danger to others or gravely disabled.

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

psychiatric health facility. BHS operates two Crisis Community Response Teams. Services are available 24/7.

Documentation of Achievement in performance outcomes:

The Crisis med room continues to be an integral part of the Crisis Services allowing us to provide emergency medication services to those members in a mental health crisis as well as medication services to those members who are placed at the Crisis Residential Facilities. In addition, the med room provides services which include but is not limited to providing a majority of the basic medical and psychiatric needs of those members placed at the crisis residential facilities and those that are recent discharges from outside psychiatric hospitals serving as a link to the post psychiatric hospitalization clinic and other BHS treatment teams to help improve continuity of care post psychiatric hospitalization. For FY 23/24 response times for urgent conditions continue to remain around 98% thus ensuring continued meeting of the set goals. In FY 23/24 the Crisis Community Response Team received around 15,792 crisis visits, requests for evaluation from San Joquin County Hospitals, family and support persons, community members, law enforcement, law enforcement immediate support requests, and other providers within San Joaquin County with an average of 1,316 a month. Crisis Community Response Team for FY 23/24 handled approximately 12,120 crisis clinic contacts/ referrals with an average of 1,010 a month. These calls are added to the total number of calls as previously mentioned statistics for all referrals. About 23% of all calls/referrals to the Crisis Community Response team resulted in legal detainments/ holds which subsequently led to hospitalization/treatment at psychiatric health facilities. The Crisis program continues to update our technological programs to obtain and report valuable statistics with the intent to improve member care as well as provide accurate reporting and data collection as expected by the state of California. Crisis continues to be innovative in its e-faxing and electronic member tracking systems thus streamlining service delivery and improving program performance. Crisis continues to add tracking features into the Crisis registration log which includes detainment date and time, placement status, LPS status, and many other categories to ensure data collection and continuity of care for members being referred to Crisis services. The CRF (crisis residential facility) tracker is like the CIS tracker in that it provides real time electronic Display Board that enables staff to easily track members placed in CRFs making it easily visible the house the member is in, how many days they have been admitted to the facility, and the crisis clinician assigned to the member ensuring that ongoing treatment and care is streamlined accurate, and readily available. Like e-faxing, the CIS display board and the CRF display board has simplified many internal processes allowing for more focus to be shifted back to member care and ongoing service linkage. Since its beginning in 2009, the Warmline/ Consumer support program, which remains a phone-based support service, continues to be available to members 24/7 and 365 days a year. It continues to be staffed by both full-time and part- time BHOWs of whom some are PSSC trained/ qualified. The BHOWs are composed of staff with diverse backgrounds and lived experiences and take calls from any member or consumer who calls including those within San Joaquin County, outside San Joquin County, out of state etc. The team continues to grow in staffing levels which range from 2-5 each shift to support the growing roles of the Warmline team. Warmline staff BHOWs are trained in Medi-Cal signups to help support members in securing Medi-Cal insurance in the Crisis clinic as well as in CSU, PHF, and CRFs. The BHOWs of the Warmline have also begun pursuing the PSSC certification and supporting members (both adolescents in adults) both pre and post hospitalization care.

Challenges or barriers:

The program continues to struggle with covering shifts and the various unit staff have been subjected to an increased need for overtime work thus leading to increased employee burnout to meet the growing demands of the programs to service the needs of the members or San Joaquin County. Recruitment to fill positions within the 24-hour services continues to be a barrier in achieving program outcomes. Crisis lost all part-time and after-hours Mental Health Clinicians in FY 22/23 and has only been able to hire one in FY 23/24. Crisis has also lost several part-time mental health specialists, BHOWs, and psychiatric technicians for weekends and after hours only being able to hire a few thus continuing to put strain on the full-time and existing part-time staff to maintain staffing. With the implementation of the 24-hour MCRT team, the Crisis team lost several outpatient staff that helped cover weekends/ after-hour shifts thus resulting in the coverage of those shifts being done by existing Crisis staff leading to signs of burnout. Crisis continues to recruit part time staff and utilizes the incentives provided but San Joaquin County to attract appropriate candidates and improve staff retention. Crisis continues to struggle with obtaining accurate data collection and achieve billing after the switch to CalMHSA SmartCare EHR due to the struggles of appropriate coding and documentation of services while receiving services from Crisis. Despite ongoing work with CalMHSA many errors still occur with billing regarding the templates and documentation of appropriate services. In addition, due to the tedious nature of documenting various services, particularly Warmline calls, many calls are not able to be accurately recorded in a timely manner or get missed all together thus resulting in a lack of accurate data. In addition, with the expansion of the BHOWs duties on the Warmline, calls are not being recorded while the staff are performing transport for the SALT/Crisis team and with limited staffing we are unable to keep the Warmline staffed fully. There is also a need for more focused training for our Warmline Staff to better serve the members by calling the line. As a 24- hour service program, Crisis continues to experience computer issues that range from connectivity and server issues, program malfunctions that highly interrupt, delay, and at times totally prevent the program from providing services and responding to immediate calls. The Crisis team can use additional IT support after hours and weekends to reduce the impact of program and computer issues that impair direct member care. Power outages without the support of the backup generator being operational severely impair the ability for the team to ensure timely services and accurate reporting of provided services due to systems, computers, and the EHR being down. Finally, Crisis staff, particularly the mental health clinicians, need ongoing training specifically focused on SB43 and the added detainment criteria for WI5150/WI5585 to ensure accuracy and safety of the member and Crisis staff.

CSS Project 22 – Co-Occuring Disorders Program

Mental health treatment providers in San Joaquin County Behavioral Health Services have seen a great proportion of people with severe mental illness and co-occurring substance use disorders (SUDs) in recent years. These co-occurring SUDs were and are substantially interfering with the effectiveness of their clients' mental health treatment. There are some individuals for whom the extreme extent of their SUD behavior created challenges and reduced the effectiveness of treatment as usual. This persistent behavioral health challenge has rarely been successfully addressed by traditional methods/interventions.

A central aspect of the issues lies in the fact that mental health treatment and SUD treatment are similar and overlap each other, but there are some areas that are significantly different in approach, training, and philosophy. These areas include, but are not limited to, engagement versus enabling, abstinence versus meeting the client where they are at in their life, hopefulness for recovery versus the desire to drink or use drugs without consequence, empowerment of the individual versus acceptance of the individual's powerlessness over drugs and alcohol use.

PROGRAM DESCRIPTION

The proposed Co-Occurring Disorders (COD) Program would be an outpatient program in San Joaquin County Behavioral Health Services, Substance Use Disorder System of Care. COD will utilize the Assertive Community Treatment model, an evidenced-based model which aims to reduce homelessness, psychiatric hospitalizations, emergency and law enforcement contacts for individuals who have been diagnosed with both a severe mental illness and a substance use disorder as the program's framework.

The goals of this program will focus of increasing the quality of services, including better outcomes by creating a shared understanding and vision amongst staff and with clients through a client-centered, stage-based approach, housing services, and through developing the "co-occurring Lens." To successfully engage and treat individuals with co-occurring severe mental illness and substance use disorders, the emphasis is to develop Stage-Based Treatment framework for both mental health and SUD concurrently and deliberately, addressing the sometimes-contradictory strategies indicated for each behavioral health challenge separately. While all behavioral health programs serving adults work with this issue and should have the capability to diagnose and treat SUDs, there are many individuals for whom the extreme extent of their SUD behavior creates challenges and reduces the effectiveness of treatment as usual. As a result, this population is significantly un/underserved and in need of a non-traditional approach, thus creating the need for treatment through a "co-occurring lens."

To support individuals, COD will provide mental health therapy, substance use disorder counseling, psychoeducation and support, and case management & peer support services to link and increase

access to community services such as substance use treatment, social security, housing, natural resources, community supports, and medication services.

TARGET POPULATION

Transitional Age Young Adults –18-25.
Adults – age range 26-59
Older Adults – age 60+

SERVICES AND ACTIVITIES

Initially, COD will provide outreach and engagement services to build relationships with this "hard to reach" population who may have refused services in the past and have been found difficult to engage and/or are transitioning out of higher levels of care (PHF, Residential SUD Treatment, etc). The program will utilize a "whatever it takes" approach with individuals and "think outside of the box" of traditional mental health and SUD treatment. The program will strive to utilize a "Housing First" model that incorporates the philosophy that clients can feel safe to address mental health and substance use concerns, once their primary needs are addressed. Once engaged, COD provides mental health, psychiatric, SUD, peer support, and case management services.

Documentation of Achievements in performance outcomes:

In FY23-24 there were a total of 115 mental health screenings. This number likely would have been much higher, however due to the clinician vacancy rate in substance use services, there was one of three full time clinicians completing screenings for the substance use population receiving services in residential. Of the 115 screened for mental health, 44 members were referred to the managed care plans for mild to moderate mental health concerns, 71 members met eligibility and were referred to the county ran co-occurring program. The majority of the year the program has operated with three staff serving the COD caseload with one full time Substance Use Counselor and Mental Health Specialist, whom recently promoted to the clinician position and a part time Mental Health Specialist and four vacancies. Although this program was established and services were being provided, the staff were fulfilling internship hours in other programs while their office space was under renovation, yet the team had designated days they would come together for case consultation and care coordination of members. The full time Mental Health Specialist took the lead on the majority of cases due to the experience of working with the co-occurring population. All staff worked directly with the substance use residential programs, attended case conferences, provided services at the facility, linked and coordinated care to mental health. The co-occurring team was able to successfully link their members to medications services with a psychiatrist specializing in addiction treatment, which ultimately assisted in the seamless transition to outpatient mental health and substance use treatment. Due to available housing funds for this population the continuum of care expanded enabling members to be placed in environments free of substances while continuing treatment and learning to manage everyday life while

building their life skills. Individuals suffering from addiction and other mental health issues often need help with life skills and a component of the program is to provide comprehensive services to achieve varying levels of independence and self-sufficiency by teaching the necessary skills for everyday healthy living. Success is different for all members and the team acknowledges them along their recovery path.

The later part of the year, the office space for the co-occurring program was completed. The staff now have a location to call their own with work stations to hold team meetings, and expand on the dynamics of the existing team.

Outcomes:

115 Mental Health Screenings

44 referred to Managed Care Plans

71 members referred to COD

37 Female

34 Male

Highlights:

1 Member started a CNA Program

2 Members have been med compliant for over a year and living a life free from substances

1 Members started school Substance Use Certification

2 Members secured Housing Vouchers

1 Member completed 30 days at Family Ties and transitioned to New Directions and completed 90 days, she successfully obtained custody of her children was able to move into her own apartment.

Challenges or barriers:

Renovating the office space delayed the certification for medi-cal and bringing the team together and hiring for the vacancies

Educating other systems of care about co-occurring disorders and the complexities

Hiring for the vacant positions has been a challenge

Having one clinician in substance use to complete the MH screenings likely added to the lower numbers being served

CSS Project 23 – Transitional Age Youth (TAY) Outpatient Care

Project Description

Seamless transitions between different levels of care are imperative to ensuring youth do not drop out of services. As a youth progresses in treatment, they may no longer need the intensity of services provided in a Full Service Partnership (FSP). This transition of care often results in a new agency and new providers treating the youth. During this transition, many youths opt out of treatment and only return when crisis services are needed. The intent of this program is to encourage continuity of care as youth move go through their process of recovery. This program will be linked to an FSP that will transition youth to their outpatient program as they meet their treatment goals.

Target Population

This program will serve youth ages 16 through 20 who are stepping down from Full Service Partnership Programs (FSP) but still need Specialty Mental Health Services (SMHS) as well as individuals aged 18 and over that would be more appropriate for a TAY-focused program to support them in meeting their goals

Project Components

1. Specialty Mental Health Services
2. Medication management and monitoring services
3. Case Management
4. Assessments
5. Referrals to Vocational and Employment resources

Documentation of Achievements in performance outcomes:

This program began on the Fiscal Year 24/25 (no data to report for 2023-24)

Challenges or barriers:

This program began on the Fiscal Year 24/25 (no data to report for 2023-24)

CSS Project 24 – JCID Restart Program (Formally known as the Justice Decriminalization Forensics Restart Program)

The Restart program provides a variety of extensive outpatient services and care coordination to help reduce jail and hospital recidivism, reduce time in custody, and reduce overall justice involvement by providing culturally responsive treatment to individuals with behavioral health challenges who are justice involved or at risk of future justice involvement. Through a trauma focused and peer driven lens, participants should reduce criminal activity and improve their quality of life.

The Restart Program is an innovative approach to building a community program to improve care coordination and integration across multiple systems (BHS, Correctional Health, Probation, Courts, etc.). The Program consists of two Mental Health Clinicians, two Mental Health Specialists, and two Mental Health Outreach Workers to serve the justice involved or at risk of justice involved population who are struggling with mental health issues and are 18 years and older, with a focus on supporting people of color, refuges, and those who identify as LGBTQ+ from unserved or underserved communities. The Restart Program provides intensive outpatient services and care coordination in hopes of reducing the following: Jail and hospital recidivism, time in custody, overall justice involvement, and mental health and substance abuse related symptoms; and hopes to improve the client and family experience in achieving and maintaining wellness and recovery. The Restart Program also provides linkages to housing and employment resources, culturally appropriate treatment, and peer-support services; with an overall goal towards assisting justice involved or at risk of justice involved clients to achieve and maintain wellness.

Target Population

Adults (18-59) and Older Adults (60+) with SMI or Co-Occurring Disorder, justice involved or at risk of justice involvement.

Project Objectives

- Improve the client and family experience in achieving and maintaining wellness and recovery
- Improve care coordination and integration across multiple systems.
- Increase client's ability for self-advocacy.
- Decrease barriers to accessing and receiving services.
- Decrease risk of justice involvement
- Decrease recidivism rates.

Project Goals

1. Increase mental health stabilization as evidenced by a decrease in overall justice involvement, with a goal of 60% or more of active clients not picking up new charges while receiving Restart services.
2. At least 50% of active clients will improve their knowledge and ability on accessing community services.

3. Less than 20% of active clients will access crisis services.
4. At least 50% of active clients who identify housing as a need will obtain or retain shelter (permanent or temporary).
5. The Restart Program will maintain an annual consumer satisfaction level of 75% of those completing the survey.

Documentation of Achievement in performance outcomes:

During FY 2023/2024, Restart was developed as a new program for the Justice and Community Integration Division and began providing services to members on October 27, 2023. During the 8 months between commencement and the end of the fiscal year, Restart served 119 members.

In February 2024, the Restart staff were also tasked with co-case managing members who were enrolled in the Felony Diversion program at Everwell. Their goal was to assist in transitioning members from Everwell to Restart at the conclusion of their obligation to the program and providing an ongoing continuum of care and case management. Restart staff co-case managed 20 Everwell clients between February-June 2024.

Challenges or barriers and Strategies:

Staff turnover and continued staff vacancies have been a challenge in this FY. Staff vacancies have included Case Managers and Peer Support staff. Currently, Restart is down two Behavioral Health Outreach Workers. The Clinician and Case Manager positions are now fully staffed.

CSS Project 25: System Development Expansion

Project Description

System Development Expansion Services include the outpatient clinic system that provides planned mental health treatment services (scheduled appointments). Prior to the provision of the MHSA, specialty mental health services served a smaller population of consumers. During the original CSS planning process in FY 2005/06, BHS estimated that 11,000 consumers received mental health services. Since 2004, and in accordance with MHSA, BHS has conducted assertive community outreach and engagement to increase access to mental health services amongst unserved and underserved individuals. Over the past ten years, the number of consumers served annually has increased 25%, to over 16,000.

MHSA funding is used to expand mental health services and/or program capacity beyond what was previously provided (*CA Code of Regulations:* § 3410 (a)(1)).

Areas of expansion include:

- Expanded range of outpatient specialty mental health services available.
- Increased program capacity to serve an estimated 5,000 additional clients.
- Enhanced consumer-friendly and culturally competent screening, assessment, and linkage to services
- Development of consumer and family driven services, including the use of peer partners, recovery coaches, and consumer or family member outreach workers throughout the mental health system of care.
- Expanded use of nurses and psychiatric nurse practitioners to strengthen linkages between specialty mental health and primary care providers.
- Expanded use of supportive services for Independent Living and Interpersonal Skills programming.
- In 2023-24 and 2024-25 - La Familia and Black Awareness Community Outreach Program's with outpatient (system development) clients will be transitioned to contracted Culturally Based Community Providers to provide enhanced culturally congruent and linguistically appropriate mental health services and culturally based case management services.

VI. Prevention and Early Intervention

Overview

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

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

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

Finally, all PEI programs shall apply effective methods likely to bring about intended outcomes, such as the use of evidence based or promising practices. (California Code of Regulations §3740) Desired outcomes include a reduction of negative outcomes and an increase in correlated positive outcomes associated with housing, education, employment, stability, and wellness.

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

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

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

San Joaquin PEI Prevention Programs – Children, Youth, and their Families

- Skill Building for Parents and Guardians
- Prevention for Children 0-5
- Mentoring for Transitional Age youth
- CARES and CARES Plus Project

San Joaquin County PEI Prevention Program – Adults and Older Adults

- Whole Person Care Project

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

San Joaquin PEI Early Intervention Programs – Children and Youth

- Early Interventions to Treat Psychosis
- Community Trauma Services for TAY

San Joaquin PEI Early Intervention Programs – Adults and Older Adults

- Community Trauma Services for Adults
- Prevention and Early Intervention for Older Adults
- Misdemeanor IST Diversion Early Intervention

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

- Whole Person Care Project

Outreach for Increasing Recognition of Early Signs of a Mental Illness: Outreach is the process of engaging, encouraging, educating, training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

"Potential Responders" includes families, primary care providers, school personnel, community service providers, peer providers, law enforcement personnel, etc. (California Code of Regulations § 3715)

- Increasing Recognition of Mental Illnesses
- Cultural Brokers Program

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

- Information and Education Campaign

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

- Suicide Prevention with Schools
- Suicide Prevention for the Community

Prevention and Early Intervention Priority Areas Fiscal Year 2024-25							
PEI Project #	**Name of Program**	**1-Child Trauma PEI**	**2-Early Psychosis**	**3-Youth Outreach**	**4-Culturally Comp**	**5-Older Adults**	**6- Justice and/or Homeless PEI Programming**
1	Skill Building for Parents and Guardians	X					
2	Prevention for Children 0-5	X					
3	Mentoring for Transitional Aged Youth	X		X			
4	CARES Project	X		X			
5	Early Interventions to Treat Psychosis		X				
6	Community Trauma Services for Adults &TAY			X	X		

7	Prevention & Early Intervention for Older Adults					X	
8	Misdemeanor IST Diversion – Early Intervention						X
9	Whole Person Care						X
10	Increasing Recognition of Mental Illness			X			
11	Information and Education Campaign			X	X	X	
12	Suicide Prevention with Schools			X			
13	Suicide Prevention in the Community					X	
PRIORITY AREAS							
1 - Childhood Trauma							
2 - Early Psychosis and Mood Disorder Detection and Intervention							
3 - Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program							
4 - Culturally Competent and Linguistically Appropriate Prevention and Intervention							
5 - Strategies Targeting the Mental Health Needs of Older Adults							
6 - Homeless and Justice Involved PEI Programming							

** All MHSA funded prevention programs utilize evidence based and/or promising practices. San Joaquin County includes documentation of achievement in performance outcomes Prevention and Early Intervention (PEI), under each program and in the appendix of this document entitled MHSA Three Year Prevention and Early Intervention Evaluation Report encompassing data that identifies children, transitional aged youth (TAY), adults, and older adults to be served and the cost per person for Prevention and Early Intervention (PEI)

Significant Changes for the 2025-26 Update on PEI Projects approved in the 2023-2026 MHSA Three Year Plan –

PEI Project #10 (In the 2024-25 Annual Update) – Cultural Brokers Program

With the transition of Prevention programs away from upcoming BHSA transition in July 2026, the MHSA/BHSA team has begun to expand outreach and engagement efforts to accommodate the transition of MHSA to BHSA. With the expansion of the BHSA team, a Behavioral Health Outreach Coordinator and two Behavioral Health Outreach workers have taken on the task to provide stigma reduction education and community engagement throughout the community. This team will take on the task of providing further outreach and engagement activities in collaboration with community leaders to promote, destigmatize, and educate the community on all related Behavioral Health needs. Beginning in FY 2025-26 – portions of the Cultural Programs Program will now be embedded with the BHSA Outreach Team.

PEI Project 1: Skill-Building for Parents and Guardians

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

Project Description
Community-based organizations will facilitate evidence based and/or community defined promising practice parenting classes or groups in communities throughout San Joaquin County. Parenting classes or groups will target underserved populations, including classes for older generation guardians, and be conducted in multiple languages.

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

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

Potential evidence-based parenting classes include:

> *Nurturing Parenting Program* is a series of 10-12 independent 60–90-minute lessons designed to teach parents alternatives to physical punishment and improve parenting skills, including: 1) understanding feelings; 2) alternatives to spanking; 3) communicating with respect; 4) building self-worth in children; 5) praising children and their behavior; 6) ages and stages of growth for infants and toddlers; 7) the philosophy and practices of Nurturing Parenting; 8) learning positive ways to deal with stress and anger; 9) understanding and developing family morals, values and rules; and 10) ways to enhance positive brain development in children and teens. For more details about the evidence-based Nurturing Parenting Program see: http://www.nurturingparenting.com
>
> *Strengthening Families* is a 20-session program designed to engage parents in meaningful conversations about research based protective factors that mitigate the negative impacts of trauma. Protective factors include: 1) parental resilience; 2) social connection; 3) knowledge of parenting and of child and youth development; 4) concrete support in times of need; 5) children's social and emotional development; and 6) parent-child relationships. For more details about the evidence-based Strengthening Families program see: http://www.strengtheningfamiliesprogram.org
>
> *Parent Cafes* is a model derived from the Strengthening Families Initiative and is a distinct process that engages parents in meaningful conversations about what matters most – their

family and how to strengthen that family by building protective factors. Parent Cafés are focused on building the 5 research based protective factors that mitigate the negative impacts of trauma. See: http://www.bestrongfamilies.net/build-protective-factors/parent-cafes/

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

Documentation of Achievement in performance outcomes:

Catholic Charities

*Came up 1 short of meeting the goal of providing 21 (10-12) session courses.
*Exceeded goal of providing 9 courses in Spanish.
*Met providing a minimum of 9 courses throughout San Joaquin County. Met providing at least 1 course in Stockton, Lodi, Tracy and Manteca. Also met providing 1 course in Lockeford, Linden or Thornton.
*Exceeded goal of serving 300 parents.
*Exceeded goal of 63-76% of participants graduating.
*Met goal of 80% of graduates demonstrating improvements in at least one of the following risk factors: Inappropriate expectations, Low levels of empathy, Strong value of corporal punishment, Reversed family roles and Restricted power and independence.

Child Abuse Prevention Council

*Exceeded goal of providing 35 groups.
*Met goal of providing groups in NE Stockton, South Stockton, SE Stockton. Lodi, Tracy & Manteca
*Met goal of providing at least 3 groups in the following locations: Linden, French Camp, Ripon, Thorton, Escalon, Victor, Acampo, Lockeford, Woodbridge and Lathrop
* Met goal of 80% of graduates demonstrating improvements in at least one of the following risk factors: Inappropriate expectations, Low levels of empathy, Strong value of corporal punishment, Reversed family roles and Restricted power and independence.
*Exceed goal of providing 525 group sessions.

Parents By Choice

*Exceeded goal of providing 40 parent groups.
*Exceeded goals of providing groups in the following locations: North Stockton, South Stockton and Manteca/Lathrop/Tracy. Each location had a goal of 8.
*Exceeded goal of 4 groups that included parents raising teenagers.
*Exceeded goal of providing 6 groups in Spanish
*Exceeded goal of having 240 parents graduating for the year.

*Exceeded the minimum of 60% of graduates showing improvement as measured by Parent Tasks Checklist and Parenting Scale tools.

Challenges or barriers and Strategies:

Catholic Charities

*Participant attendance was challenged due to mothers needing to go to work to support their families. Attendance was also affected by children's class or school breaks. 4th Quarter is typically low due to summer breaks. Most families travel to Mexico and stay for several weeks or months. These families may also be working and are working long hours.
*At some of the sites, there was not a room available to provide childcare services.
*Catholic Charities applauded their Child Care Provider for her services, but there were times her services were challenged due to the weather. Not sure if the challenges were transportation issues or illness related.

Child Abuse Prevention Council

*Quarter 1: Tracy Unified School District needed School Board approval before groups can start. Groups started late in Sept and Oct. CAPC had planned to make up for lost sessions in Quarters 3 & 4.
*Quarter 3: Joseph Widmer Elementary groups were delayed to mid-Feb due to new administrative staffing and contracts with the school needed to be re-approved. With the delay, CAPC was still able to meet goals.
*Quarter 4: Given the challenges in previous quarters, Program Manager and Program Coordinator learned to navigate and prepare for potential hiccups.

PEI Project 2: Prevention Services for Children 0-5 and Caregivers

Community Need

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

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

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

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

Project Description

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

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

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

Project Components

Dedicated clinical staff will work directly with children 0-5 and their caregivers through weekly community-based individual and group interventions. Services may be provided in children's homes, day cares, schools, or in the community. Services would focus on both the child and the caregiver.

Interventions and support could include but are not limited to:

- Individual screenings
- Group Services: Facilitate age-appropriate social or other educational rehabilitative groups to help children and their caregivers practice emotional regulation, positive and affirming relationships, and encourage and support bonding. Group rehabilitation services will consist of the use of a short-term evidence based or promising practice curriculum
- One on one relationship-focused services with children and their caregivers that encourages responsiveness, attunement, and attachment.
- Education, information, and support about developmentally appropriate expectations, activities, and strategies for caregivers to feel successful with their child.
- Case Management: Targeted case management services to help children and their caregivers reach their social and emotional goals, by providing education and linking children and/or their caregivers to additional services to support their progress including other Prevention and Early Intervention programs, community resources, or linkage to Behavioral Health Services or another behavioral health provider as appropriate
- Community Outreach, Presentations and Trainings: educate and inform caregivers and other interested community members on relevant issues or topics including but not limited to: signs and symptoms of mental health issues, the effects of trauma, secure attachment, responsive caregiving, the meaning of behavior, developmental ages and stages.
- Collaboration with other providers in a child's life including relatives, care providers, etc.
- Development of interventions for aggressive or other maladaptive behavior
- Supporting parents in coping with/understanding their feelings in order to consistently address and reduce any parenting/attachment issues related to the parent's anger, depression, or other mental health struggles.

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

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

Referrals sources may include but are not limited to:

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

Documentation of Performance Outcomes

•95% (19/20) of referrals had first contract within 48 hours or referral (excluding weekends and holidays)
•100% (1/1) of individuals showed an improvement in Post PSI scores.

Challenges or barriers and Strategies:

In the beginning there was a challenge to inform our community of our services. Towards the end of the year, there was a challenge completing assessments on time due to families canceling and making it difficult to contact them.

PEI Project 3: Mentoring for Transitional Age Youth

Community Need

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

Project Description

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

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

Project Components

Program Referrals: Individuals needing additional mentoring and support to prevent the onset of serious mental illness may be referred to the program. Referral sources may include but are not limited to: Mobile Crisis Support Team, the Juvenile Justice Center clinical team, other BHS programs, local police departments, the County Probation Department, schools, hospitals, community based organizations, or self-referral.

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

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

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

TIP mentoring:

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

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

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

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

Documentation of Performance Outcomes

Child Abuse Prevention Council and PREVAIL

*Exceeded goal of providing 40 parent groups.
*Exceeded goals of providing groups in the following locations: North Stockton, South Stockton and Manteca/Lathrop/Tracy. Each location had a goal of 8.
*Exceeded goal of 4 groups that included parents raising teenagers.
*Exceeded goal of providing 6 groups in Spanish
*Exceeded goal of having 240 parents graduating for the year.
*Exceeded the minimum of 60% of graduates showing improvement as measured by Parent Tasks Checklist and Parenting Scale tools.

Challenges or barriers and Strategies:

Child Abuse Prevention Council and PREVAIL

*Quarter 1: Scheduled a Spanish Teen Class but had a low turnout. The class was changed to ages 0-12.
*Quarter 2: George Kumore Elementary had a low turnout of participants. This school was not counted in the Quarterly Report.
*Quarter 4: Great Valley Elementary had a low turnout of participants. This school was not counted in the Quarterly Report

PEI Project 4: Coping and Resiliency Education Services

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

Project Description
This project serves children and youth who are engaged by or at risk of engagement by the Child Welfare system. Projects operate in partnership with San Joaquin Child Welfare Services and other child-serving systems. Services are designed to align with statewide mandates to provide early mental health support services to high-risk youth.

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

Program Components

Safe, stable, nurturing relationships for children and their caregivers can provide a buffer against the effects of potential stressors, including exposure to trauma, and are fundamental to developing healthy brain architecture. They also shape the development of children's physical, emotional, social, behavioral, and intellectual capacities. As a result, promoting safe, stable, nurturing relationships and environments can have a positive impact on the development of skills that help children reach their full potential.

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

This project provides screening, individual and group rehabilitative interventions, and referrals to higher levels of care for children who have experienced or are at risk of trauma.

- ***Project Activities:*** San Joaquin County Behavioral Health Services will:
  - Screen children and youth for trauma and trauma-related symptoms.
  - Refer children and youth to appropriate levels of care, including comprehensive behavioral health assessment, as appropriate.
  - Provide short-term problem solving, safety planning, coping and resiliency skill-building to children who do not meet medical necessity for Specialty Mental Health Services.
  - Provide early intervention services for children/youth that may benefit from short duration therapeutic services.

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

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

- *Child Intensive Model —12 session program for children ages 5-11. This curriculum mirrors the PRAXES components but is interactive and configured for younger children.*

- *Youth Intensive Model—12 session program for youth ages 12-18. This curriculum mirrors the PRAXES components but is interactive and configured for adolescents.*

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

Early Intervention Services

CARES Plus: The CARES Plus Program provides timely, coordinated, comprehensive, and community-based specialty mental health services, linkage, advocacy, and support to Medi-Cal beneficiaries ages 6 to 21. The goal of the program is to reduce the effects of any traumatic experiences or toxic stress through early intervention provided by clinicians and mental health specialists. A diverse array of mental health and rehabilitation services will be offered including Individual Therapy, Family Therapy, Group Therapy, Skill building, and Case Management. For young people who demonstrate a need to be linked to a higher level of care (i.e. medication/psychiatric evaluation) staff will assist and support with linkage, as needed.

Trauma Informed Training: BHS will offer training on the causes and effects of adverse childhood experiences such as child abuse and neglect, strategies for dealing with trauma reactions; and strategies for self-care. BHS will use an evidence-based curriculum such as:

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

Collaborative Meetings: San Joaquin County BHS participates in ongoing meetings with other child serving systems and committees. Meeting objectives will include the ongoing development of seamless referral processes to support timely trauma screenings and interventions. The collaborative will explore community needs, service gaps, and effective strategies for addressing childhood and adolescent trauma within the County.

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

Documentation of Achievement in performance outcomes:

The CARES Prevention Early Intervention Program saw above average attendance community outreach events. The program was able to outreach to over 3,000 members in the community. Youth referrals from schools and other community organizations more than doubled. The program was able to relaunch group services at local schools which had been on hiatus since Covid.

Challenges & Barriers:

The program was moved to an external site, which required a lot of pivoting and flexibility for staff. There was a higher than average number of rollover cases from the previous fiscal year. Conversations with caregivers revealed that many had taken on additional shifts or employment to assist with increasing bills and expenses, and this impacted ability to participate consistently. The plan is to closely monitor cases for level of engagement and work closely with caregivers to provide flexibility in service delivery.

PEI Project 5: Early Interventions to Treat Psychosis

Community Need

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

Project Description

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

Promising models include, but are not limited to:

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

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

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

Project Components

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

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

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

Documentation of Performance Outcomes

Telecare

75% of consumers who had a decrease of 1 full scale level on the positive symptoms scale of the Scale of Prodromal Symptoms (SOPS) from baseline to 12 months or discharge

63 consumers served during the quarter which is 13 over contract min

Challenges or barriers and Strategies:

Telecare

Members have been more engaged this quarter and attending more groups and appointments. 6 graduates are going off to a 4-year college. Those who graduated have support systems in place for sustainability in their recovery.
MFG groups continue to be a challenge due to families not having enough time to participate. Staff still provide family with one on one support.

PEI Project 6: Community Trauma Services for Adults and Transitional Age Youth

Community Need

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

Project Description

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

The target populations for this program are adults (26-59) and transitional age youth (16-25) who are especially vulnerable to the adverse consequences of mental health challenges. Vulnerable populations include, but are not limited to communities of color, immigrants, refugees, uninsured adults, Veterans, LGBTQ individuals, those with Limited English Proficient (LEP), and adults & TAY with disabilities.

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

Additional priority populations are:

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

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

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

Project Components

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

1. **Screening and Assessment:** Use of a validated screening or assessment tool to screen for trauma, anxiety, depression, or other behavioral health concerns. Examples of validated tools

include, but are not limited to, the PHQ-9, PTSD Checklist, Life Event Checklist, Abbreviated PCL-L, Trauma Symptom Checklist -40, Los Angeles Symptom Checklist (Adult Version), etc. Screening and assessment tools must be approved by BHS prior to beginning services.

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

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

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

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

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

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

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

7. **Referrals:** All participants screened will be assessed to determine if they are appropriate for the short-term intervention or whether they should be immediately referred to more specialized services. BHS may refer clients to this program.

8. **Staffing: At** least one of the staff dedicated to each project will be a licensed mental health clinician, with two years post licensure, to supervise the work of other clinical staff.

PEI Project 7: Prevention and Early Intervention for Older Adults

Community Need:

Community stakeholders and older adults have expressed the need for prevention services for older adults in San Joaquin County. Older adults, those aged 60 or above, may suffer from undiagnosed developing mental health disorders. As a growing age group in San Joaquin County, it is imperative to provide prevention services to those individuals in need of additional prevention and early intervention supports by skill building and early intervention supports.

Target Population:

Older Adults (60+ years old), including individuals from underserved populations such as Latino, Asian, African American, LGBTQ, low income, and geographically isolated.

Project Description

BHS will implement the Program to Encourage Active, Rewarding Lives (PEARLS), evidence-based program, to educate older adults about depression (and is not) and helps them develop skills they need for self-sufficiency and more active lives. This program takes place in six to eight sessions over the course of four to five months in an older adult's home or a community-based setting that is more accessible and comfortable for older adults who do not see other mental health programs as a good fit for them.

- PEARLS is an effective skill-building program that helps older adults manage and reduce their feelings of depression and isolation
- PEARLS adapts to the participant and the place and the need
- PEARLS is adaptable to various community needs and helps expand access to depression care in underserved communities, including rural ones.
- PEARLS meets older adults where they are, especially those who have limited access to depression care because of systematic racism, trauma, language barriers, low income, and other factor leading to determinants of health

Project Components:

Program providers (internal and community-based providers) will be fully trained in the evidence-based model for PEARLS. The PEARLS program will be the catalyst for initial engagement with the older adult population to provide key skill building supports and provide access to timely medically necessary early intervention services.

Program Goals

- Early identification of mental/emotional difficulties and increased timely access to medically necessary services

- Increased provider awareness of the mental health needs of older adults and linkage to appropriate community resources
- Reduced stigma around mental health and help seeking with the older adult community
- Reduced prolonged suffering by increasing protective factors and reducing risk factors

Documentation of Achievement in performance outcomes:

PEARLS currently have 27 referrals with 9 active clients
Increased referrals to PEARLS
Increased Outreach to community partners, CBO, and governmental agencies and senior centers
Active participation at the Commission on Aging

Challenges or barriers:
Stigma continues to hamper participation
Minimal staffing
Uncertainty regarding future funding source

Strategies
Increased outreach
Hire staff
Increased advocacy for Older Adult with Mild depression and Isolation

PEI Project 8: Misdemeanor IST Diversion – Early Intervention Program

Community Need:

This program is for those diagnosed with mental illnesses or suspected mental illness, like schizophrenia and other psychotic disorders who have committed a criminal act and have been found to be incompetent to stand trial. To be eligible for this program a judge has suspended court proceedings based on competency and has referred the individual to behavioral health for early intervention services to determine if a behavioral health disorder is present and if so, to assist with the linkage to appropriate treatment services as well as providing behavioral health services as part of a diversion program, which will be a subset of an existing Forensics FSP.

The courts have seen an increase in misdemeanor IST. Due to this increase, they are creating a separate court calendar to address the unique needs of these MIST clients and would like to partner with BHS in serving these individuals to divert clients away from ConRep, State Hospital placements, decrease the risks for recidivism, and help prevent client's justice involvement escalating to felony charges.

Currently there are no programs that serve this population in collaboration with our judicial partners. Without collaborative services between BH and our Justice partners, clients are at risk of escalating to felony charges and being at risk of needing a higher level of care.

This is a collaboration between the DA's office, probation, the court, the Public Defender's Office, and San Joaquin County Behavioral Health, and partnering community programs. As a result, clients would be referred to SJCBHS for treatment.

Project Description

San Joaquin County Behavioral Health will develop a program that will work with individuals with mental health concerns that, left untreated are resulting in repeat incarcerations, prolonged suffering, and risk of homelessness. This is a collaboration between the DA's office, probation, the court, the Public Defender's Office, and San Joaquin County Behavioral Health, and partnering community programs. This program will include early intervention to determine if a behavioral health disorder is present with case management and linkages to appropriate treatment services. As a subset of our current Forensics FSP, this program will also provide diversion services in collaboration with our justice partners that includes behavioral health treatment to reduce recidivism, CARE Court petitions, and risk for state hospital placement or more serious felony charges.

In conjunction with SJBHS FSP program standards a "Whatever it takes" approach. The focus of the diversion program is to provide intensive treatment and wraparound services in a community-based, home-like setting. Activities may include but are not limited to screening and assessment, individualized case management, rehabilitative groups and activities, and navigation support to engage and maintain in needed treatment services, peer support, and substance use treatment services.

Upon successful completion of the diversion program, the court may dismiss charges.

Project Components:

- Outreach: Meet with clients while they are in custody or remanded to court to establish rapport
- Rapport building: emphasis on the client-provider relationship is stressed by vision/ideology/values of the program.
- Client Engagement: Provide frequent, low demand contacts with clients where they live or are most comfortable.
- Individualized case planning based on needs: upon entering the program an assigned team member will "meet the client where they're at" with their unique goals.
- Assessment: continuous assessment by the clinical team of client's symptoms and impairments and what role they play in client's functionality
- Case management: Assist clients in accessing primary and behavioral health care services, peer-based services, and financial, educational, prevocational, rehabilitative, or other community-based services and supports needed by clients to meet their personal goals. (TRANSPORTATION)
- Medication evaluation and support: Access to a psychiatrist and continued support by staff for medication adherence/compliance
- Benefits acquisition: assisting client in acquiring all benefits they are eligible for in the community (Medical, SSI, Cal Fresh, free phones)
- Intervention and stabilization/ Housing: Based on client symptoms and impairments utilizing the appropriate types of housing in our housing continuing of care (SLE-Board and care- bright house- transitional board and care)
- Ongoing specialized mental health services: (what else do they need to be successful? Unconventional therapy, volunteering/vocational opportunities)
- Crisis response: having skills to meet the level of crisis and best mitigate the (lost my train of thought)
- Community building: building partnerships with community members to remove barriers for appropriate referrals and intervention.

Program Goals

- Improve clinical outcomes and functioning of the client.
- Help clients define/establish a meaningful life.
- Reduce recidivism.
- Reduce the number of IST referred to State Hospital programs.
- Reduce CARE Court involvement.
- Reduce criminal activity.
- Prevent incarceration (jail days)
- Identify and link clients to appropriate resources (wrap around services)
- Prevent homelessness.
- Enhance public safety!

Documentation of Performance Outcomes
This program began on the Fiscal Year 24/25 (no data to report for 2023-24)

Challenges or barriers and Strategies

This program began on the Fiscal Year 24/25 (no data to report for 2023-24)

PEI Project 9: Whole Person Care

Community Need

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

Project Description

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

Project Components

Public Health Whole Person Care, Outreach, Education, and Engagement Team:

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

BHS Linkage and Treatment Team:

- *BHS Linkage Team* will work with homeless outreach team to provide street outreach, communication and coordination with law enforcement partners, enthusiastic engagement and screening for behavioral health concerns, transport to clinic or other locations for psychosocial

assessments, ongoing case management, be the warm hand team to receive referrals from the community into treatment services, family engagement / reunification opportunities.

Documentation of Performance Outcomes

100% of new clients who received a service from Whole Person Care were engaged in discussions about referrals to various services. The following is a summary of data on mental health treatment referrals[1] documented by the WPC program during the 2023/24 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project documented referrals for 49 individuals to treatment provided, funded, administered, or overseen by County programs.
- Of the 49 County-referred individuals, 30 (61%) were known to have engaged in treatment, defined as attending at least one mental health service within 60 days.
- The average interval between referral and treatment was 10.8 days.

Challenges or barriers and Strategies

1.Whole person care will continue to work towards building good care coordination within our continuum as well as with our community partners to mitigate and or at least decrease and advocate when barriers arise. Continue to work within the system to address and remedy internal controllable barriers.

2. Whole person care will work internally to ensure data and collection and input is more consistent and understood as a whole and the importance of accurate and timely data input and collection is a priority

3. continue to look at strategies and interventions and see where our system and program can adjust. Keeping up to date on new resources and opportunities for our members as well as looking internally for how best to pivot and and adjust to best serve our community as a whole system of care.

PEI Project 10: Increasing Recognition of Mental Illnesses

Community Need

Mental illnesses are common, and failure to provide appropriate and timely treatment can have serious and detrimental consequences for individuals, families, and communities. Community trainings to increase the recognition of early signs of mental illnesses and to effectively respond and link individuals to services are needed to improve timely access to mental health services for all individuals, and especially for individuals and/or families from underserved populations.

Project Description

Trainings will reach out to community leaders and community-based organizations, service providers, college instructors, religious or spiritual leaders, and consumers and family members to provide information on how to increase recognition and respond effectively to the signs and symptoms of potentially severe and disabling mental illness. Training is also offered to consumers, parents/guardians, and other family members in order to provide information about mental health conditions that encourage individuals and families to overcome negative attitudes or perceptions about mental illnesses, recent diagnosis, and/or help seeking behavior.

Project Goal: *To develop community members as effective partners in identifying individuals in need of treatment interventions early in the emergence of a mental illness and preventing the escalation of mental health crises and promoting behavioral health recovery.*

Project Components

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

Project 1: Community Trainings for Potential Responders

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

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

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

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

- **Trauma-Informed Care:** Training will assist responders in recognizing trauma-related symptoms and concerns and in the interventions helpful to individuals affected by trauma.

Project 2: Community Education:

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

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

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

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

Documentation of Performance Outcomes

NAMI did not meet the number of trainings that it proposed to provide. Trainings and the number trainings proposed were:
Provider Education Program - 2 (None was given)
In Our Own Voices - 32 (A total of 28 trainings were given)
In Our Own Voices (Spanish) - 8 (None was given)
Family to Family - 2 (1 was given)
Peer to Peer - 3 (1 was given)
NAMI Basics - 1 (None was given)

Challenges or barriers and Strategies

Quarterly Reports and invoices have been delayed for fiscal year 2023-24. With the change of staff as of December, the timely submission of reporting and invoicing is better.

PEI Project 11: Information and Education Campaign

Community Need

Too many individuals remain unserved by community mental health services owing to negative feelings attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services. The overarching purpose of the *PEI Information and Education Campaign* is to increase acceptance and understanding of mental illnesses, substance use disorders and seeking behavioral health services; to increase help seeking behaviors; and to promote equity in care and reduce disparities in access to mental health services and substance use disorder services.

Project Description

BHS will work with a contracted program partner to develop, host, and manage a public information and education campaign intended to reduce multiple stigmas that have been shown to discourage individuals from seeking mental health services and substance use disorder services. The information and education campaign will include language, approaches, and social/media markets that are culturally and linguistically relevant and congruent with the values of underserved populations.

Project Goal: *To reduce stigma towards individuals with a mental illness and/or substance use disorder and increase self-acceptance, dignity, inclusion and equity for individuals with a behavioral health challenge and members of their family.*

Project Components

To develop and promote a public information and education campaign using: (1) positive, factual messages and approaches with a focus on recovery, wellness, and resilience; (2) culturally relevant language, practices, and concepts geared to the diverse population of San Joaquin County; and (3) straightforward terms – not jargon – to explain when, where, and how to get help.

Self-Acceptance: Understanding and accepting a mental health and or substance use disorder diagnosis can be a lengthy process for consumers and their family members; one made more difficult by a lack of relevant information. The primary focus of the *Information and Education Campaign* will be a re-imagining of how information about mental illness, substance use disorder, treatment options, and pathways to services are made available to consumers and family members. Currently BHS and others rely heavily on website pages and brochures which provide relatively static information. With today's technology, there are better and more easily navigable ways to provide individualized information on mental illnesses and substance use disorders and how to get the help needed. Accepting a diagnosis is easier when there are meaningful examples of recovery; accessible pathways to services; tangible recovery milestones; and clarity on when, why, and how treatment is escalated. A secondary purpose of this work will be to increase *timely* access to services for those first accepting a diagnosis of a mental illness and/or substance use disorder.

Dignity: Promoting dignity in the delivery of mental health services and/or substance use services is a fundamental value of San Joaquin County Behavioral Health Services. At BHS, consumer driven services are a fundamental tenant of how treatment and recovery plans are developed. The *Information and*

Education Campaign will include the development of simple step-by-step instructions for consumers to develop their own recovery pathway. Specific education campaign items will be accessed through the website, touch screen portals, and informational brochures. Examples of the types of items that will be addressed include but are not limited to: developing and updating a Wellness Recovery Action Plan (WRAP), having a peer partner assigned; asking for a second opinion; patient rights, expectations for timely access to services; and escalating questions or concerns to a consumer advocate.

Inclusion: The target population for the *Information and Education* campaign will be all residents of San Joaquin County and it is important to provide education to people who are not actively seeking information on mental health issues and substance use disorders such that there is broader acceptance of behavioral health concerns as a normalized experience; and a broader acceptance of people with mental illnesses in classrooms, workplaces, on playgrounds, and in the community. Hence, some efforts are needed to ensure that the education materials designed to reduce stigma towards mental illness and substance use disorders are broadly accessible in the community: on billboards, information kiosks, and prominently posted in public locations such as libraries, community colleges, post offices, court houses.

Equity: Equity means equal access to services; but it also means equal inclusion in the development of services and supports, the information that is generated about services and supports, and in the distribution of information and education materials. In developing a stigma and discrimination reduction campaign that is linguistically competent and culturally congruent to the values of the population the developers of the *Information and Education Campaign* will engage consumers, family members, youth, and underserved communities to provide guidance and feedback on the development of the *Information and Education Campaign.* At a minimum it is anticipated that *Information and Education Campaign* materials will be developed in English and Spanish and that a targeted information and education campaign will be developed for Spanish-speaking residents of San Joaquin County which may include billboards, social media, or other public or direct-contact approaches.

PEI Project 12: Suicide Prevention with Schools

Community Need

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

Project Description

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

- Comprehensive school-based suicide prevention programs for students and school personnel in San Joaquin County. Targeted suicide prevention activities will include:
  - Evidence-based suicide education campaigns.
  - Depression screenings and referrals to appropriate mental health interventions.

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

Project Components

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

- School personnel will be trained in an evidence-based practice to understand suicide, recognize suicide risk behavior in students, and to refer students for assistance, and
- Students at participating schools receive evidence-based suicide prevention education.

<u>An Evidence-Based Suicide Education Campaign</u>
Implement one or more of the following evidence-based practices for both school personnel and students:

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

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

Suicide Prevention Education and Awareness Training

Planning conversations will be coordinated with participating schools to evaluate and select an education model suitable to that school and student population. Options to select from include but are not limited to: QPR and/or SafeTALK.

- Question, Persuade, Refer (QPR)
  Provide QPR Gatekeeper Training for Suicide Prevention to school personnel to train them to engage and intervene with youth who are displaying or discussing suicidal or self-harming behaviors. QPR will be implemented in accordance with the evidence-based practice described at: http://www.qprinstitute.com

- SafeTALK Workshops
  Provide *SafeTALK* workshops for individuals ages 15 and over at participating schools to assist in the recognition and identification of individuals with thoughts of suicide, and to connect them to mental health resources. *SafeTALK* will be implemented in accordance with the evidence-based program detailed at: https://www.livingworks.net/programs/safetalk/

  SafeTALK workshops teach youth to be "alert helpers" who are better able to move beyond common tendencies to miss, dismiss, or avoid suicide; to identify individuals with suicidal thoughts; and to help connect a person with suicidal thoughts to suicide intervention responders.

  SafeTALK includes the following practice requirements:
  - Workshops must be conducted by a registered SafeTALK trainer and held over three consecutive hours.
  - A community support resource (such as a trained volunteer, safety officer, or mental health professional) must be present to support any participants who experience difficulty.
  - Each workshop will have between 10 and 30 participants.

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

Depression Screening and Referral

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

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

levels of depression. For more information on CES-DC see: http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf

Following the screenings, youth may be referred to one or more of the following: individual therapy with a qualified mental health clinician; further assessments and screenings for medication evaluation; and/or school-based depression support groups including but not limited to:

The CAST curriculum is a high school-based suicide prevention program targeting youth 14 to 19 years old. CAST delivers life-skills training and social support in a small group format (6-8 students per group). The program consists of twelve 55-minute group sessions administered over 6 weeks. CAST serves as a follow-up program for youth who have been identified through screening as being at significant risk for suicide. CAST's skills training sessions target three overall goals: increased mood management (depression and anger), improved school performance, and decreased drug involvement. Group sessions incorporate key concepts, objectives, and skills that inform a group generated implementation plan for the CAST leader. Sessions focus on group support, goal setting and monitoring, self-esteem, decision making skills, better management of anger and depression, "school smarts," control of drug use with relapse prevention, and self-recognition of progress through the program. Each session helps youth apply newly acquired skills and increase support from family and other trusted adults. Detailed lesson plans specify the type of motivational preparation, teaching, skills practice, and coaching activities appropriate for at-risk youth. Every session ends with "Lifework" assignments that call for the youth to practice the session's skills with a specific person in their school, home, or peer-group environment.'

Break Free from Depression is a school-based curriculum designed to increase adolescents' awareness and knowledge about depression, enhance their ability to recognize signs and symptoms in themselves and their friends, and increase students' skills and strategies for finding help for themselves and their peers. This 4-session curriculum for high school students combines didactic and interactive activities. The cornerstone of the curriculum is a documentary that focuses on a diverse group of real adolescents (not actors) talking about their struggles with depression and suicide in their own words. They discuss stigmas often associated with depression, their symptoms, the course of their illness, and the methods they have used to manage their depression. Each session lasts 45 to 60 minutes.

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

Documentation of Performance Outcomes

*Met minimum goal of 5,500 students receiving Yellow Ribbon Campaign messaging and reported increased knowledge of suicidal signs, risk and protective factors. Students also indicated increased understanding of how to ask for help.
*Met having 15 high schools engaged with the Yellow Ribbon Campaign.
*Met goal of 150 youth completing the Ask 4 Help Youth Gatekeeper Trainer Training.
*Exceeded goal of 150 participants completing the SafeTALK training.
*Met goal of 250 parents/guardians completing the Be A Link Adult Gatekeeper training.

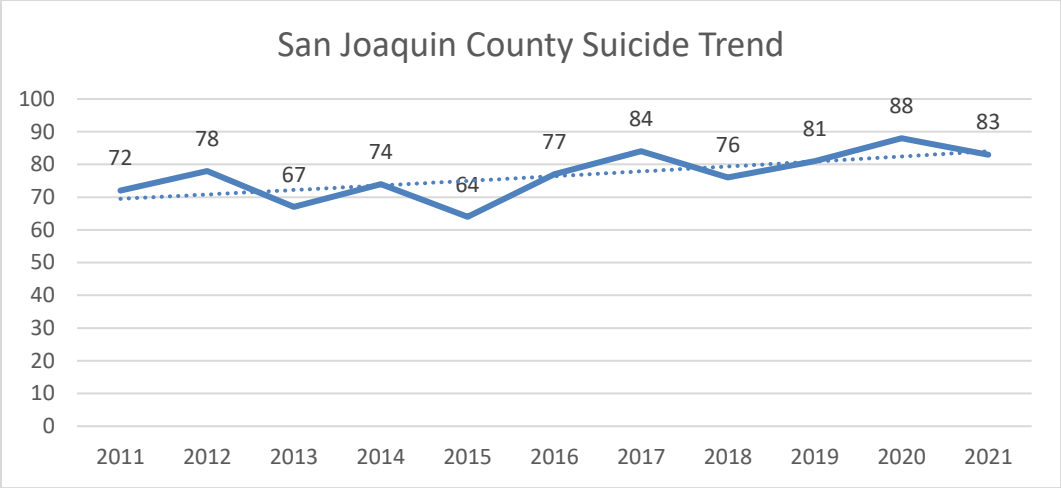
Challenges or barriers and Strategies

Did not report any barriers or challenges throughout the year.

PEI Project 13: Suicide Prevention and Education in the Community

Community Need

There is an increase in the numbers of suicide deaths occurring over the past 10 years, according to the Office of the Coroner, and as shown in the chart below. Increases are somewhat higher than the prior 10 years in which suicides deaths were relatively flat, accounting for between 50 – 60 deaths annually. This is consistent with national research which shows that while suicide rates remained relatively stable between the late nineties and mid-2000's there is a significant increase in suicide deaths in the last ten years[1].



Suicide is the preventable consequence of untreated mental illness. PEI currently funds a suicide prevention campaign in local schools. Additional resources are needed for a suicide prevention campaign targeting adults and older adults.

National data also indicates that the suicide prevention activities need to better target males, who account for the majority of suicide deaths (75% of suicides nationally, and 85% of San Joaquin's suicide deaths, in 2017); and need to better target young men and adults between the ages of 15 – 64 with special outreach to young men and adults living in non-urban areas.

Project Description

In coordination with the PEI *Information and Education Campaign* BHS will work with a contracted program provider to develop a local suicide prevention campaign targeting young men and adults between the ages of 15-64. Suicide prevention campaign information will align its messaging with existing major suicide prevention initiatives, including national suicide prevention hotline and text lines,

[1] See: Centers for Disease Control and Prevention, National Center for Health Statistics, *Suicide Mortality in the United States 1999 – 2017.* https://www.cdc.gov/nchs/products/databriefs/db330.htm

while simultaneously promoting local resources for a range of wellness concerns including depression, anxiety, and stress management.

Project Goal: Increase awareness and understanding of suicide as an illness and how to connect with a mental health professional in the community to address suicide thoughts or planning for yourself or a friend.

Project Components

Suicide Prevention for the Community

Develop and promote a suicide prevention and information campaign using a range of multi-media platforms, including billboards, websites, social media and/or smart-device applications which will guide users to local resources in San Joaquin County. Gun violence is the most prevalent mode of suicide death in San Joaquin County. Suicide prevention and information campaign efforts will include facts about non-homicide firearm-related deaths and measures that can be taken to limit easy access to a gun for someone who may be at risk for suicide. Education on suicide prevention can be provided to the community through this program.

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

VII. Innovation

Innovation Component Funding Guidelines:

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

Innovation funding may be used for the following purposes:

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

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

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

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

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

BHS received approval by the Mental Health Services Oversight and Accountability Commission (MHSOAC) in January 2023 to implement one INN program.

Project 1: CalMHSA EHR Multi-County Innovation Project

INN Project 1: CalMHSA EHR Multi-County Innovation Project

Community Need: County Behavioral Health Plans (BHPs) have had a limited number of options from which to choose when looking to implement a new EHR. The majority of EHR vendors develop products to meet the needs of the much larger physical health care market, while the few national vendors that cater to the behavioral health market have been disincentivized from operating in California by the many unique aspects of the California behavioral health landscape. This has resulted in most county BHPs largely dissatisfied with their current EHRs, yet with few viable choices when it comes to implementing innovative solutions. The pervasive difficulties of 1) configuring the existing EHRs to meet the everchanging California requirements, 2) collecting and reporting on meaningful outcomes for all of the county BH services (including MHSA-funded activities), and 3) providing direct service staff and the clients they serve with tools that enhance rather than hinder care have been difficult and costly to tackle on an individual county basis.

Proposed Solution: Semi-Statewide Enterprise Health Record
CalMHSA is currently partnering with 20+ California Counties – collectively responsible for over half of the state's Medi-Cal beneficiaries – to enter into a Semi-Statewide Enterprise Health Record project. This project is unique in that it engages counties to collaboratively design a lean and modern EHR to meet the needs of counties and the communities they serve both now and into the intermediate future. The key principles of the EHR project include:

- **Enterprise Solution**: Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of County Behavioral Health Plans.

- **Collective Activism**: Moving from solutions developed within individual counties to a semi-statewide scale allows counties to achieve alignment, pool resources, and bring forward scaled solutions to current problems, thus reducing waste, mitigating risk, and improving quality.

- **Leveraging CalAIM**: CalAIM implementation represents a transformative moment when primary components within an EHR are being re-designed (clinical documentation and Medi-Cal claiming) while data exchange and interoperability with physical health care towards improving care coordination and client outcomes are being both required and supported by the State.

Optimizing EHR platforms used by providers to meet their daily workflow needs can enhance their working conditions, increase efficiencies, and reduce burnout. This increased efficiency translates into more time to meet the needs of Californians with serious behavioral health challenges, while improving overall client care and increasing provider retention.

Multi-County Innovation (INN) Project:
In October 2021, CalMHSA administered a survey to 20 BHPs who had previously expressed interest in participating in the Semi-Statewide EHR. Subsequent to the survey, there has been additional interest in the project. This survey gathered preliminary data related to current EHR system usage, such as the total number of active EHR users, active users by staff classification, service provision, and interoperability capabilities. Survey participants reflect the diverse populations across California counties, with representation from each of the five (5) state regions (Bay Area, Central, Southern, Superior, Los

Angeles) as well as county sizes (small-rural, small, medium, large, very large). Based on responses from all 20 counties, it is anticipated that this project could potentially impact more than 20,000 EHR users, depending upon the number of counties choosing to participate.

The proposed INN Project will include the initial cohort of counties who are scheduled to "go live" with the Semi-Statewide EHR during Fiscal Year 2022/2023. A foundational goal of this project is to engage key stakeholders and human-centered design experts *prior to* the new EHR implementation and include their experience and feedback to optimize the user experience and layout of the incoming EHR.
The INN project will have three (3) phases:

1) **Formative Evaluation**: Prior to implementation of the new EHR, the project will measure key indicators of time, effort, cognitive burden, and satisfaction while providers utilize their current or "legacy" EHR systems. The data collected by direct observation of staff workflows currently in use will then be assembled and analyzed using quantitative scales. Objective data for example, length of time moving between screens, number of mouse clicks, and amount of time required, as well as subjective data to measure user satisfaction, will be incorporated into the evaluation process.

2) **Design Phase**: Based on data gathered from the initial phase, Human-centered design (HCD) experts will assist with identifying solutions to problems identified during the evaluation of the legacy products. This process will help ensure the needs of service providers, inclusive of licensed professionals, paraprofessionals, and peers, and in turn their clients, will be at the forefront of the design and implementation of the new EHR. In order to create as many efficiencies as feasible, the design phase will be iterative, to ensure feedback from users and stakeholders is incorporated throughout the process.

3) **Summative Evaluation**: After implementation of the new EHR, the same variables collected during the Formulative Evaluation will be re-measured to assess the impact of the Design Phase interventions.

The HCD approach is supported by research and is a key component of this project. Enlisting providers' knowledge and expertise of their daily clinical operations in order to inform solutions in the Design Phase is vital to ensuring the new EHR is responsive to the needs of the BHP workforce as well as the clients they serve.

Project Management and Administration

• **CalMHSA**: CalMHSA will serve as the Administrative Entity and Project Manager. CalMHSA will execute Participation Agreements with each respective county, as well as contracts with the selected EHR Vendor and Evaluator.

• **Streamline Healthcare Solutions**: This vendor will be responsible for the development, implementation, and maintenance of the Semi-Statewide EHR.

• **RAND**: As the evaluation vendor, RAND will assist in ensuring the INN project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the INN project. These indicators include, but may not be limited to, impacts of human-centered design principles with emphasis on provider satisfaction, efficiencies, and retention. In addition, RAND will

subcontract with a subject matter expert in the science of human-centered design to ensure the project is developed in a manner that is most congruent to the needs of the behavioral health workforce and the diverse communities they serve.

Project Objectives

CalMHSA will partner with RAND to achieve the following preliminary objectives:

• **Objective I**: *Shared decision making and collective impact*. Over the course of the EHR project, RAND will evaluate stakeholder perceptions of and satisfaction with the decision-making process as well as suggestions for improvement.

• **Objective II**: *Formative assessment*. RAND will conduct formative assessments to iteratively improve the new EHR's user experience and usability during design, development, and pilot implementation phases. This will include:

o A discovery process identifying key challenges that the new EHR is aiming to improve and establish strategic areas for testing (e.g., efficiency, cognitive load, effectiveness, naturalness, satisfaction).

o Testing EHR usage with core workflows (e.g., writing progress notes; creating a new client records) as well as common case scenarios (e.g., potential client calls an "Access Center" for services, before or after hours; sending referrals to other agencies or teams) in order to identify opportunities for increased efficiencies / standardization.

o Iterative testing and feedback of new EHR vendor's design (wireframes and prototypes) using agreed-upon scenarios, including interviews and heuristic evaluation workshops as appropriate.

o Identifying performance indicators to gauge success, such as measures of efficiency (e.g., amount of time spent completing a task; number of clicks to access a needed form or pertinent client information), provider effectiveness, naturalness of a task, and provider cognitive load / burden and satisfaction.

• **Objective III**: *Summative assessment*. Conduct a summative evaluation of user experience and satisfaction with the new EHR compared to legacy EHRs, as well as a post-implementation assessment of key indicators.

Project Learning Goals

1. Using a Human Centered Design approach, identify the design elements of a new Enterprise Health Record to improve California's public mental health workforce's job effectiveness, satisfaction, and retention.

2. Implement a new EHR that is more efficient to use, resulting in a projected 30% reduction in time spent documenting services, thereby increasing the time spent providing direct client care.

3. Implement a new EHR that facilitates a client-centered approach to service delivery, founded upon creating and supporting a positive therapeutic alliance between the service provider and the client.

Community Planning Narrative and Project Budget can be found in the Appendix of the 2023-26 MHSA Three Year Plan

*San Joaquin County includes documentation of achievement in performance outcomes for Innovations (INN) program in the appendix of this document entitled Annual INN Evaluation Report

VIII. Workforce Education and Training

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

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

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

Significant Considerations in Workforce, Education and Training

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

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

(1) Training and Technical Assistance

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

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

(2) Mental Health Career Pathway Programs

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

(3) Residency and Internship Programs

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

(4) Financial Incentive Programs

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

(5) Workforce Staffing Support

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

In 2025/26, BHS will refund the Workforce Education and Training projects with a transfer of funds into the WET account from CSS. Funds must be spent within 10 years of the date of transfer.

WET Project 1: Training and Technical Assistance Academy

Community Need

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

Project Description

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

Project Components

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

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

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

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

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

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

WET Project 2: Internship and Financial Assistance Program

Community Need:

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

Project Description:

BHS will coordinate an internship and financial assistance program to meet the shortage within our community. This project will enhance BHS' efforts to continue to recruit and train talented graduates of mental health programs and provide a pathway of opportunity in four distinct components. BHS will partner with CalMHSA to provide funding for the following project components. BHS will also fund clinical supervision for interns looking to be part of the mental health profession within San Joaquin County.

Project Components:

- Hiring bonus for new clinicians
- Longevity bonus for existing clinical licensed staff
- Educational stipends to advance existing staff to clinician level
- Internship opportunities to engage staff through post education work commitments
- Central Regional collaboration with Department of Health Care Access and Information (HCAI) (Formally, Office of Statewide Health and Planning Development ((OSHPD)) and the WET central region partnership to improve recruitment and training.
- CalMHSA Workforce Loan Repayment Program
- 1 FTE Clinical Field Supervisor Position for Clinical Supervision for interns

IX. Capital Facilities and Technological Needs

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

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

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

Since 2013, additional needs have been identified and have been subsequently described in the 2023-2026 Three Year Program and Expenditure Plan.

Past CFTN funding has been used to:

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

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

In 2025-26 BHS will refund the Capital Facilities and Technology Needs project fund with a transfer of funds into the CFTN account from CSS. Funds must be spent within 10 years from the date of transfer. Proposed new projects are outlined and described below.

CF/TN Project 1: Facility Renovations

Funding will be allocated to upgrade and renovate Behavioral Health facilities. Capital Facility funds will be used for projects that have been identified as critical to ensuring clean, safe, and accessible access to services for all populations. Projects include installation of security cameras, dedicated parking for the Children's Crisis services, restroom upgrades (for ADA compliance and safety), exterior painting to prevent structural damage, and other facility renovations.

CF/TN Project 2: Facility Repair and Upgrades

Funding will be allocated for a variety of facility repairs and upgrades to ensure facilities remain in good working order and provide comfortable and effective workspaces for all program activities. Projects include but are not limited to: repairs or upgrades to roofing, flooring, workstations, meeting rooms, waiting rooms, and other public spaces; repairs or upgrades to heating and ventilation equipment, lighting, alarms, windows, acoustics, etc.; and other projects as needed to ensure that BHS facilities are in good repair and working order. Projects may include additional refurbishments to ensure that all clinical spaces are warm and inviting places that support healing and recovery. Upgrades may include interior re-configurations to accommodate increased staffing, new technologies, or other changes to "back-office" services needed to improve overall service delivery.

CF/TN Project 3: Technology Equipment and Software

Additional technology upgrades are needed. Software upgrades and equipment are necessary to ensure compatibility with the latest versions of financial, HR, project, and client case management systems, and to ensure all information is protected and retained in the event of an emergency. CF/TN funds will be used for a range of software, hardware, networking, and technology consultations to improve client services. Electronic Health Records project, in partnership with CalMHSA, will be funded from this project component.

X. MHSA Funds – Reduction of the Prudent Reserve Balance

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

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

- Requirement to establish and maintain a prudent reserve that does not exceed 33 percent of the average community services and support (CSS) revenue received for Local Mental Health Services Fund in the preceding given years, and to reassess and certify the maximum amount every five years.
- Each county must calculate an amount to establish its prudent reserve that does not exceed 33 percent of the average amount allocated to the CSS Component in FY 2018-19, FY 2019-20, FY 2020-21, FY 2021-22, FY 2022-23. To determine the average amount allocated to the CSS Component of those five years a county must calculate the sum of all distributions form the Mental Health Services Fund from July 2018 through June 2023, multiply that sum by 76, and divide that product by five.
- To determine the maximum prudent reserve level, a county must multiply the average amount allocated to the CSS component of the previous five years by 33 percent.

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

San Joaquin County		
Prudent Reserve Maximum		
June 30, 2024, Assessment		
		MHSF Distribution
FY 2018-19		$ 33,266,868.17
FY 2019-20		$ 31,114,735.39
FY 2020-21		$ 47,491,888.25
FY 2021-22		$ 55,356,593.63
FY 2022-23		$ 36,475,739.90
	Total	$ 203,705,825.34
CSS allocation (76%)		$ 154,816,427.26
5-Year Average		$ 30,965,841.18
Prudent Reserve Maximum (33% of 5-yr average)		**$ 10,218,727.59**

XI. Attachments: Evaluation and Planning Reports

2024-2025 Cultural Competency Plan Update

2023-2024 Three-Year PEI Evaluation

INN Project 1: CalMHSA EHR Multi-County Innovation Proje*ct Report*

Genevieve Valentine, LMFT, BHS Director
Fay Viera, LMFT, Assistant Director, Clinical
Cara Dunn, MPA, Assistant Director, Administrative

San Joaquin County Behavioral Health Services
2024-25 Annual Update to the 2010 Cultural Competency Plan

San Joaquin County Behavioral Health Services (BHS) continuously seeks to improve by evaluating, strategizing, and enhancing service delivery. To meet the prevention, intervention, treatment and recovery needs of San Joaquin County residents, BHS provides a broad range of behavioral health services, including mental health and substance use disorder services, in a culturally competent and linguistically appropriate manner.

The 2024-25 Annual Update to the 2010 Cultural Competency Plan (Annual Update) reviews the efforts of Fiscal Year (FY) 2023-2024 and guides upcoming efforts for FY 2024-2025. The Annual Update will focus on the eight criteria laid out by the State's Cultural Competency Plan Requirements of 2010.

Criterion 1: Commitment to Cultural Competence
(CLAS Standard 2, 3, 4, 9, 15)

FY 2023-2024 Accomplishment: Continuance of enhanced agency commitment to Cultural Competency by:

- Hired para-professional staff to oversee cultural competency committee, cultural competency plan requirements, and additional health equity needs of BHS MHSA Cultural
- BACOP Full-Service Partnership (Black Awareness Community Outreach Program) was fully contracted with cultural Community Based Organization (CBO) within the community to enhance community partnership and provide culturally congruent services within the community.

FY 2024-2025 Strategies:

1. Build out cultural and health equity cultural competency committee to include contract staff, additional community members, and expand consumer/ family member involvement by June, 2025
2. Latino/x Cultural Full-Service Partnerships (La Familia) will be fully contracted with cultural Community Based Organizations (CBO's) within the community to enhance community partnership and provide culturally congruent services through local provider by June, 2025

Criterion 2: Updated Assessment of Service Needs
(CLAS Standard 2, 11)

FY 2023-2024 Accomplishments: BHS implemented a comprehensive community planning process with these components:

- 19 community stakeholder discussions about the needs and challenges experienced by mental health consumers, with a focus on the diverse range of consumers served.
- Two targeted discussion groups with mental health consumers, family members
- Review of service needs including utilization, timeliness, and client satisfaction.

BHS reviewed service needs using two methods:

1. The Mental Health Services Act (MHSA) Community Planning Process incorporated discussion with stakeholders on the needs of diverse communities in the County, and gaps in available services. The

assessment of service needs is detailed in the 2023-2026 MHSA e Three Year Program and Expenditure Plan, pages 7 through 21. (Attachment 3)

2. Review of San Joaquin County Medi-Cal Approved Claims Data for mental health (MH) and substance use disorders (SUD) utilization, provided by CALEQRO. The data provided by CALEQRO contains Medi-Cal Beneficiaries served by race and ethnicity including penetration rates by age, gender, and ethnicity (See Attachment 5).

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

- African Americans were enrolled at higher rates compared to their proportion of the general population (15% of participants while comprising 7% of the population of the County).
- Latino/x are enrolled at lower rates compared to their proportion of the general population (25% of participants while comprising 43% of the population) – a two percent decrease from the previous year
- Participation amongst children and youth is more reflective of the racial demographics of the overall population, with over a third of services provided to young Latino/x (35%), suggesting that while stigma, language or cultural barriers, or access to health care services continue to impede access for Latino adults with behavioral health needs, more services are reaching the younger Latino populations.
- Survey Input and Stakeholder feedback displayed race/ethnicity data reflective of the BHS client population. Adult survey respondents were more likely to be Latino/x, African American, Asian, or Native American than is reflective of the general population in San Joaquin County.
- Feedback from self-reported demographics indicated that adult consumers represented 8% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQIA+).

Data provided by CALEQRO for MH Medi-Cal Beneficiaries (CY 22) indicated the following:

- The penetration rate for individuals 60+ continues to be higher than the statewide average, similar to the previous year.
- The penetration rate for Asian/Pacific Islanders is statistically identical with the statewide average.
- The penetration rate for Latino/Hispanic communities (2.53%) is lower than the statewide average of 3.51% and slightly lower with the rate of other large-sized counties (3.60%).

Data provided by CALEQRO for SUD Medi-Cal Beneficiaries CY 2021 (as of this draft CY 2022 was unavailable) indicated the following:

- The penetration rate for individuals 65+ is higher than the statewide average, similar to the previous year.
- The penetration rate for African Americans (1.22%) is statistically the same across both large county (1.29%) and statewide average (1.19%).
- The penetration rate for Latino/Hispanic communities (.72%) is higher that the statewide average (.69%).

FY 2024-2025 Strategies:

- BHS will again host a series of MHSA community planning discussions on the needs and challenges experienced by mental health consumers, with a focus on the diverse range of consumers served by December 15, 2024.
- BHS will develop online and paper stakeholder surveys to reach individuals who are unable to attend community planning sessions, or who may be unwilling or unable to provide public comment in person at meetings, by October 1,2024.
- BHS will distribute and collect needs assessment surveys by October 15, 2024.
- BHS will complete an annual MHSA assessment of needs by January 15, 2025.
- Distribute and collect SUD needs assessment surveys by March 2025. (Strategy Carryover from 20-21 Plan)

- Complete analysis of SUD assessment survey by May 15, 2025. (Strategy Carryover from 20-21 Plan)

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

(CLAS Standard 1, 10, 14)

FY2023-24 Accomplishments

- Finalize Performance Improvement Project (PIP) and begin focus on Latino/a/x Engagement, Access, and Equity
- Defined framework of PIP project to encompass Universal, Selective, and Indicated strategies to increase Latino/a/x penetration rates
- The Cultural Competency Committee added PIP agenda item to the monthly agenda to increase engagement and to provide a continuous feedback loop to the PIP

FY 2024-2025 Strategies:

- All staff training. The PIP Workgroup reviewed several Latinx-specific behavioral health trainings and have identified the following one-hour webinar, proposed as a mandatory training for all BHS staff and contractors: The Impact of Immigration on SMI in Undocumented Latinx Population by January, 2025
- Acculturated stress scale with immigrant and first-generation American clients: Participating BHS divisions will pilot a self-administered Acculturated Stress Scale with immigrant and first-generation American clients. The tool will used by the clients, providers and caregivers by December 2024
- Implement an annual "Bienvenidos: Make Each Clinic More Culturally Welcoming" competition for Hispanic Heritage Month (Sept 15 – Oct 15) by September 15, 2024
- Incorporate Welcoming Competition for the Black/African American community for February 2025 and Asian Pacific Islander community in May 2025
- As of this report, the PIP Latino/X workgroup will be transitioned and moved to the Cultural Competency Committee to monitor strategies outlined above beginning in January 2025

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

(CLAS Standard 13)

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

1. The Cultural Competency Committee is comprised of BHS staff, consumers/family members, and other stakeholders.
2. The MHSA Consortium, established in 2007, is comprised of a variety of stakeholders: representatives of community based organizations, consumers and family members, community members and BHS staff.

The Cultural Competency committee was developed in accordance with the requirements of Title IX, CA Code of Regulations, Chap. 11, Article 4 Section 1810.410, (b). BHS policy states that:

1. BHS shall maintain a Cultural Competence Committee that has representation from management staff, direct services staff, consumer/family members, community members and representatives of unserved/underserved populations from the community.
2. The Cultural Competence Committee shall meet regularly (monthly) to review BHS' adherence to the BHS Cultural Competency Plan by reviewing goals and objectives and make appropriate recommendations to BHS Administration regarding management and service provision as it relates to cultural and linguistic services and health equity.
3. The Cultural Competence Committee shall elicit, suggest, review, monitor and support strategies to increase penetration and retention rates for identified community groups.

4. The Cultural Competence Committee will collaborate with the MHSA Consortium and organizations representing various groups within the community.

The MHSA Consortium meets monthly to discuss community-wide behavioral health services in a framework of cultural diversity. Many meetings include presentations on services for diverse racial and ethnic communities and include agenda items focused on cultural competence and language proficiency. The MHSA Consortium has become a vehicle through which the Cultural Competency Committee informs stakeholders about BHS Cultural Competency efforts.

FY 2023-2024 Accomplishments: The Cultural Competency Committee achieved significant successes with the development of two major projects:

- Continuous engagement of SUD services staff at the Cultural Competency Committee
- Maintained direct partnership with QAPI Council to inform QAPI Stakeholders of continued monitoring and discussion of BHS Cultural Competency Plan Requirements
- Hired para-professional staff to oversee cultural competency committee, cultural competency plan requirements, and additional health equity needs of BHS

FY 2024-2025 Strategies:

- Host a minimum of eight meetings with representation from management staff, direct services staff, consumers, community members and representatives of culture from the community, by June 30, 2025.
- Recruit consumer representation from SUD Services and community representative to the Cultural Competency Committee, June 30, 2025
- Collaborate with the Consortium by disseminating Cultural Competency information and strategies at five Consortium meetings by June 30, 2025.

Criterion 5: County Culturally Competent Training Activities

(CLAS Standard 4)

FY 2023-2024 Accomplishments:

- BHS continues to make it mandatory to take three cultural competency training courses offered throughout the county and department.
    a. Diversity and Inclusion (Every 5 Years)
    b. Improving Cultural Competency for Behavioral Health Professionals (Annually)
    c. Limited English Proficiency (for all staff with client contact)
- In addition to the above aforementioned mandatory trainings, BHS offered:
    a. UCLA – LGBT clients in the SUD system of Care
    b. Valuing Different Perspectives – (Managers)
    c. Cultural Differences – (Managers)
    d. LGBTQ Youth – Clinical Strategies to support Sexual Orientation and Gender Identity
    e. Racial and Generational Trauma Recovery
- Cultural Competency presentations via QAPI and the MHSA Consortium

FY 2024-2025 Strategies:

- Additional trainings scheduled for this fiscal year include:
    - Multicultural Awareness & Diversity: Powerful Strategies to Advance Client Rapport and Cultural Competence
    - Social Justice, Ethics and Multicultural Issues for Mental Health Professionals
- The Training Coordinator along with the Cultural Competency Committee will investigate additional health equity training to expand and enhance the cadre of cultural competency training available at

BHS.

- **Make Mandatory Training**: The Impact of Immigration on SMI in Undocumented Latinx Population by January 30, 2025

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

(CLAS Standard 7)

FY 2023-24 Accomplishments:

- BHS reconfigured data collection technique by revamping the Staff Ethnicity and Language report through a survey monkey process. BHS also included a SOGI data collection option to collect this population and will be reported in the next iteration of the Cultural Competency Plan

BHS monitors the development of a multicultural workforce via CalEQRO Data and BHS Utilization along with Staff Ethnicity and Language Reports (Volunteered Data). A new process was put in place to track the staff ethnicity and the primary language of staff members. The following data table provides a snapshot of volunteered data provided by staff at BHS to make a partial comparison. We received a total of 374 responses totaling less than 50% of our staff census. Efforts are underway to work with Management to increase the collection of this important data set of our BHS staff population. The table below compares proportionate BHS Employment Data to client data from CALEQRO MH and SUD Beneficiary Data (Attachment 4), and United States Census data. Data shows that BHS Hispanic staff are lower in proportion to Hispanic clients.

	BHS staff % (Volunteered Responses)	MH Medi-Cal Beneficiaries Eligible % (CALEQRO CY2022)	SUD Medi-Cal Beneficiaries Eligible% (CALEQRO CY-21)	County % (Census)
Caucasian/White	34%	15%	17%	33%
Hispanic	29%	47%	47%	41%
Asian/Pacific Islander	26%	15%	16%	14.5%
Black/African American	13%	9%	10%	7%
Native American	5%	.5%	1%	.5%
Other/Prefer Not To Say	13%	15	11%	3%
Total	100%	100%	100%	100%

FY2024-2025 Strategies:

- Committee will develop and updated Staff Ethnicity Language Report to include voluntary SOGI (Sexual Orientation/Gender Identify) and Consumer/Family Member status data points by October 31, 2024
- Administration will re-survey BHS Staff with updated Staff Ethnicity/Language Report by December 20, 2024
- Administration will work with management to increase participation of staff ethnicity and language report submissions to obtain a clearer picture of the BHS Multicultural workforce at BHS by March 30, 2025

Criterion 7: County System Language Capacity

(CLAS Standard 5,6,8)

FY 2023-2024 Accomplishments:

- BHS reconfigured data collection technique by revamping the Staff Ethnicity and Language report through a survey monkey process

As of the writing of this report, a new process was put in place to track the staff ethnicity and primary language of staff members. The following data table provides a snapshot of volunteered data provided by staff at BHS to make a partial comparison of staff to client ratio

Primary languages spoken by clients and staff	# of Clients	# of BHS Staff Providing Direct Services (2023-24)	Staff to client ratio
English	14,075	354	1:102
Spanish	1224	102	1:12
Cambodian	122	8	1:15
Vietnamese	73	8	1:9
Laotian	8	7	1:1
Hmong	24	10	1:2
Tagalog	3	28	1:
Arabic and Farsi	37	4	1:9
Chinese (Mandarin and Cantonese)	7	8	1:1
American Sign Language	2	2	1:1
Korean		1	n/a

FY 2024-2025 Strategies:

- Committee will develop and updated Staff Ethnicity Language Report to include voluntary SOGI (Sexual Orientation/Gender Identify) and Consumer/Family Member status data points by October 31, 2024
- Administration will re-survey BHS Staff with updated Staff Ethnicity/Language Report by December 20, 2024
- Administration will work with management to increase participation of staff ethnicity and language report submissions to obtain a clearer picture of the BHS Multicultural workforce at BHS by March 30, 2025

Criterion 8: County Adaptation of Services

(CLAS Standard 12)

2023-24 Accomplishments:

- Contracts Management included monitoring contract providers for completion of online Cultural Competency Training.

BHS documented the necessity of cultural and linguistic competency in its contractual requirements (Attachment 5) and monitors contractors to ensure that personnel training is implemented accordingly. BHS has additionally included the requirement for cultural and linguistic competence in each of the project descriptions in its Requests for Proposals (RFP).

FY 2024-2025 Strategies:

- Quarterly reviews of contractor provider services include monitoring the provision of staff training in the areas of cultural and linguistic competency. (Attachment 6)

Attachments:

1. BHS MH QAPI Work Plan
2. BHS SUD QAPI Work Plan
3. 23-24 MHSA Annual Update to the Three Year Mental Health Services Act Program and Expenditure Plan, pages 8-17
4. San Joaquin County-specific Data provided by CALEQRO for MH and SUD
5. Boilerplate Contract Language – Cultural Competency
6. Contract Monitoring Tool – Item 6b/6d

Attachment 1: BHS MH QAPI Work Plan (Sections 5.A.1-5.A.3)

5.Cultual Competency											
5.A. Cultural Competency-The MHP incorporates cultural competency principles in the systems of care		Goals	Target	FY 22/23	FY 23/24	Status (Met/Not Met)	Data Source	Frequency of Review	Action Plan	Evaluation	Person Responsible
5.A.1	The MHP identifies strategies and resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	Create workforce that is representative of the population.	By 7/30/2024, BHS will increase the Hispanic/Latino proportion of staff to 35%.	Unable to Retrieve Data	34%	So Close, But Not Met	Human Resources	Quarterly	Enact recruitments for language-specific positions. Assess opportunities for recruitment in cultural arenas of the community and implement two strategies. strategies – partner with recruitment & retention committee (once committee is re-established)	BHS Continues to increase proportion of Hispanic/latino staff to meet the needs of the community. Our CCC plan highlights our most recent Hispanic staff data at 34% - MH Medi-cal Beneficiaries is 47% - Recommendation to keep the 35% goal for upcoming year.	Angelo Balmaceda
5.A.2	The MHP implements strategies and uses resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	Improve cultural competency of staff.	By 10/15/2024, BHS will develop an action plan to address the findings of the CBMCS Survey.	N/A	Still in Process and will update by 10/2024		I.S. Survey	Quarterly	Cultural Competency Committee is in the process of updating the Cultural Competency Plan and will develop new strategies to uses resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	Still in process for completion by 10/24	Angelo Balmaceda
5.A.3	The MHP identifies factors contributing to low Hispanic/Latino penetration rates.	Improve Hispanic/Latino penetration rates.	By 7/30/2024, BHS will identify factors contributing to low Hispanic/Latino penetration rates.	N/A	Latino/X PIP has been developed, strategies defined, and currently implementing strategies to increase Hispanic/Latino Penetration Rates	MET	AdHoc Subcommittee	Quarterly	Develop Ad Hoc Subcommittee to perform a root cause analysis to identify factors contributing to low Hispanic/Latino penetration rates. Initiate cultural competent quality improvement activities to address health equity.	Document finalizing the LatinX & Spanish-speaking Access, Engagement and Equity PIP – Proposed Strategies/Interventions Latinx PIP Proposal_032524.docx - Microsoft Word Online (live.com)	Angelo Balmaceda

Attachment 2: BHS SUD QAPI Work Plan (Sections 2C, 3A, 5A-5C)

Initiative 2: Ensure Access to Care								
#	Target	FY 22/23	FY 23/24	Status (Met/Not Met)	Data Source	FY23/24 Action Plan	Evaluation	Person Responsible
2.c	By 7/30/2024 increase penetration rates of Hispanic beneficiaries to 0.82%	Data not yet available		Not Met for 2022 data,	Penetration data	1. The Plan will continue implement recruitment strategies to increase the number of Spanish-speaking staff to improve access for monolingual Spanish-speaking clients. 2. The Plan will provide staff training on use of Language Line - including additional training on using Language Line for telephone contacts. 3. The Plan will provide advertising and resources in Spanish for distribution in prominent areas. 4. The Plan will monitor the penetration rate on a bi- monthly basis 5. The Plan will monitor the strategies through the Timeliness App and assess referral source.	1. Current EQRO Claims Data for CY 2022 (latest data) is represented at: .72% 2. Representative from SUD (Joaquin Vero, program manager) currently sits as a valued member of the MH PIP – Latino/X Committee to guide our strategies and priorities to increase Hispanic beneficiaries across the MH system. 3. MHSA Plan will RFP stigma reduction campaign (resources in Spanish) across county locations and will be focused on culturally and linguistically appropriate materials to engage our Latino/X community.	Cultural Competence Committee/Eric

Initiative 3: Improve quality of service delivery and beneficiary satisfaction								
#	Target	FY 22/23	FY 23/24	Status (Met/Not Met)	Data Source	FY23/24 Action Plan	Evaluation	Person Responsible
3.a	By 7/30/2024 increase consumer/family/advocate member participation in Cultural Competency Committee, Consumer Advisory Council, and QAPI Council by at least two members each.	CCC -0 QAPI - 0 CAC -0	CCC- 2 CAC -2 QAPI - ?	MET	Meeting minutes and sign in sheets	1. The Plan will meet with the Consumer Advisory Committee and develop a strategies to increase participation in the Cultural Compliance Committee and Quality Assessment and Improvement Council. 2. Recruitment strategies for family members who attend conferences. CAC flyers.	Cultural Competency Committee and Consumer Advisory Council has successfully fulfilled 2 slots each for consumer/family member/advocate members.	SUD Coordinator Cultural Competency Committee

Initiative 5: Staff Development and Cultural Competence								
#	Target	FY 22/23	FY 23/24	Status (Met/Not Met)	Data Source	FY23/24 Action Plan	Evaluation	Person Responsible
5a	By 7/30/2024 increase number of Spanish-speaking direct-service staff from one FTE to three FTEs.	8	5	MET	NACT	1. The Plan will review findings in QAPI Council and Cultural Competency Committee to establish recruitment objectives for fiscal year.	- Successfully increased Spanish Speaking direct service staff from one FTE to five FTE (per Eric Shingu)	Ethnic Services Manager
5b	By 7/30/2024 100% of staff will be trained in Cultural Competency and new staff will complete it within 12 months of hire.	100%		Partially Met	TPS	1. The Plan's SUD managers and supervisors will track required staff trainings - including Cultural Competence - and document staff completion. 2. The Plan will monitor the contractors on a monthly basis to ensure trainings are completed.		SUD Coordinator SUD Managers
5c	By 7/30/2024 Cultural Competency Committee will add four new members.	1	4	MET	Cultural Competence Committee meeting minutes and sign in sheets	1. The Plan will actively promote Cultural Competence Committee, providing increased opportunity for staff participation, and posting information in public areas soliciting consumer/family member participation.	- Cultural Comp Committee added a new admin lead and added 3 additional members on the roster – for a total of 4	Ethnic Services Manager

Community Program Planning and Stakeholder Process

Community Program Planning Process

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

Quantitative Analysis (Program period July 2022 – June 2023):

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

Community Discussions:

- MHSA Showcase
  - October 5, 2023 – MHSA Programs - Public Showcase, Stakeholder and Community Engagement Survey

- Behavioral Health Advisory Board (BHAB)
  - September 20, 2023
    - Announcement to BHAB of Planning Dates for the 2024-2025 MHSA Annual Update – Feed back from BHAB on areas in San Joaquin County to focus

- Public Forums – Community Planning & Stakeholder Feedback Presentations
  - October 24, 2023 – MHSA Community Planning – Lodi, CA (Lodi Public Library)
  - October 25, 2023 – MHSA Community Planning – Tracy, CA (Tracy Community Center)
  - October 26, 2023 – MHSA Community Planning – Manteca, CA (Manteca Library)
  - October 31, 2023 – MHSA Community Planning (General Community Zoom Call)
  - November 1, 2023 – MHSA Consortium (Zoom Meeting)
  - November 2,2023 – MHSA Community Planning – Stockton, CA (Catholic Charities/Spanish Session)
  - November 7, 2023 – MHSA Community Planning (Spanish Session) – Stockton, CA - El Concilio (Zoom Meeting)
  - November 8, 2023 – MHSA Community Planning (General Community Zoom Call)
  - November 14, 2023 – MHSA Community Planning – Stockton, CA (South) – Kennedy Community Center
  - November 15, 2023 – MHSA Community Planning - BHS Behavioral Health Advisory Board

- November 16, 2023 – MHSA Community Planning - Stockton, CA (East) – Garden Acres Community Center
- December 12, 2023 – Community Stakeholder Feedback Presentation - MHSA Consortium (Zoom Meeting)
- December 20, 2023 – Community Stakeholder Feedback Presentation - BHS Behavioral Health Board
- December 22, 2023 – Community Stakeholder Feedback Presentation - Consumer Advisory Council
- January 9, 2024 – Community Stakeholder Feedback Presentation - Cultural Competency Committee
- January 18, 2024 – Community Stakeholder Feedback Presentation - BHS Leadership (BHS Managers Meeting)

Targeted Discussions:

- Consumer Focus Groups
  - October 17, 2023 - Co-hosted by the Martin Gipson Socialization Center Co-hosted by the Wellness Center
  - October 19, , 2023 - Co-hosted by the Wellness Center Co-hosted by the Martin Gipson Socialization Center

Consumer and Stakeholder Surveys:

- 2023-24 MHSA Consumer and Stakeholder Surveys

Assessment of Mental Health Needs

County Demographics and County's Underserved/Unserved Populations

San Joaquin County, located in California's Central Valley, is a vibrant community with just over 783,000 individuals, with a diverse population. English is spoken by more than half of all residents, just over 180,000 residents are estimated to speak Spanish as their first language. Tagalog, Chinese, Khmer, and Vietnamese are also spoken by large components of the population. 41% of the county population is predominantly centrally situated in Stockton, the largest city in the county. Cities like Lodi, Tracy, and Manteca make up an additional 31% of the county population, while the remaining smaller cities of Ripon, Lathrop, and Escalon make up 7% of the county population. Unincorporated areas of San Joaquin County make up 21% of the remaining balance. San Joaquin County's gender ratio is 99 men to 100 women (99:100) or .99, equal to the California State average of 99:100.

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

Age Distribution	Percent of Population
0-19	29.9%
20-54	46.1%
55-64	11.2%
65 and over	12.8%

*Source: San Joaquin Council of Governments

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

Population Served

BHS provides mental health services and substance use disorder treatment to over 17,500 consumers annually. In general, program access is reflective of the diverse population of San Joaquin County, with a roughly even division of male and female clients. An analysis of services provided in 2021-22 demonstrates the program participation compared to the county population.

Mental Health Services Provided in 2022-23

Services Provided by Age	Number of Clients*	Percent of Clients
Children	3,449	20%
Transitional Age Youth	3,088	18%
Adults	9,139	52%
Older Adults	1,837	10%
Total	**17,591**	**100%**

*Source: BHS Client Services Data

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

Services Provided by Race/Ethnicity	County Population by Race/Ethnicity**	Percent of County Population	Clients Served*	Percent of Clients
White	223,036	28%	5,511	31%
Latino	337,646	43%	4,453	25%
African American	55,683	7%	2,690	15%
Asian	135,117	17%	1,297	7%
Multi-Race/Other	28,383	4%	3,050	17%
Native American	3,298	.4%	452	3%
Pacific Islander	5,116	.6%	60	0.3%
Total	**788,279**	**100%**	**17,513**	**100%**

*Source: BHS Client Services Data
**Source: https://www.dof.ca.gov/Forecasting/Demographics/Projections

The diversity of clients served is similar to the distribution in prior years. African Americans are disproportionately over-represented amongst consumers compared to their proportion of the general population (15% of participants, though comprising 7% of the population of the County). Native Americans are also over-represented within the service continuum (3% of clients are Native American). Latinos are enrolled in mental health treatment services at rates lower than expected, compared to their proportion of the general population (25% of clients versus 43% of the population). Asian clients are also underrepresented by 10%.

Services Provided by City	County Population by City**	Percent of County Population	Clients Served*	Percent of Clients
Stockton	319,731	41%	10,926	62%
Lodi	66,293	8%	1,381	8%
Tracy	95,615	12%	1,292	7%
Manteca	88,803	11%	1,114	5%
Lathrop	35,080	5%	333	2%
Ripon	15,769	2%	153	1%
Escalon	7,264	1%	126	1%
Balance of County	157590	20%	3,188	14%
Total	**786145**	**100%**	**17,513**	**100%**

*Source: BHS Client Services Data
**Source: Estimates-E1 | Department of Finance (ca.gov)

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

Stakeholder Involvement:

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

Discussion Group Input and Stakeholder Feedback

San Joaquin County provided two outlets of community planning and stakeholder engagement; in person meetings and zoom meetings. The hybrid model allowed for a robust opportunity to engage with community and stakeholder members throughout the County.

Community Program Planning for 2023-24:

Behavioral Health Advisory Board (BHAB) Agenda Items

At the September 2023 Behavioral Health Board meeting, the MHSA Coordinator announced that the MHSA Plan's community program planning process would begin in October 2023. He shared the methodology and timeline for the annual planning process, which informed the Plan's 2024-2025 Annual Update to the 2023-26 Program and Expenditure Plan. The BHAB also provided recommendations on geographic areas to focus within San Joaquin County for the community program planning process. Promotional flyers with details for both consumer and community discussion groups were distributed to the Board electronically.

Community Stakeholder and Consumer Discussion Groups

There were 18 community discussion groups convened between October 2023 – January 2024, two of which specifically targeted adult consumers and family members. Two of the 18 community discussion groups were held in a Behavioral Health Advisory Board meeting so stakeholders could present their input directly to members of the Board.

All community discussion groups began with a training and overview of the MHSA, a summary of its five components, and the intent and purpose of the different components including:

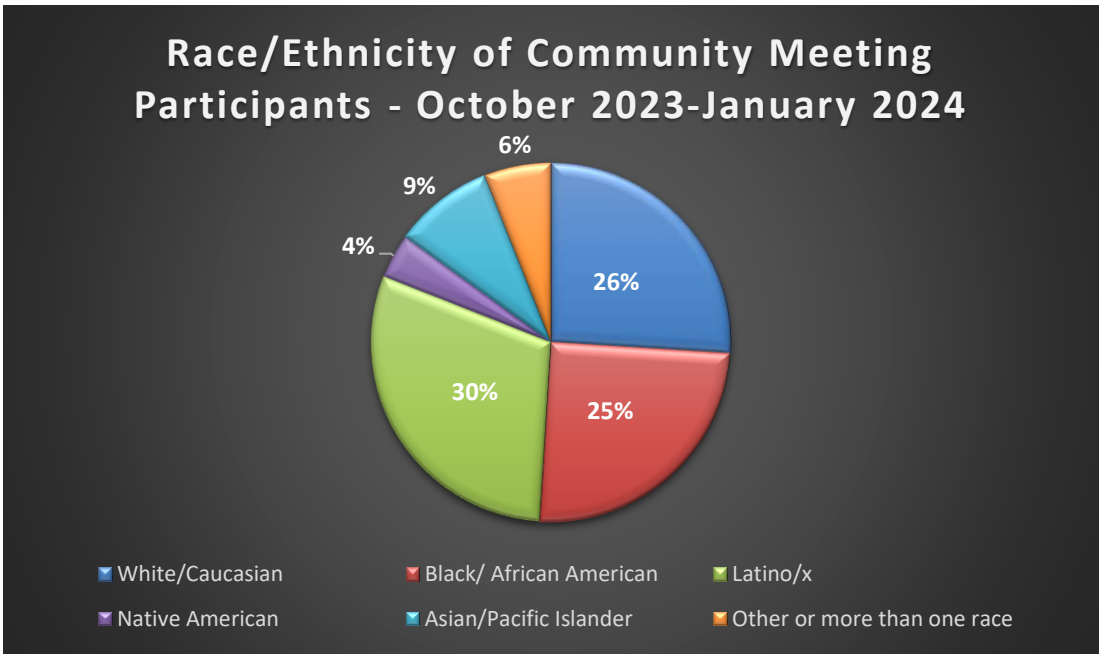
- Funding priorities
- Populations of need
- Regulations guiding the use of MHSA funding.

Stakeholder participation was tracked through Sign-In Sheets, zoom chat and completed anonymous demographic Survey Monkey links. Stakeholder participants were demographically diverse and included representatives of unserved and underserved populations, according to the surveys. The community discussion and focus groups had participation by over 200 individuals, nearly 90% of whom self-identified as a consumer of public mental health services or as a family member of a consumer. The majority of participants identified as adults ages 26-59, 14% were older adults over 59 years of age, and 16% were transitional age youth ages 18-25.

Community discussion groups were also attended by individuals representing the following groups:

- Consumer Advocates/Family Members
- Substance use disorder treatment providers
- Community-based organizations (Behavioral Health & Non Behavioral Health Providers)
- Children and family services
- Law Enforcement
- Veteran's services
- Senior services
- Housing providers
- Hospital & Health care providers
- Public Health
- County mental health and substance use disorder department staff

A diverse range of individuals from racial and ethnic backgrounds attended the community stakeholder discussions and focus groups. Similar to the County's demographic breakdown and those BHS provides services to, no one racial or ethnic group comprised a majority of participants. Latino/x and African American participants were moderately represented in meetings to express immediate needs in the community, compared to the County population.



Survey Input and Stakeholder Feedback

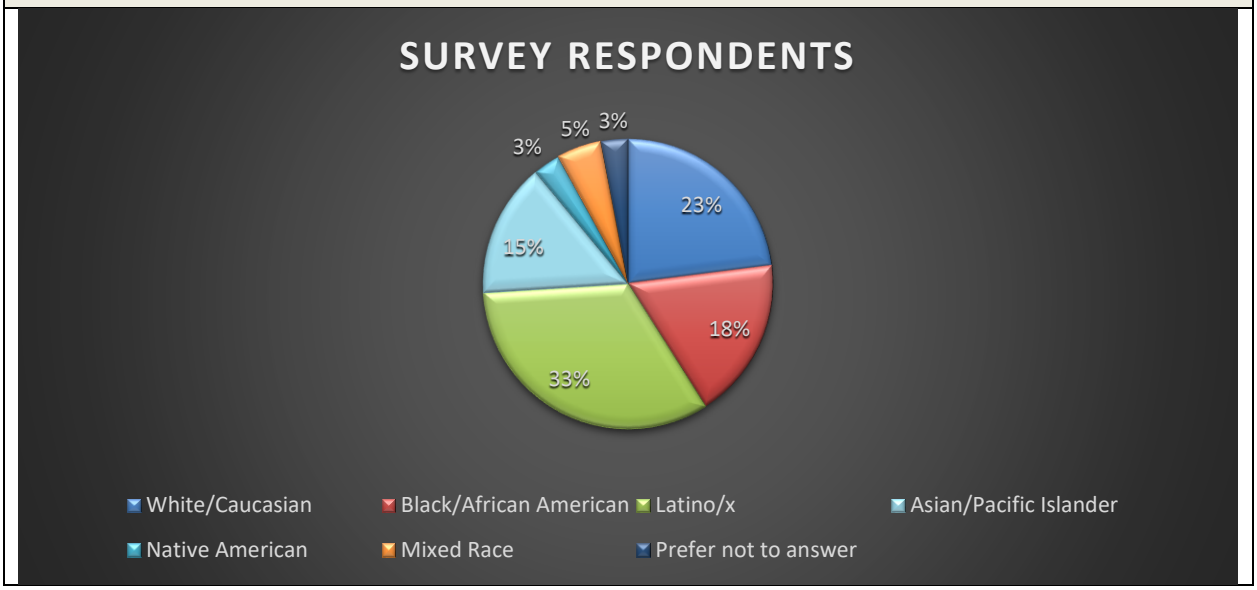
In October 2023 and January of 2024, BHS distributed electronic and paper surveys to consumers, family members, and stakeholders to learn more about the perspectives, needs, and lives of clients served through mental health programs. Surveys were completed online and in person with multiple-choice answers and responses were tallied through Survey Monkey reports. There were 300 surveys completed. Survey instruments can be reviewed in the Appendix.

BHS consumers and their family members reported mid to high levels of satisfaction with the services provided to address mental health and/or substance use disorders, with 92% of respondents reporting that they would recommend BHS services to others. According to respondents, BHS Informational materials such as flyers, brochures and website need to be updated. A large majority of respondents reported that the BHS Lobby and reception areas are friendly and welcoming from a cultural and linguistic perspective. Respondents agreed strongly with statements regarding staff courtesy and professionalism, respect for cultural heritage, and their capacity to explain things in an easily understood manner.

In the interest of learning more about individuals who use mental health services, survey respondents were asked to anonymously self-report additional demographic information. The objective was to have a more nuanced understanding of the clients and respondents from the data collected in standardized BHS intake forms. The respondent data revealed a deeper understanding of client demographics, criminal justice experiences, and their living situations that was previously unknown.

Survey respondents were diverse and identified as: White/Caucasian (23%), Latino/x (33%), African American (18%), Asian/Pacific Islander (16%), Native American (3%), and Mixed Race (4%)

Self-Reported Race and Ethnicity of Stakeholder Survey Respondents
MHSA 2023-24 Consumer and Stakeholder Surveys



Self-Reported Age/Gender of Stakeholder Survey Respondents

Age Range	Percent
Under 18	.5%
18-25	11%
26-59	76%
60 and over	10%
Prefer not to say	2.5%

Gender	Percent
Male	30%
Female	66%
Transgender	1%
Non-Binary	0%
Prefer not to say	3%

The 300 respondents surveyed represent the broad diversity of stakeholders in the community and consumers served by BHS. 32% of respondents identify as someone who is receiving, or who needs, mental health treatment services. More than half of respondents have children, with 53% describing themselves as parents. Consistent with the general population, 8% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQ). Nearly 17% of respondents identified with having a physical or developmental disability. Few are military veterans, with 5% reporting that they have served in the US Armed Forces. 10% of consumers reported experiencing homelessness more than four times or being homeless for at least a year; and 18% of respondents reported having been arrested or detained by the police.

Community Mental Health Issues

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

Strengthening services and supports for children, youth and their families remains a major concern in San Joaquin County Stakeholders continue to assert that more needs to be done to support and strengthen families, particularly those where risk factors for mental illness are present. In several of the Community Discussion and Focus groups, stakeholders discussed the importance of prevention and earlier interventions, and education for children and families with expansion of services for PEI Services for skill building for parents and guardians.

- Parental involvement – Bridge between school, caregiver capacity, family stressors, integration of home and case management
- Reduce Stigma around mental health through after school programs for parent nights – programming for MH Prevention (BEYOND THE BELL)
- Needs to address generational and cultural gap between parents and children around mental health diagnosis.
- Stakeholders expressed a need for education and training for all family/caregivers to recognize signs and symptoms of mental health concerns and possibly expanding MH Services in afterschool programs.

Recommendations to Strengthen Services for Children and Youth:

- Provide Youth Mental Health First Aid Training for the community and schools.
- Provide Family Services for African American, Asian/Pacific Islander and Latino Community to educate parents on signs and symptoms of mental illness and stigma reduction with an emphasis on cultural consideration.
- Provide funding for older generation guardians and caregivers skill building programs.
- Fully support California Youth Behavioral Health Initiative (CYBHI) to enhance school based intervention services for local schools.

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

Stakeholders expressed the most concern for transition age youth (TAY) who have aged out of the foster care system, are college-age, or are from communities that are historically unserved or underserved by mental health services. Aside from a few specialty treatment programs, most interventions target either children and youth, or adults. Despite these gaps, stakeholders remain optimistic that current resources can be leveraged in a better way to serve transitional age youth.

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

Recommendations to Strengthen Services for Transition Age Youth

- Expand Mentoring for Transitional Age Youth PEI Project to include community culturally based providers to meet the needs of the underserved African American and Latino Youth in San Joaquin County
- Provide workforce development and training opportunities through community providers to build vocational opportunities for Transitional Age Youth
- Develop programming with Community Based Organizations to enhance Access and linkage efforts with focus on vulnerable communities that represent the TAY Population.
- Expand existing Mentoring for Transitional Aged Youth program with focus on trauma informed care practice and exploring the use of culturally rooted healing practices for TAY Population

Key Issues for Adults

Consumers and stakeholders discussed the challenges of being homeless while recovering from a mental illness, and the need to develop more housing for people with mental illnesses. Consumers and stakeholders expressed the lack of Mental health Information in public and community settings. Peers continue to be an integral part of the collaborative team approach for treatment teams.

- Individuals with mental illnesses, and co-occurring disorders that are homeless lack wrap around services and specialized housing case management.
- Housing options continue to be scarce for adults. Homeless individuals need more outreach/engagement and a clear pathway to housing options with intensive treatment for MH and SUD Challenges.
- Promoting MH Services around the county is important in educating the public on MH and SUD services.
- Lack of groups and group therapy on main campus for adults.

Recommendations to Strengthen Services for Adults

- BHS should continue to strengthen the housing continuum for people with serious mental illnesses by expanding opportunities for housing options.
- BHS should promote and MH Services and Warm Line number in all public communities (libraries, city hall, county buildings) – focused on culturally appropriate and community integrated messaging.
- BHS should tap into the public libraries and local community centers throughout the County to educate community on MH Services
- BHS should utilize peer specialists to enhance treatment and support options further supporting recovery efforts for consumers and family members.
- BHS should expand group and group therapy throughout several locations outside of the main campus to provide group services readily available to the community.
- BHS should consider utilizing community centers to provide community driven/culturally appropriate education for communities of color, LGBTQIA, and Asian communities – exploring opportunities to enhance and develop support groups throughout the county.

Key Issues for Older Adults

Older adults with mild to moderate mental health concerns remain at-risk for untreated depression and suicide ideation. More articulation is needed with senior and older adult service providers to offer interventions for older adults that have escalating behavioral health challenges. More public information and education about the risk of suicide in adults and older adults is needed; particularly focusing on adult men who are at the highest risk for suicide in San Joaquin County. Finally, stakeholders identified the biggest risk among older adults living independently as social isolation, especially in light of the COVID-19 Pandemic. Stakeholders encouraged more behavioral health services co-located at county community centers that provide senior activities, services, and support throughout the County.

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

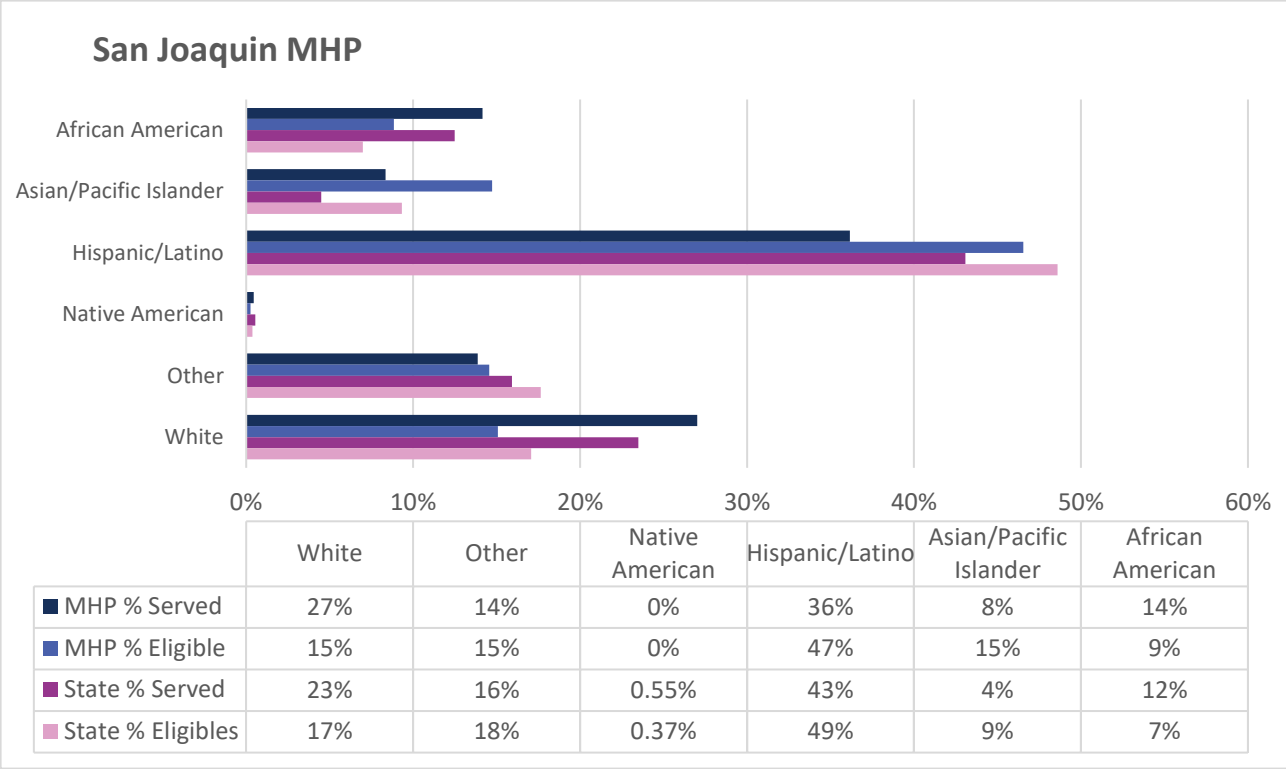
Recommendations to Strengthen Services for Older Adults:

- BHS Older Adult Services should provide meaningful alternatives such as a “day program” for daily living that combats depression and isolation including more socialization activities and more activities that prevent memory deterioration or loss of cognitive functioning.
- Strengthen newly developed Prevention & Early Intervention for Older Adults by providing presentation in the community on the vital prevention service for the older adult population.
- Broaden suicide prevention efforts to target the older adult community. Include targeted prevention information for middle age and older adult men. Address handgun and firearm safety when living with loved ones experiencing depression.

Attachment 4: San Joaquin County Specific Data provided by CALEQRO for MH and SUD

CALEQRO PERFORMANCE MEASURES CY 22 – SAN JOAQUIN MHP

Table 4: MHP Beneficiaries Served by Race/Ethnicity vs State CY 2022

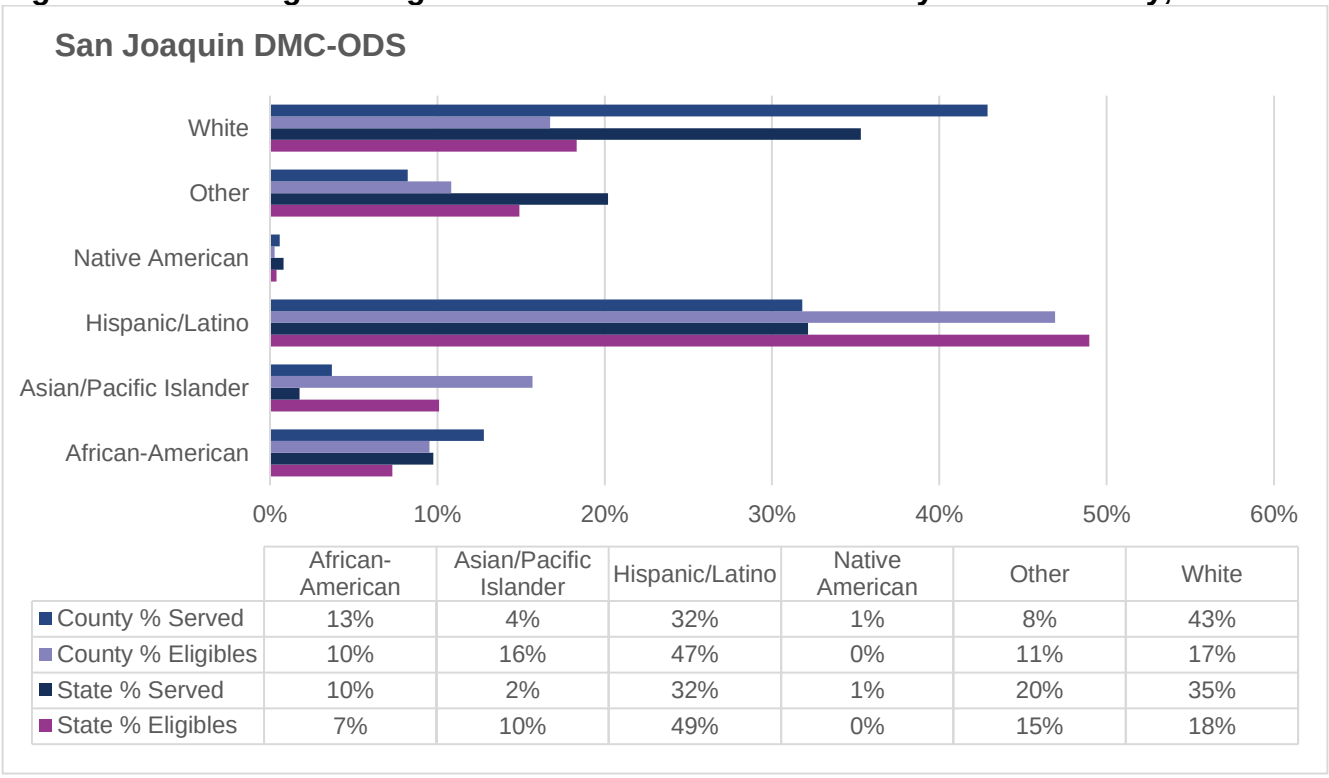


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	27%	14%	0%	36%	8%	14%
MHP % Eligible	15%	15%	0%	47%	15%	9%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

Percentage of Eligibles and Clients Served by Race/Ethnicity, CY 21 (SUD)

Table 1: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Race/Ethnicity, CY 2021

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2021



	African-American	Asian/Pacific Islander	Hispanic/Latino	Native American	Other	White
County % Served	13%	4%	32%	1%	8%	43%
County % Eligibles	10%	16%	47%	0%	11%	17%
State % Served	10%	2%	32%	1%	20%	35%
State % Eligibles	7%	10%	49%	0%	15%	18%

15. Cultural and Linguistic Proficiency:

a. To ensure equal access to quality care by diverse populations, CONTRACTOR shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards.

b. When the consumer served by CONTRACTOR is a non-English or limited-English speaking person, CONTRACTOR shall take all steps necessary to develop and maintain an appropriate capability for communicating in that consumer's primary or preferred language to ensure full and effective communication between the consumer and CONTRACTOR staff. CONTRACTOR shall provide immediate translation to non-English or limited-English speaking consumers whose conditions are such that failure to immediately translate would risk serious impairment. CONTRACTOR shall provide notices in prominent places in the facility of the availability of free translation in necessary other languages.

c. CONTRACTOR shall make available forms, documents and brochures in the San Joaquin County threshold languages of English and Spanish to reflect the cultural needs of the community~~.~~

d. CONTRACTOR is responsible for providing culturally and linguistically appropriate services. Services are to be provided by professional and paraprofessional staff with similar cultural and linguistic backgrounds to the consumers being served.

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

MHSA Three Year Prevention and Early Intervention Evaluation Report

San Joaquin County Behavioral Health Services

Fiscal Years 2021/22, 2022/23, 2023/24

Table of Contents

Introduction

In October 2015 the State of California Office of Administrative Law (OAL) approved new Prevention and Early Intervention (PEI) regulations[1,2]. Under these regulations, San Joaquin County (SJCBHS) must submit an annual Prevention and Early Intervention Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC). This report has been compiled to meet that requirement, including both annual data as well as the three-year evaluation component.

SJCBHS's PEI Projects are classified into specific Program and Strategy categories per State regulation. Each of these Program and Strategy categories has a specific set of reporting requirements. Table 1 illustrates the distribution of SJCBHS's PEI Projects into these seven Program and Strategy categories:

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

This report includes a brief description of each SJCBHS Project along with the required information for each Program and Strategy as specified in Section 3560.010 of the CCR. In addition, this report includes evaluation findings for three fiscal years: 2021/22, 2022/23 2023/24 per Section 3560.020 of the CCR.

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

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

Table 1. Program and Strategy Categories

San Joaquin County PEI Projects	Program Category	Required Strategies		
		Help Create Access & Linkage to Treatment	Improve Timely Access to Services for Underserved Populations	Use Strategies that are Non-Stigmatizing and Non-Discriminatory
Skill-Building for Parents and Guardians	Prevention	X	X	X
Mentoring for Transitional Age Youth (TAY)	Prevention	X	X	X
Coping and Resilience Education Services (CARES)	Prevention	X	X	X
Prevention Services for Children 0-5 and Caregivers (0 to 5)	Prevention	X	X	X
School Based Interventions	Prevention	X	X	X
Early Intervention to Treat Psychosis (TEIR)	Early Intervention	X	X	X
Community Trauma Services for Adults	Early Intervention	X	X	X
Community Trainings - Outreach	Outreach for Increasing Recognition	X	X	X
Community Trainings - Stigma	Stigma & Discrimination Reduction	X	X	
Suicide Prevention Project	Suicide Prevention	X	X	X
Whole Person Care	Access and Linkage to Treatment		X	X

Key Findings

The following is a summary of key findings.

Prevention Projects

Skill-Building for Parents and Guardians: Three community-based organizations offered 129 courses, served 1,855 individuals, and graduated 1,000 parents and guardians from evidence-based parenting classes during FY 2023/24. Surveys were conducted at the beginning and end of the courses during the three-year evaluation period. These revealed that across the programs, 83% of graduating participants had gained knowledge, skills, behaviors, or improved attitudes about parenting. With three distinct evaluation measures, the three-year evaluation analysis found the following highlights:

- Parent Cafes saw 96% of participants show improvements in *parental resiliency*
- The Nurturing Parenting Program saw the highest gains in *beliefs about corporeal punishment* (90%)
- Positive Parenting Program demonstrated shifts in *setting self-efficacy* (81%)

Transitional Age Youth: In FY 2023/24, two community-based organizations provided evidence-based mentoring to 623 youth aged 16-25 with emotional and behavioral health difficulties. Project-wide, 58% of participants graduated (achieved at least one self-identified goal). A three-year evaluation analysis found the following:

- The most prevalent concerns among CAPC youth related to participation in community life (75% presented with actionable needs at intake). Among these participants, half (50%) showed improvement.
- The most prevalent issues faced by PREVAIL participants involved residential stability – roughly half of youth (51%) presented with actionable scores at intake. Among these participants, 41% showed improvement at discharge.

Coping and Resilience Education Services (CARES): BHS's Children and Youth Services (CYS) provided trauma screening and intensive evidence-based skill-building trainings to caregivers and children who had been exposed to trauma. The program served 296 children and 142 caregivers during the 2023/24 fiscal year. The three-year evaluation found that 84% of children experienced an overall increase in psychosocial functioning (i.e., reduction in PSC-35 score).

Prevention Services for Children 0-5 and Caregivers (0 to 5) : The 0 to 5 project served 20 children (and 29 of their caregivers) who were at risk of emerging mental health concerns or who had experienced or at risk for trauma or abuse. In this first year of programming, 16 of the 20 children received home visits (an average of 17 visits per child). Eight caregivers participated in an 11-session Parent Café**.**

School Based Interventions: In FY 2023/24, three community-based organizations provided prevention services to 573 students through partnerships with schools. Additionally, there were 118 prevention-oriented presentations targeting school personnel, and 13 presentations for parents/caregivers.

A three-year outcomes evaluation of students participating in the prevention services found 71% demonstrated improvement as a result of services. Program specific highlights:

- CAPC assessments showed that the most prevalent actionable need was around social functioning; 45% of students presented with actionable need at intake and 65% of those students demonstrated improvement in that area.
- The most prevalent need in the population served by Parents By Choice was Adjustment to Trauma; 28% of students presented with actionable need at intake and 60% of those students demonstrated improvement in that area.
- Students served at Sow A Seed presented with lower actionable needs at intake than the other two programs; the most pressing need was demonstrated with impulsivity—17% of students presented with actionable need at intake and 62% of those students demonstrated improvement in that area.

Early Intervention Projects

Early Intervention and Recovery (TEIR): Telecare provided an integrated set of promising practices intended to slow the progression of psychosis to 88 transitional age youth and their family members over the course of the 2023/24 fiscal year. During the three-year outcomes evaluation period, TEIR reported that 52 clients were discharged, with a total of 22 (42%) completing program objectives. Assessments were planned for regular intervals using the Scale of Prodromal Symptoms (SOPS). Of the 61 clients with assessments during the three-year evaluation period that could be compared to intake, 48 of the participants demonstrated favorable change (79%).

Community Trauma Services for Adults (Trauma Services): In FY 2023/24, three community-based organizations provided services to 272 adults who were referred for screening due to trauma history and traumatic stress symptoms. The three providers offered varying models of implementation, each with a distinct emphasis:

- Individual therapy –Child Abuse Prevention Council (CAPC)
- Screening and mental health referrals with rehabilitative services—El Concilio
- Case management and community referrals (Vietnamese Voluntary Foundation (Vivo)

Taken together, a total of 186 clients received therapy or rehabilitation services, with an average of 6.6 hours of service per client.

Providers used the Los Angeles Symptom Checklist (LASC) as a screening tool at intake and periodically during therapeutic services to evaluate ongoing progress. The outcome evaluation found general improvements in LASC scores across all three programs (statistically significant for CAPC and VIVO).

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

NAMI's Outreach for Increasing Recognition of Early Signs of Mental Illness program: During the 2023/24 fiscal year, San Joaquin County's chapter of National Alliance on Mental Illness delivered 15-hour NAMI Provider Education classes to 32 behavioral health providers considered potential responders. **NAMI's Stigma and Discrimination Reduction Program** provided In Our Own Voices presentations, Family to Family and Peer to Peer trainings to 209 participants. During the three-year outcome evaluation period, program surveys found that 78% of participants showed positive change in attitudes, knowledge and/or behaviors related to mental illness and seeking mental health services.

Suicide Prevention

Suicide Prevention Program: During fiscal year 2023/24, the Child Abuse Prevention Council (CAPC) facilitated a Yellow Ribbon Suicide Prevention Campaign in 15 high-risk high schools within the county, reaching 6,396 individuals. The program trained 564 school personnel and 325 youth "gatekeepers," and provided intensive SafeTalk training to 322 community members throughout the county. As a result of 298 individual depression screenings, the Suicide Prevention project referred 65 individuals to a higher level of mental health care.

The three-year evaluation found that, on average, 87% of Yellow Ribbon Campaign recipients demonstrated an increase in ability to recognize signs, symptoms and risks of suicide. A similar portion (85%) demonstrated greater knowledge about professional and peer resources available to help people at risk of suicide. Nearly all (98%) of SafeTalk participants were more knowledgeable about how to intervene as a result of their training.

Access and Linkage to Treatment

Whole Person Care: The Whole Person Care project provided case management to 107 individuals who are high utilizers of health care services and at high risk for untreated mental illness. On average, individuals received 11 service contacts and 14 hours of service. One hundred percent of clients (100%) who received services were engaged in discussions about referrals to other services. Over half (61%) of those with documented referrals to mental health care were known to have been linked to services (received screening, assessment, or treatment).

Access and Linkage to Treatment Strategy

All Prevention and Early Intervention Programs were required to implement an *Access and Linkage to Treatment Strategy*[3]. The following table provides a summary of fiscal year 2023/24 referrals made by PEI programs to mental health treatment; to County mental health providers in particular; and known linkages to treatment, as defined by having engaged in at least one service within sixty days. In total, there were 402 known referrals to mental health treatment, 339 of which were to SJCBHS administered programs, allowing them to be tracked. Records documented 180 linkages to treatment within 60 days of referral (53% of referrals).

	Referrals		Linkage	
	To MH treatment	To County MH treatment	To County MH treatment	Percent
Skill-Building for Parents and Guardians	37	26	5	19.2%
Mentoring for Transitional Age Youth (TAY)	69	67	17	25.4%
Coping and Resilience Education Services (CARES)	24	24	14	58.3%
Early Intervention to Treat Psychosis (TEIR)	5	5	1	20.0%
Community Trauma Services for Adults	153	150	106	70.7%
Suicide Prevention Project	65	18	7	38.9%
Whole Person Care	49	49	30	61.2%
Totals	402	339	180	53.1%

Timely Services to Underserved Populations

All Prevention and Early Intervention Programs were required to implement a strategy to *Improve Timely Services to Underserved Populations*[4]. Approved claims penetration rates indicate that in

[3] "Access and Linkage to Treatment" means connecting children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs

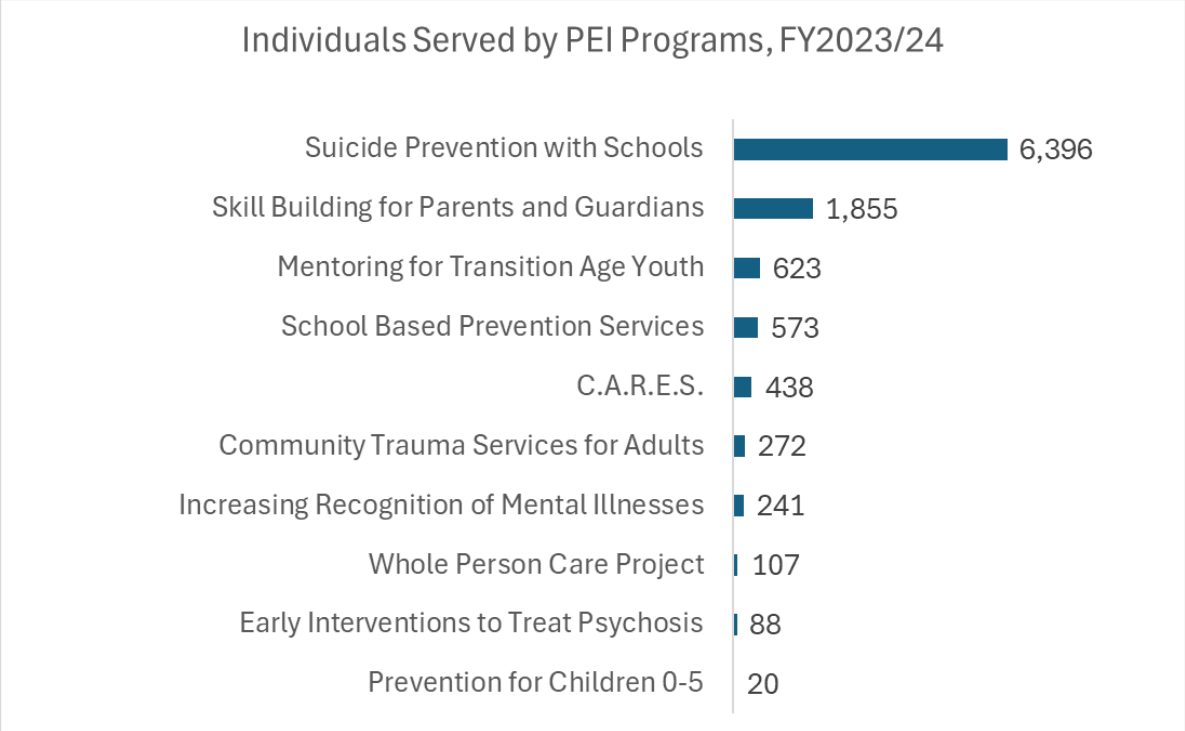
[4] "Improving Timely Access to Services for Underserved Populations" means to increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as

San Joaquin County Asian and Hispanic/Latino individuals have lower engagement with County-administered services than the overall County population. For this reason, SJBHS identified these two populations as the focus of the strategy for timely access to services.

State PEI regulations ask counties to report the number of referrals made to underserved populations, including referrals for mental health services and other PEI programs. Altogether, programs made 616 referrals to mental health treatment or other PEI programs. Just over half (52%, n=321) were for Hispanic individuals. Eleven percent (11%, n=69) of referral recipients identified as Asian.

Total number of individuals served

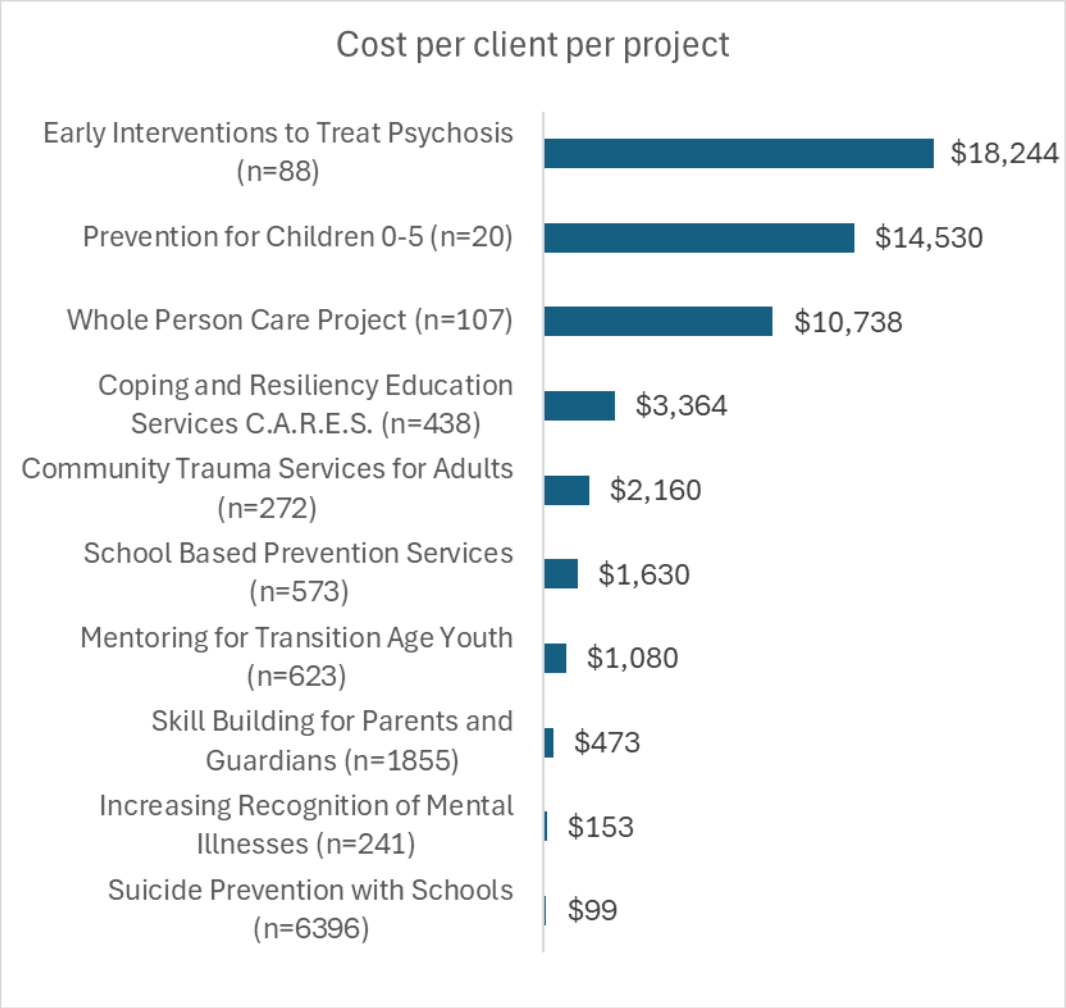
The following chart shows the total number of individuals served in each PEI program, for comparative purposes. This graph does not include data related to the intensity of services, thus, a program that serves many participants may provide low touch services and a program that serves relatively few individuals may provide more intensive services. The Suicide Prevention program, for example, provides both low-touch presentations and higher touch depression screenings, referrals, and support groups.



accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.

Cost per individual served

The following chart summarizes the FY 2023/34 cost per individual served in each of the projects. The programs are sorted by cost per client (program size is indicated in the parentheses) For example, TEIR may be the most intensive program, though it is one of the smallest, as measured in the number of clients served. Another thing to keep in mind is that this chart does not offset costs with Medi-Cal generated revenue.



Methods

Each PEI program is expected to keep records of the numbers of individuals served through the various components of programming and to document that information quarterly. When possible, clinical records and billing information were also used to compile the output figures in this report.

Demographic and referral summaries were compiled from demographic surveys and referral information that programs submitted via an online application (“PEI App”). Client IDs (or names

and birthdates) were used to match referrals to billed services. Any billed mental health service that transpired within sixty days of referral date was considered a linkage to service[5].

Following state and federal privacy laws, efforts have been made to exclude personally identifiable information. A supplemental file that contains all required data, including that which was excluded from this narrative report, will be submitted to the state under separate cover.

All projects identified as Prevention and/or Early Intervention include an outcome evaluation. Methodologies used to measure outcomes are described within the individual project sections of the report.

[5] This process of matching provider data to county mental health records could undercount linkages due to discrepancies in how client identifiers were recorded.

Prevention

Skill Building for Parents and Guardians

Project Description

Community-based organizations offer evidence-based parenting classes throughout San Joaquin County with the goal of reducing risk factors for mental illness and increasing protective factors associated with social connectedness, parent and family resilience, and knowledge of child development.

In FY 2023/24, the Skill Building for Parents and Guardian Project was delivered by three community-based providers:

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

Project Outputs

In the 2023/24 fiscal year, the Skill Building project served a total of 1,855 parents and guardians. The following table shows that 1,000 (54%) graduated. Participants attended an average of 5.6 sessions. The table below demonstrated s that CAPC provided services to the highest number of participants; Parents by Choice graduated the highest proportion of participants and had the smallest class size, Nurturing Parenting Program was the most intensive (i.e., average number of sessions attended per participant)

Skill-Building for Parents and Guardians				
Outputs FY 2023/24				
	CAPC-PC	CC-NPP	PBC - Triple P	Total Skill-building
Unduplicated parent/guardian participants	872	440	543	1,855
Duplicated parent/guardian participants (sign ins)	4,514	3,216	2,710	10,440
Number of unduplicated individuals who completed/graduated*	345	260	395	1,000
Percent who completed/graduated	40%	59%	73%	54%
Total number of groups delivered	49	20	60	129
Total number of sessions delivered	590	240	360	1,190

Average number of participants per group (group size)	17.8	22.0	9.1	14.4
Average number of sessions delivered per group (dosage offered)	12.0	12.0	6.0	9.2
Average number of sessions attended per participant (dosage received)	5.2	7.3	5.0	5.6

*Graduation definitions: For CC-NPP defined as completing at least 7 of the 10 course topics; For PBC defined as attending 80% of Triple P classes and completing Assessment Tool and a Client Satisfaction Survey; for CAPC defined as attending 50% or more of the 15 Parent Café sessions.

Outputs across three years

The table below shows key outputs across the past three years. The number of participants has steadily increased, as has the graduation rate and the average group size.

Skill-Building for Parents and Guardians				
Outputs: Three Year Comparison				
	FY21/22	FY22/23	FY23/24	Yearly Average
Unduplicated parent/guardian participants	1,561	1,617	1,855	1,678
Duplicated parent/guardian participants (sign ins)	n/a	8,217	10,440	9,329
Percent who completed/graduated*	48%	52%	54%	51%
Total number of groups delivered	132	130	129	130
Total number of sessions delivered	1,165	1,156	1,190	1,170
Average number of participants per group (group size)	11.8	12.4	14.4	12.9
Average number of sessions delivered per group (dosage offered)	8.8	8.9	9.2	9.0
Average number of sessions attended per participant (dosage received)	4.9	5.1	5.6	5.2

*Graduation definitions: For CC-NPP defined as completing at least 7 of the 10 course topics; For PBC defined as attending 80% of Triple P classes and completing Assessment Tool and a Client Satisfaction Survey; for CAPC defined as attending 50% or more of the 15 Parent Café sessions.

Demographics

Demographic forms were collected upon intake or initiation of services. Based on the information provided in the demographic forms collected[6] (n=1,870), the program population can broadly be described as adults between the ages of 26 and 59 (90%), and predominantly women (82%) . A majority (74%) who answered questions about their ethnic background identified themselves as

[6] This narrative description is based on the number of participants who provided a response to each demographic category. Between 21% and 38% of participants declined to answer any given demographic question.

Mexican/Mexican-American. Ten percent (7%) identified themselves as Black or African American.

Demographic tables from 2023/24 are included in the appendix to this report.

Participant Outcomes

Each of the three Skill Building for Parents and Guardians programs followed a different evidence-based curriculum and implemented an applicable validated instrument to measure progress towards intended outcomes[7].

Parent Cafés (Child Abuse Prevention Council)

Participants in CAPC Parent Cafés completed a Protective Factors survey during their first and last session of the program. The table below shows that they were able to collect pre and post surveys from 934 participants over the three-year reporting period. The largest gains were demonstrated in *parental resiliency* (96% showed improvement). Parent/child relationships proved to be the most challenging domain (still with high levels of success: 88% of participants showed improvement).

Skill-Building for Parents and Guardians *Program: Parent Cafés (Child Abuse Prevention Council)*		
Outcomes -Three Years FY 2021/22, 2022/23, 2023/24		
Instrument: Protective Factors Survey Frequency of administration: First and last session		
Unduplicated individuals served	2,492	
Number of graduates	934	37%
Number of graduates w/ matched pre/post	934	100%
Number who showed improvement in:		
Knowledge of parenting skills	891	95%
Access to support	852	91%
Parental resiliency	894	96%
Social connections	855	92%
Parent/child relationships	824	88%
Total participants who showed improvement*	**863**	92%

* Based on average number who showed improvement in each domain

Nurturing Parenting Program (Catholic Charities)

Participants in Catholic Charities Nurturing Parenting Program completed the Adult Adolescent Parenting Inventory (AAPI) during their first and last session of the program. The table below

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

shows that the program was able to collect matched inventories from 603 participants during the three-year reporting period. Highest gains were demonstrated in *beliefs in corporeal punishment*, showing improvement among 90% of participants. On average, 76% of participants showed improvement over the course of their engagement in the program.

Skill-Building for Parents and Guardians Program: Nurturing Parenting Program (Catholic Charities)		
Outcomes -Three Years FY 2021/22, 2022/23, 2023/24		
Instrument: Adult Adolescent Parenting Inventory (AAPI) Administered first and last session		
Unduplicated individuals served	1,169	
Number of graduates	604	52%
Number of graduates w/ matched pre/post	603	100%
Number who showed improvement in:		
Inappropriate expectations	439	73%
Low level of empathy	465	77%
Belief in corporeal punishment	540	90%
Reverse family roles	403	67%
Restricts power and independence	436	72%
Total participants who showed improvement*	**457**	**76%**

* Based on average number who showed improvement in each domain

Positive Parenting Program (Parents by Choice)

The Positive Parenting Program included three components: Triple P (general parenting classes), Parents of Teens, and Family Transitions (co-parenting). Each class used a different tool to measure progress towards outcomes. The largest class was Triple P, with 883 graduates. Eighty percent (80%) of Triple P participants showed improvement. Parents of Teens saw 72% of participants improve. The Family Transitions class was the smallest; six of the eight participants made improvements (75%).

Skill-Building for Parents and Guardians Program: Positive Parenting Program (Parents by Choice)		
Outcomes -Three Years FY 2021/22, 2022/23, 2023/24		
Unduplicated individuals served	1,372	
Number of graduates	1,059	77%
Regular Triple P classes *Instruments: Parenting Tasks Checklist (PTC) & Parenting Scale (PS)* Number of graduates w/ matched pre/post: 883		
	Showed improvement #	 %
Setting self-efficacy (PTC)	716	81%
Behavioral self-efficacy (PTC)	709	80%
Laxness and Overreactivity (PS)	695	79%
Total*	707	80%
Parents of Teen classes *Instruments: Conflict Behavior Questionnaire (CBQ) & Parenting Scale (PS)* Number of graduates w/ matched pre/post: 168		
	Showed improvement #	 %
Conflict behavior (CBQ)	122	73%
Laxness and Overreactivity (PS)	120	71%
Total*	121	72%
Family Transitions: Acrimony Scale & Depression Anxiety Stress Scale (DASS) *Instrument: Acrimony Scale & Depression Anxiety Stress Scale (DASS)* Number of graduates w/ matched pre/post: 8		
	Showed improvement #	 %
Acrimony Scale	6	75%
DASS (Depression, Anxiety, Stress) Scale	6	75%
Total*	6	75%
Total participants for all programs who showed overall improvement*	**834**	79%

* Based on average number who showed improvement in each domain

Cost/Benefit Analysis

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

The project cost $447 per individual served, $829 per graduate, and $1,001 per graduate who demonstrated improvement in parenting skills.

Skill-Building for Parents and Guardians				
Expenditure/Benefit FY 2023/24				
	CAPC-PC	CC-NPP	PBC - Triple P	Total Skill-building
*Program expenditures^*	*$247,427*	*$273,252*	*$308,079*	*$828,758*
Unduplicated individuals served	872	440	543	1,855
Expenditure per individual served	*$284*	*$621*	*$567*	*$447*
Number who graduated	345	260	395	1,000
Expenditure per graduate	*$717*	*$1,051*	*$780*	*$829*
Number of graduates who showed improvement*	319	197	312	828
Expenditure per individual who showed improvement	*$776*	*$1,388*	*$987*	*$1,001*

^Based on invoiced amounts

*As defined under Participant Outcomes

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbance to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, and BHS compares referral information to electronic health records to track linkages to service.

The following is a summary of data on mental health treatment referrals from the Skill Building for Parents and Guardians program during the 2023/24 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made 37 referrals to mental health treatment. Of the 37 referrals, 26 were for treatment provided, funded, administered, or overseen by County mental health programs. The average duration of untreated mental illness was 18.5 months.
- Of the 26 County-referred individuals, five (19%) were known to have engaged in treatment, defined as attending at least one service within 60 days.
- The average interval between referral and service was 21.8 days.

Skill-Building for Parents and Guardians				
Access and Linkage to Treatment Strategy FY 2023/24				
	CAPC-PC	CC-NPP	PBC - Triple P	Total Skill-building
Referrals to MH treatment				
Individuals referred	0	36	1	37
Duration of untreated mental illness (months)				
Average	-	18.5	n/a	18.5
Standard deviation	-	23.5	n/a	23.5
(Count of cases with duration data, used to calculate average and SD)	0	29	0	29
Linkages to county administered MH treatment				
Individuals referred to county MH treatment	0	25	1	26
# Engaged*	0	5	0	5
% Engaged	-	20%	-	19%
Calendar days between referral and service				
Average	-	21.8	-	21.8
Standard deviation	-	22.2	-	22.2

*Engaged in a service within 60 days after referral
n/a= data not available

Timely Access to Services for Underserved Populations Strategy

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

The following is a summary of referrals to mental health treatment and PEI programs for these two underserved populations during the 2023/24 fiscal year.

- During the 2023/24 fiscal year, Skill Building for Parents and Guardians referred 52 **Hispanic/Latino** individuals to mental health treatment or another PEI program; this represents 70% of all Skill Building for Parents and Guardians referrals.
- None of the referrals were made on behalf of **Asian and Pacific Islander** individuals.

More detailed referral and linkage data for underserved populations are included in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Skill Building for Parents and Guardians Project encourage access to services and follow through by training staff on how to make referrals

to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations. Here are other examples from the providers[8]:

- CAPC Parent Café encourages access to services by inviting service providers to groups to discuss their services and eligibility requirements. This way participants have "immediate access to these agencies/programs, making it easier for them to receive support and have their questions addressed." Parent Café Staff have also been using social media to promote other resources available to the community.
- Catholic Charities Nurturing Parenting Program: *"Catholic Charities' Parent Support Program continues to mention the program referral services when sensible topics are open during class time. The participants have an opportunity at class time to talk and ask about our program referral services."*
- Parents by Choice Triple P: "*Our staff continue to make this a priority for those parents who seem like they would benefit from additional support."*

[8] Quotations edited for clarity and concision

Mentoring for Transitional Age Youth

Project Description

Community-based organizations provide intensive mentoring and support to transitional age youth (16-25) with emotional and behavioral difficulties who do not meet the criteria for specialty mental health care. The project targets very high-risk youth to reduce the possibility of youth developing serious and persistent mental illnesses which are associated with adverse childhood experiences, severe trauma or ongoing stress, family or domestic violence, and/or self-harm or suicidal thoughts.

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

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

In FY 2023/24, the Mentoring for Transitional Age Youth (TAY Mentoring) Project was delivered by two community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC)
- PREVAIL (Pioneering Restoration and Elevating Voices of Advocacy, Idealism and Leadership)

Project Outputs

In FY 2023/24, the TAY Mentoring Project served a total of 623 individuals. The following table shows the number of youths directly served and the number of individual service sessions delivered by each provider. The table also includes TIP model fidelity scores. The Organizational Survey fidelity scores, rated by program managers, are a composite of 9 items related to staffing, services, supervision and other system-level items, and the TIP Practice Probes are a composite of the scores of three interview questions posed to program staff related to their knowledge and practices.

Mentoring for Transitional Age Youth			
Outputs FY 2023/24			
	CAPC	PREVAIL	Total Tay
Unduplicated individuals served	389	234	623
Unduplicated individuals enrolled during fiscal year	301	162	463
Number of individuals who exited program	318	160	478
Number of individuals who graduated*	219	143	362
Percent who graduated	69%	89%	76%
Number of sessions delivered	1,757	1,131	2,888
Average number of sessions delivered per individual	4.5	4.8	4.6
Organizational Survey fidelity scores (average)	94%	83%	83%
TIP Practice Probes fidelity scores (average)	82%	97%	97%

*Graduated=completed at least one self-identified goal

Outputs across three years

The table below shows key outputs across the past three years. The number of participants has steadily increased; the graduation rate has also ticked up especially compared to FY21/22.

Mentoring for Transitional Age Youth				
Outputs: Three Year Comparison				
	FY21/22	FY22/23	FY23/24	Yearly Average
Unduplicated individuals served	529	602	623	585
Unduplicated individuals enrolled during fiscal year	435	490	463	463
Number of individuals who graduated*	302	318	362	327
Percent who graduated	57%	74%	76%	69%
Number of sessions delivered	2,625	2,732	2,888	2,748
Average number of sessions delivered per individual	5.0	4.5	4.6	4.7
Organizational Survey fidelity scores (average)	95%	N/A	83%	89%

TIP Practice Probes fidelity scores (average)	88%	89%	97%	91%

*Graduated=completed his/her goals/ graduated from the program as defined by TIP model

Demographics

Demographic forms were collected upon intake or initiation of services. Based on the information provided in the demographic forms collected[9] (n=437), the program population can broadly be described as young adults between the ages of 16 and 25, with 59% identifying as female, 38% male, and 3% identifying as transgender, non-binary or another gender identity. TAY participants are racially and ethnically diverse; twenty percent (20%) identified themselves as Black or African-American, 22% said they were more than one race, and 53% who answered questions about their ethnic background identified themselves as Mexican/Mexican-American. Nearly one in four (23%) indicated they were homeless.

Demographic tables from 2023/24 are included in the appendix to this report.

Participant Outcomes

The TAY program measured impacts by evaluating progress in three outcome areas: graduation rates, progress toward self-identified goals (measured by TIP Tracker), and reduction in risk (as measured by assessing needs and strengths using an abbreviated CANSA). The three-year outcome analysis is presented separately for each of the two providers.

CAPC

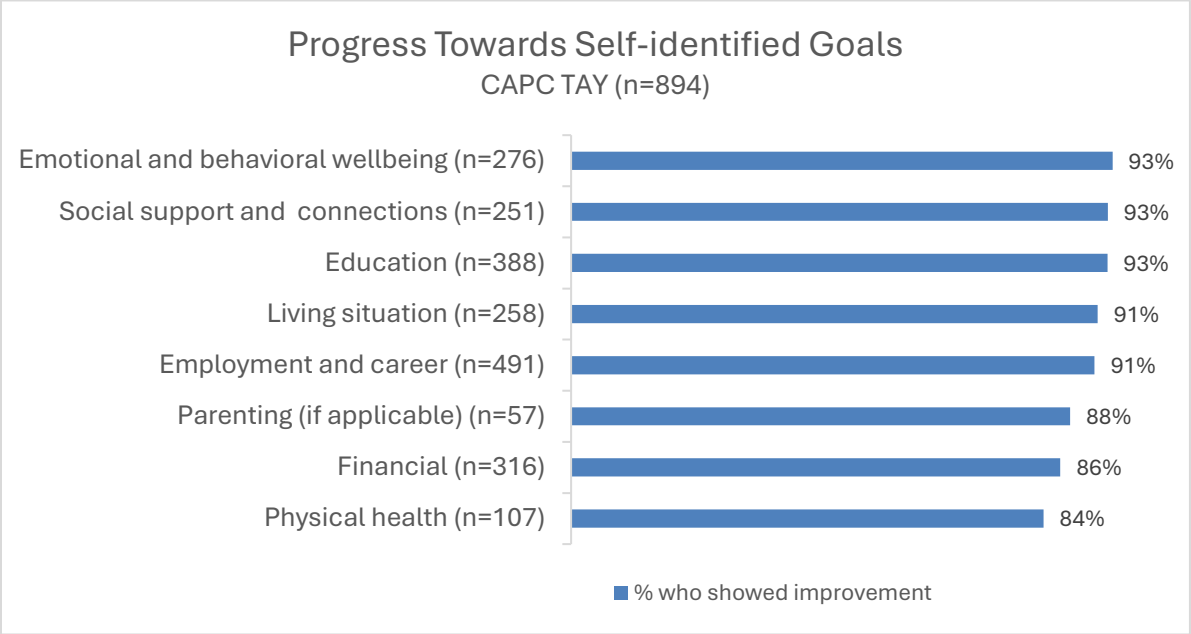
Graduation from this program was defined (by the TIP model) as participants having completed at least one of their self-identified program goals. Over the three-year evaluation period, sixty-nine percent (69%) of the clients who exited the program had successfully completed at least one of their self-identified goals.

Progress towards self-identified goals

The TIP Tracker rated each participant at discharge on progress towards or the completion of their self-identified goals in up to 8 categories. TAY participants at CAPC demonstrated a high success rate across all areas. Over the three-year evaluation period, they were most successful in the areas of emotional/behavioral wellbeing, social support, and education, with 93% of participants who targeted those areas making progress. Participants targeting financial goals and physical health had the lowest rate of success, though still a solid majority showed favorable outcomes with 86% and 84% of participants making progress, respectively.

[9] This narrative description is based on the number of participants who provided a response to each demographic category. Up to 9% of demographic survey participants declined to answer any given demographic question.

The TIP category of employment and career was the most commonly targeted goal area (as indicated by the total number of participants who identified goals in that category, n=491, just over half of all participants).



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

Reduced risk

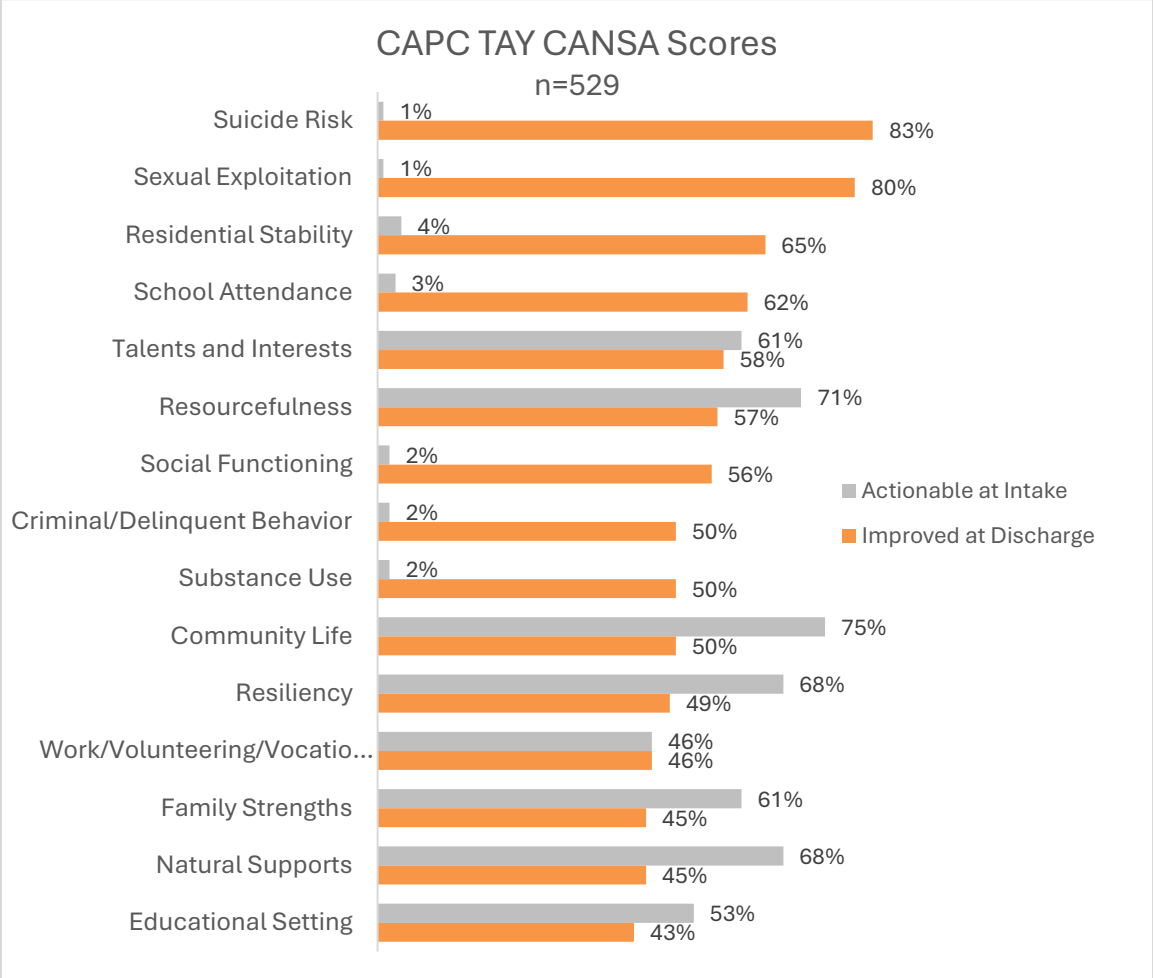
The third outcome area involves changes in participant needs and strengths, measured with an abbreviated CANSA tool comprised of 15 items that program managers felt could be addressed through the TIP model. At intake and at discharge, participants were scored on these 15 areas.

The figure below shows two measures that are essential to evaluate together when reviewing TAY Outcomes.

- Actionable Needs. CANSA scores range from 0 to 3, with protocol designating a score of a 2 or a 3 as a need in that designated area. This part of the graphic tells us what portion of the clients presented with needs at intake.
- Improved. For any client with an actionable need, a discharge score that is lower than the intake score is considered an improvement. For example, an intake score of 3, followed by a discharge score of 2, would be considered *improved*.

CAPC saw the highest rates of improvement (orange bars) among clients who demonstrated needs in the areas of suicide risk and sexual exploitation, however neither of these were domains that were particularly common among CAPC clients (grey bars show only 1% of clients presented with actionable needs). The most prevalent need area among CAPC TAY clients involved Community Life (75% presented with actionable needs at intake). Among these clients, half (50%)

showed improvement. Another prevalent issue for CAPC Tay clients was resourcefulness, where 57% of clients showed improvement.



Calculations were based on participants with complete data for both pre and post assessments (n=529)

* Work calculations were based on a smaller subset based on item relevance (n=218)

**School calculations were based on a smaller subset based on item relevance (n=372)

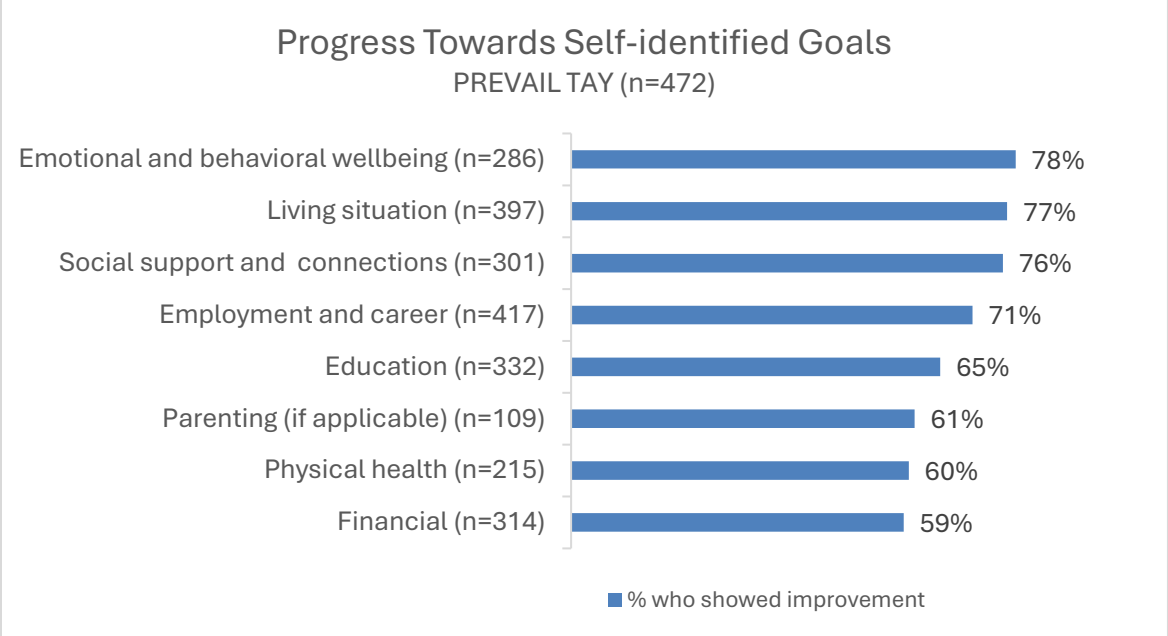
PREVAIL

Graduation from this program was defined (by the TIP model) as participants having completed at least one of their self-identified program goals. Over the three-year evaluation period, eighty-eight percent (88%) of the clients who exited the program had successfully completed at least one of their self-identified goals.

Progress towards self-identified goals

The TIP Tracker rated each participant at discharge on progress towards or the completion of their self-identified goals in up to 8 categories. TAY participants at Prevail were most successful in targeting the area of emotional and behavioral wellbeing, with 78% making progress. Other areas of success included living situation and social support, where 77% and 76% of participants made progress (respectively). The categories that proved most challenging were parenting, physical health, and financial where roughly 6 in 10 graduating participants documented progress.

The TIP category of employment was the most common targeted goal area (as indicated by the total number of participants that identified goals in that category, n=417).



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

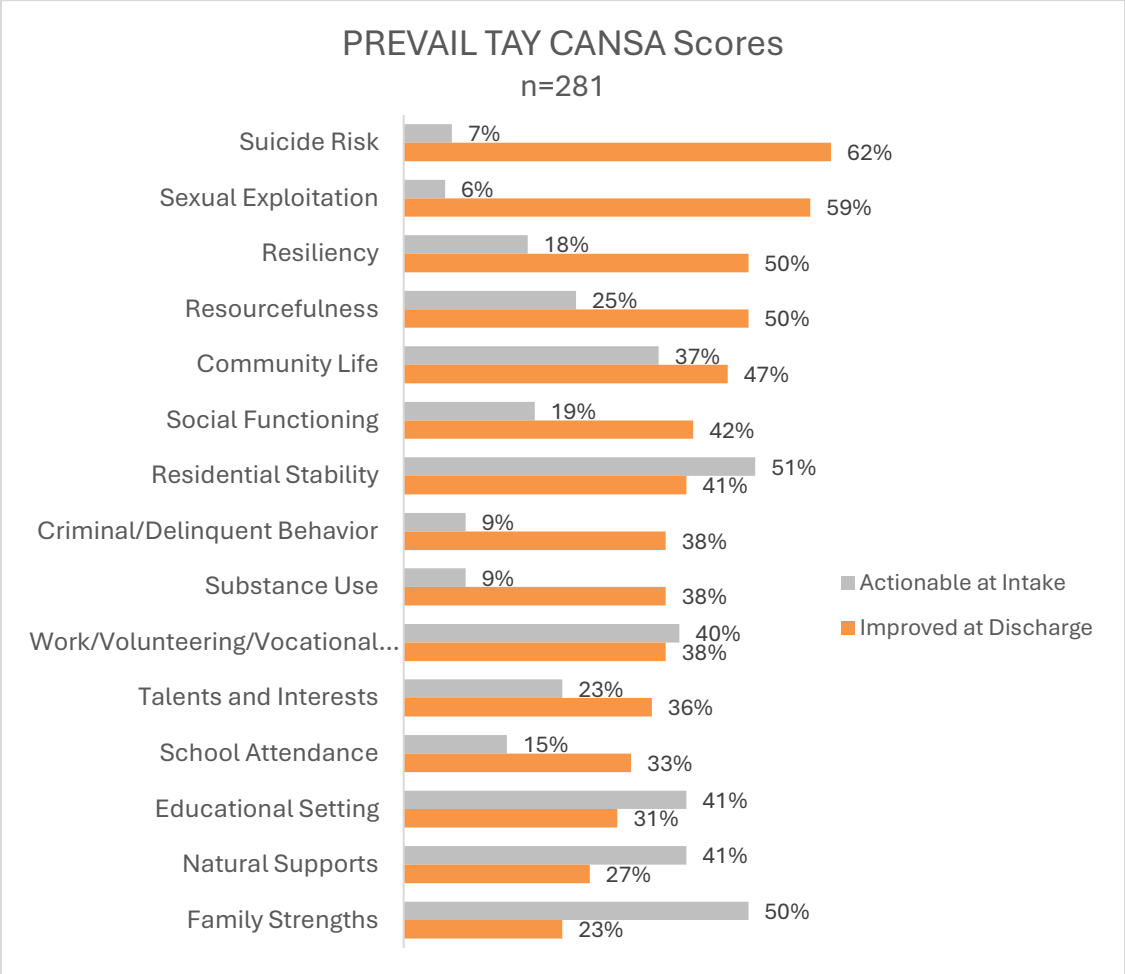
Reduced risk

The third outcome area involves changes in participant needs and strengths, measured with an abbreviated CANSA tool comprised of 15 items that program managers felt could be addressed through the TIP model. At intake and at discharge, participants were scored on these 15 areas.

The figure below shows two measures that are essential to evaluate together when reviewing TAY Outcomes.

- Actionable Needs. CANSA scores range from 0 to 3, with protocol designating a score of a 2 or a 3 as a need in that designated area. This part of the graphic tells us what portion of the clients presented with needs at intake.
- Improved. For any client with an actionable need, a discharge score that is lower than the intake score is considered an improvement. For example, an intake score of 3, followed by a discharge score of 2, would be considered *improved*.

Prevail saw the highest rates of improvement (orange bars) among clients who demonstrated needs in the areas of suicide risk and sexual exploitation, however neither of these were domains that were particularly common among Prevail clients (grey bars show 6-7% of clients with actionable needs). The most prevalent issues faced by Prevail participants involved residential stability – roughly half of clients (51%) presented with actionable scores at intake. Among these clients, 41% showed improvement at discharge. The domain that was most resistant to improvement was family strengths; only 23% of clients with actionable needs saw improvement.



Calculations were based on participants with complete data for both pre and post assessments (n=281)
* Work calculations were based on a smaller subset based on item relevance (n=221)
**School calculations were based on a smaller subset based on item relevance (n=61)

Cost/Benefit Analysis

The following table shows several key indicators of performance for each provider and the TAY Project as a whole, including costs of the project (based on invoiced amounts) as well as cost per participant and cost per participant with successful completion (“graduate”) .

The project cost $1,129 per individual served and $1,943 per graduate.

Mentoring for Transitional Age Youth			
Expenditure/Benefit FY 2023/24			
	CAPC	PREVAIL	Total TAY
*Program Expenditures^*	*$378,042*	*$325,224*	*$703,266*
Unduplicated individuals served	389	234	623
Expenditures per individual served	*$972*	*$1,390*	*$1,129*
Number who graduated*	219	143	362
Expenditures per graduate	*$1,726*	*$2,274*	*$1,943*

^Based on invoiced amounts
*Completed at least one self-identified goal

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbance to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, and BHS compared referral information to electronic health records to track linkages to service.

The following is a summary of data on mental health treatment referrals from the TAY Mentoring Project during the 2023/24 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for 178 participants to mental health treatment, 150 of which were for treatment provided, funded, administered, or overseen by County mental health programs.
- The average duration of untreated mental illness was 23.6 months.
- Of the 150 County-referred individuals, 25 (17%) were known to have engaged in treatment within 60 days, with an average interval of 14 days between referral and treatment.

Mentoring for Transitional Age Youth			
Access and Linkage to Treatment Strategy FY 2023/24			
	CAPC	PREVAIL	Total TAY
Referrals to MH treatment			
Individuals referred	62	116	178

Duration of untreated mental illness (months)			
Average	6.5	45.2	23.6
Standard deviation	9	67.2	48.7
(Count of cases with duration data, used to calculate average and SD)	33	26	59
Linkages to county administered MH treatment			
Individuals referred to county MH treatment	61	89	150
# Engaged*	8	17	25
% Engaged	13%	19%	17%
Calendar days between referral and service			
Average	10	16	14
Standard deviation	11.2	14.6	13.7

*Engaged in a service within 60 days after referral

Timely Access to Services for Underserved Populations Strategy

PEI reporting requirements ask for details about referrals to mental health treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[10]. Below is a brief summary of the findings.

- Forty-three percent (48%) of referrals were made on behalf of **Latino/Hispanic** individuals.
- Ten percent (10%) of referrals were made on behalf of **Asian/Pacific Islander** individuals.

More detailed referral and linkage data for underserved populations are included in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the TAY program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations. Here are two other examples from the providers:

- CAPC: *"Once referrals to other providers are made, staff keep detailed notes in client records to reflect whether the resource has been accessed, and continue to encourage clients to follow up during their weekly interactions."*

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

- Prevail: *"Processes have been developed with outside agencies to assist client with referrals to parenting, housing. others. Staff have access to the CAL Benefits portal to assist clients in completing applications for government financial, food stamps and Medi-Cal assistance. Staff engage with clients weekly to follow up and make additional referrals as needed."*

Coping and Resilience Education Services (CARES)

Project Description

CYS's CARES project serves children and youth (ages 5-18), and their caregivers, who are at risk for CPS involvement, exposed to trauma, or other risk factors , but who do not meet medical necessity for specialty mental health services. Children and youth are screened for trauma-related symptoms and receive a 12- session evidence-informed intervention to address previous traumas and sustain them through difficult situations. Families receive trauma-informed training using the Parents Reach Achieve and Excel through Empowerment Strategies (PRAXES) curriculum. Children participate in the Child Intensive Model or the Youth Intensive Model. Staff provide one-on-one and group support.

Project Outputs

In the 2023/24 fiscal year, the CARES project served a total of 438 individuals—296 children and 142 parents/caregivers. The following table shows the number of individuals who attended an outreach event related to CARES, number who participated in and then completed the children and youth (CIM/YIM) and parents/caregiver (PRAXES) curriculums.

Coping and Resilience Education Services (CARES)	
Outputs FY 2023/24	
Number of new children/youths referred to program	395
Number of new children/youths screened into program	187
Number of children served in the program	296
Number of caregivers served in the program	142
Unduplicated number of participants*	**438**
Number of adults who completed PRAXES curriculum	50
Number of children who completed CIM/YIM curriculum	145
Total number of individuals who completed (graduated) from program**	**195**

*Includes rollovers from previous fiscal year

**Not all individuals were expected to graduate within the fiscal year; individuals who began participation later in the year may graduate during the subsequent fiscal year

Outputs across three years

The table below shows key outputs across the past three years. The number of participants has increased slightly each year.

Coping and Resilience Education Services (CARES)				
Outputs: Three Year Comparison				
	FY21/22	FY22/23	FY23/24	Yearly Average
Number of children/youth referred to program	241	419	395	352
Number of children/youth screened into program	N/A	218	187	203

Number of children served in the program	174	239	296	236
Number of caregivers served in the program	102	160	142	135
Unduplicated number of participants*	**276**	**399**	**438**	**371**
Number of adults who completed PRAXES curriculum	29	45	50	41
Number of children who completed CIM/YIM curriculum	68	108	145	107
Total number of individuals who completed (graduated) from program**	**97**	**153**	**195**	**148**

*Includes rollovers from previous fiscal year
**Not all individuals were expected to graduate within the fiscal year; individuals who began participation later in the year may graduate during the subsequent fiscal year

Demographics

Demographic forms were collected upon intake or initiation of services. Based on the information provided in the demographic forms collected[11] (n=254), the program population primarily consists of youth under 16 (64%), young adults aged 16-25 (5%), and adults (31)%. Seventy-five percent (75%) of the adults identified themselves as female. Seventy percent (70%) of those who answered questions about their ethnic background identified themselves as Mexican/Mexican-American.

Demographic tables from 2023/24 are included in the appendix to this report.

Participant Outcomes

CARES used the Pediatric Symptom Checklist to measure youth risk. Over the course of the three-year evaluation period, CARES was able to document a matched pre and post assessment for 327 youth (self-assessment) and 66 adult administrations (screening on behalf of the child). A simple comparison of pre and post scores found that 84% of child screenings and 83% of adult screenings showed a reduction in symptoms. The average youth score dropped just over eight points from 25.7 to 17.4, which was statistically significant[12] . The adult administered screening dropped just ten points from 52.6 to 42.6. This difference was also statistically significant[13] .

Outcomes -Three Years FY 2021/22, 2022/23, 2023/24		
Instrument: Pediatric Symptom Checklist (Adult and Youth Versions) *Frequency of administration: Intake and discharge**		
	Youth	Adults
Number of participants	578	217

[11] Up to 20% of participants declined to answer any given demographic question.
[12] t(326)=15.593, p=0.000
[13] t(65)=6.853, p=0.000

Number of matched pre and post tests	327	66
Number and % of individuals showing reduction in symptoms (lower score at discharge)	275 (84%)	55 (83%)
Average pre score	25.7	52.6
Average post score	17.4	42.6
Average Difference	-8.2	-10.0
Standard Deviation of Difference	9.6	11.8

*Includes youth participants who closed between July 1, 2021 and June 30, 2024 and who had matched pre and post scores. The adult version of the PSC was introduced in FY22/23; this sample includes adults who closed between July 1, 2022 and June 30, 2024 and had matched pre and post scores. Participants engaged in the program at the conclusion of FY23/24 were not expected to have discharge scores.

Cost/Benefit Analysis

The following table shows key indicators of performance for the CARES program (based on county expenditure reports), including costs of the project, cost per participant, and cost per individual who showed improved outcomes.

The programs cost $3,364 per individual served and $ 4,005 per participant who demonstrated improvement.

Coping and Resilience Education Services (CARES)	
Expenditure/Benefit FY 2023/24	
*Program Expenditures^*	*$1,473,385*
Unduplicated individuals served	438
Expenditures per individual served	*$3,364*
Percent who showed improvement*	84%
*Expenditure per individual who showed improvement**	*$4,005*

^based on county expenditure reports
*As defined under Participant Outcomes and extrapolated from existing sample of participants with matching pre and post scores

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbance to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, and BHS compared referral information to electronic health records to track linkages to service.

The following is a summary of data on mental health treatment referrals from the CARES program during the 2023/24 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for 24 individuals, all of which were mental health referrals for treatment provided, funded, administered, or overseen by County mental health programs.
- Of the 24 County-referred individuals, 14 (58%) were known to have engaged in treatment within sixty days. Among these individuals who linked to service, the average duration between referral and service was 13 days.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2023/24 referrals to mental health treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[14].

- Fifty-four percent (54%) of referrals were made on behalf of **Latino/Hispanic** individuals.
- None of the referrals were made on behalf of Asian participants.

More detailed referral and linkage data for underserved populations are included in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the CARES program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

During 2023/24 fiscal year, program staff provided 10 presentations to various community-based organizations and child serving systems. The purpose of these presentations was to ensure that agency staff are informed of available services and are educated on how to make referrals and link individuals to mental health services.

Additionally, staff outreached to 3,284 community members through attendance at various community events, health fairs, and school functions. The purpose of the outreach was to reduce stigma and provide information on linkage to and supports available through Behavioral Health.

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

Prevention Services for Children and Caregivers (age 0 to 5)

Project Description

The 0 to 5 project serves very young children and their caregivers who are at risk of emerging mental health concerns or who have experienced or at risk for trauma or abuse. Supportive prevention services aim to help children and caregivers build secure attachments, promote healthy development, encourage strong emotional health, and prevent emotional disturbances from taking root. Services consist of monthly and weekly home visits from trained staff who provide parenting education and support for optimal family functioning as well as case management and linkage to other community supports, as appropriate, in addition to group services and other training opportunities to address identified needs.

This was the first year of the 0 to 5 project, managed by Victor Community Support Services. For much of this year the focus was on outreach and engagement with the community. The team attended community events and led in-person presentations at local schools. In the fall of 2023, families began enrolling in Victor's program, referenced as the Stepping Stones program.

Project Outputs

In the 2023/24 fiscal year, Stepping Stones served a total of 49 individuals—20 children and 29 parents/caregivers. Sixteen children (and twelve caregivers) received home visits, with an average of 17 visits per child.

When the program was designed, the intention was to conduct cohort-based parenting classes, offered in 8 sessions per class. In this first year, two sessions were offered with one parent participating. Caregivers also had access to drop-in Parent Café sessions; eight parents participated in eleven different sessions. Youth group opportunities were provided, when possible, which involved 14 participants.

Prevention Services for Children 0-5 and Caregivers	
Outputs FY 2023/24	
Number of unique (unduplicated) clients, aged 0 to 5, who were referred to services	20
Number of unique (unduplicated) clients, aged 0 to 5, who participated in PEI services	20
Number of unique caregivers who participated in PEI services	29
Home Visits	
Unduplicated number of caregivers	12
Unduplicated number of children	16
Total number of home visits	269
Average number of home visits per child	17
Groups	
Number of Parent Café sessions	11
Number of Parent Café participants	8

Number of Parenting Classes	2
Number of Parenting Class participants	1
Number of youth groups	4
Number of youth participants	14

Demographics

Demographic forms were collected upon intake or initiation of services. Based on the information provided in the demographic forms collected[15] (n=19), 60% of the primary clients (youth) identified as Mexican/Mexican-American and 42% speak Spanish as a primary language .

Demographic tables from 2023/24 are included in the appendix to this report.

Participant Outcomes

During most of the 2023/24 fiscal year, Stepping Stones was in an early implementation phase. The program uses the Parent Stress Index as their evaluation tool. The assessment is conducted at the point of enrollment and at discharge, with updates conducted annually if the client is in service for more than one year.

In FY23/24, intake assessments were collected for nineteen of the clients. The first analysis of pre and post assessments will be conducted at the conclusion of FY24-25.

Cost/Benefit Analysis

The following table total costs for the 0 to 5 project, including costs and cost per participant. In future analysis this will include the cost per individual who showed improved outcomes.

Prevention Services for Children 0-5 and Caregivers	
Expenditure/Benefit FY 2023/24	
*Program Expenditures^*	*$290,592*
Unduplicated individuals served	20
Expenditures per individual child served	*$14,530*

^Based on invoiced amounts

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbance to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, if any are made, and BHS compares referral information to electronic health records to track linkages to service. In FY23-24 the Stepping Stones program reported no referrals to a higher level of mental health treatment.

[15] Up to 21% of participants declined to answer any given demographic question.

Timely Access to Services for Underserved Populations Strategy

The program reported no mental health or PEI referrals to either of the populations identified as underserved[16].

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

School Based Intervention for Children and Youth

Project Description

School Based Interventions provide brief mental health counseling, including group and individual skill building and rehabilitative prevention services, for children and youth who have been impacted by adverse childhood experiences, have social-emotional or behavioral issues, and/or are at risk of severe emotional disturbance. The project focuses on a team concept, partnering school personnel with clinical staff in the classroom.

In FY 2023/24, the School Based Interventions Project was delivered by three community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC)
- Parents By Choice (PBC)
- Sow A Seed Community Foundation (SAS)

Project Outputs

In the 2023/24 fiscal year, the School Based Interventions project served a total of 573 students.

School Based Interventions				
Outputs FY 2023/24				
	CAPC	PBC	SAS	Total
Referrals received	213	295	193	701
Enrolled in services	208	196	169	573
Individual case management provided (hours)	2,015	670	1,138	3,822
Average hours per individual	10	3	7	7
Training				
Number of parent/caregiver trainings/presentations	0	10	3	13
Number of school personnel trainings/presentations	90	23	5	118

*Graduated=attended 50% or more of group sessions provided
N/A=This information was not available at the time of reporting

Outputs across three years

The table below shows key outputs across the past three years. The number of participants has declined slightly, and the number of case management hours (and hours per individual) dropped notably this year most recent year.

School Based Interventions				
Outputs: Three Year Comparison				
	FY21/22	FY22/23	FY23/24	Yearly Average
Enrolled in services	597	578	573	583
Number of students graduated*		526	N/A	526
Percent of students graduated*		91%	N/A	91%
Individual case management provided (hours)	12,776	15,217	3,822	10,605
Average hours per individual	21.4	26.0	7.0	18.1
Training				
Number of parent/caregiver trainings/presentations	3	14	13	10
Number of school personnel trainings/presentations	207	130	118	152

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

Demographics

Demographic forms were collected upon intake or initiation of services. Based on the information provided in the demographic forms collected[17](n=534), the largest ethnic group represented was Hispanic/Latino (64%). Nineteen percent (19%) said that Spanish is their primary language.

Demographic tables from 2023/24 are included in the appendix to this report.

Participant Outcomes

School-based services were intended to reduce student needs and increase strengths. These outcomes were measured with an abbreviated 8-item CANSA tool, administered at intake and discharge. The eight items were selected by program managers because they best represented needs that could be addressed through the program activities.

This analysis of the CANSA includes two measures; it is helpful to evaluate these two measures together when reviewing outcomes.

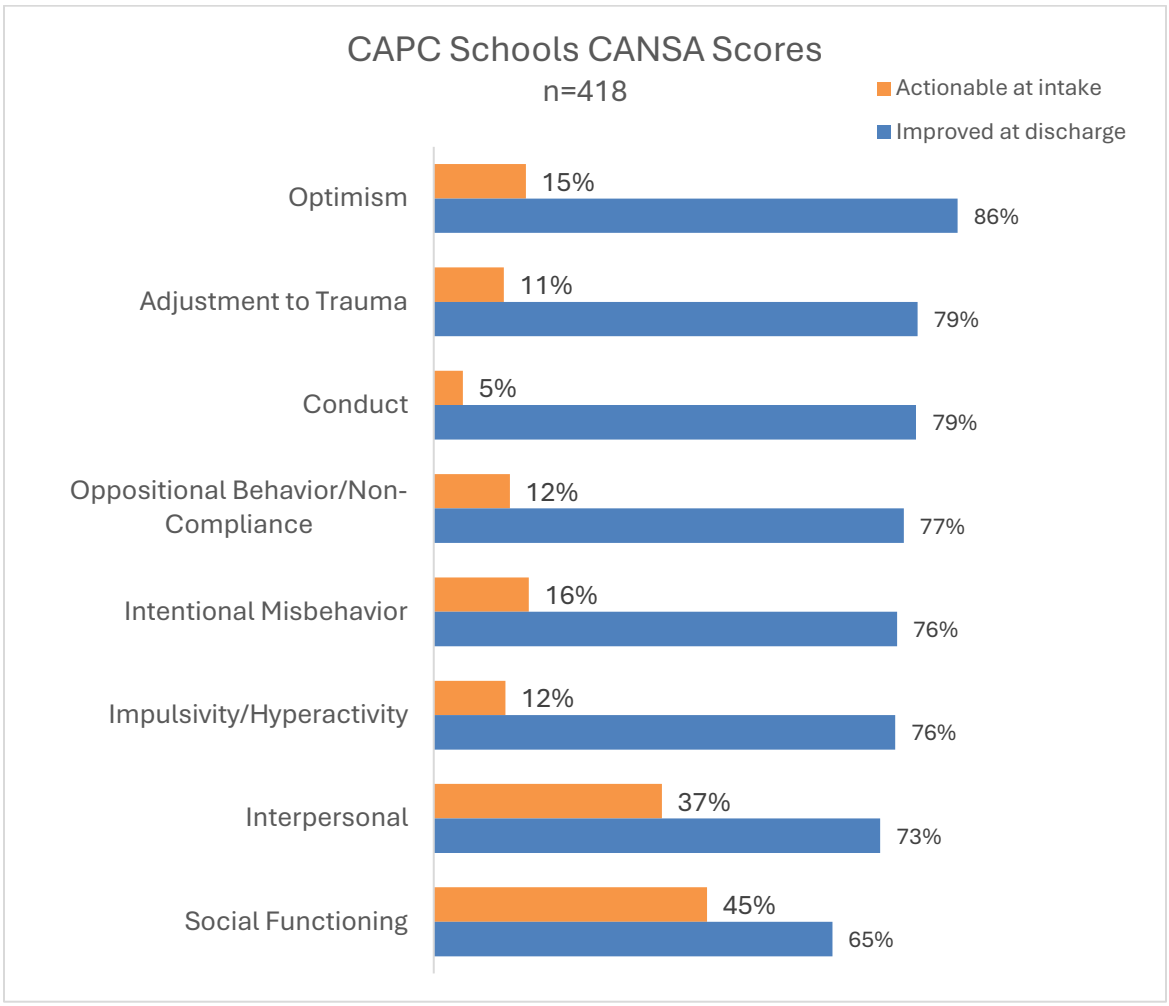
- Actionable Needs. CANSA scores range from 0 to 3; a score of a 2 or a 3 indicates a need in that designated area.
- Improved at Discharge. For any client with an actionable need, a discharge score that is lower than the intake score is considered an improvement. For example, an intake score of 3, followed by a discharge score of 2, would be considered *improved*.

CANSA findings are presented separately for each provider.

[17] Up to 10% of participants declined to answer any given demographic question.

CAPC

Over the course of the three-year outcome evaluation period, CAPC reported 611 student enrollments in their school-based services. The program collected 418 sets of intake and discharge CANSA assessments. In the figure below, the orange bars show what portion of students had actionable needs at intake. The most prevalent needs included Interpersonal (37%) and Social Functioning (45%). The blue bars show the rate of improvement for those students showing actionable need. The domain with the highest rate of improvement was optimism, where 86% of clients with actionable needs demonstrated improvement. The biggest challenge appears to be Social Functioning, which is also the area where clients were most likely face difficulties--45% of students had actionable needs and 65% of those students demonstrated improvement.

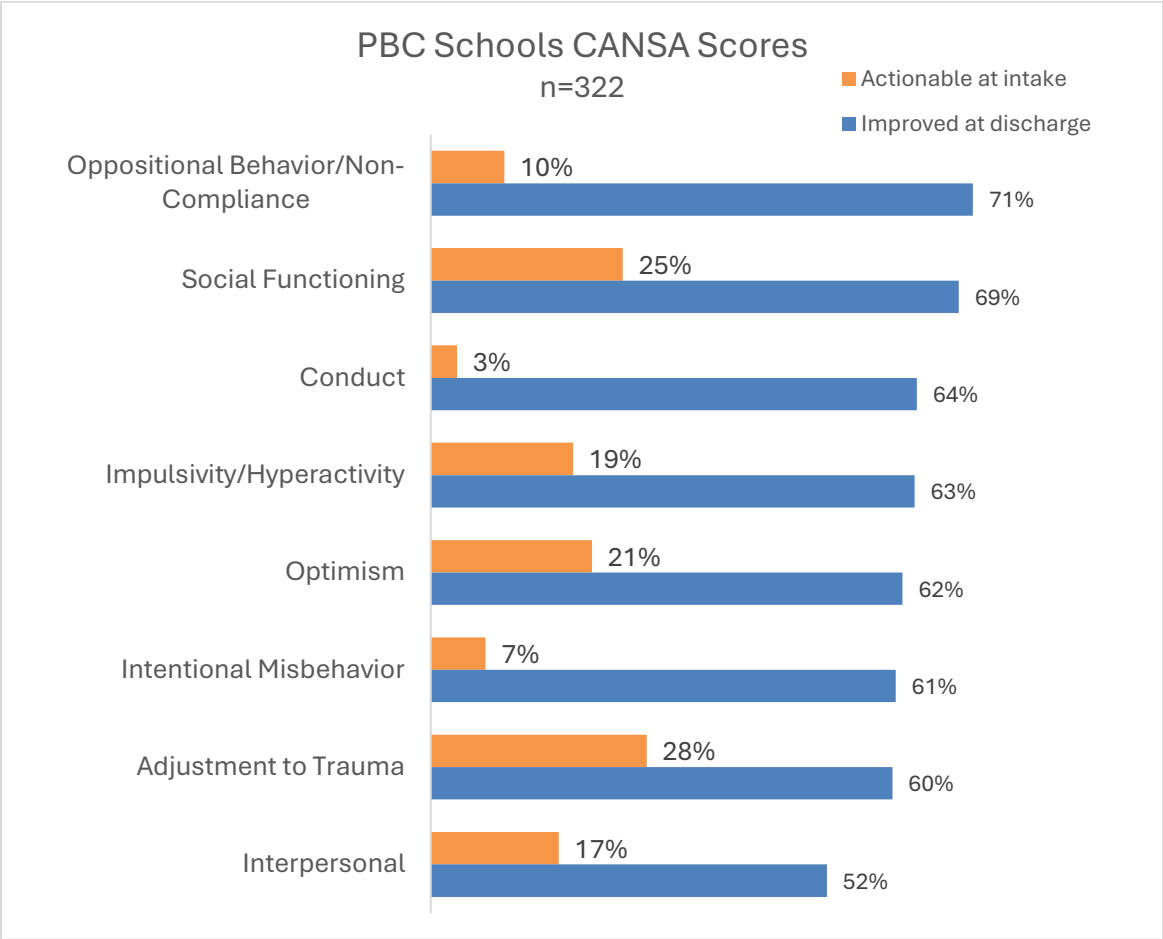


Calculations were based on participants with complete data for both pre and post assessments (n=418)
Conduct and Intentional misbehavior calculations were scored on a smaller subset based on age (6+) (n=398)

To establish a single measure of overall change across the three-year period, an index was created by summing the difference between intake and discharge for each of the eight domains for each student. Eighty-four percent (84%) of the participants had a lower score (improved) at discharge compared to the initial assessment at intake.

Parents by Choice

Over the course of the three-year outcome evaluation period, Parents by Choice reported 543 student enrollments in their school-based services. The program collected 322 sets of intake and discharge CANSA assessments. In the figure below, the orange bars show what portion of students had actionable needs at intake. The most prevalent needs included Adjustment to Trauma (28%) and Social Functioning (25%). The blue bars show the rate of improvement for those students showing actionable need. Domains with the highest rate of improvement include Social Functioning (69%) and Oppositional behavior (71%). The domain presenting the biggest challenge appears to be Interpersonal, where 17% of students had actionable needs and 52% of those with needs demonstrated improvement.

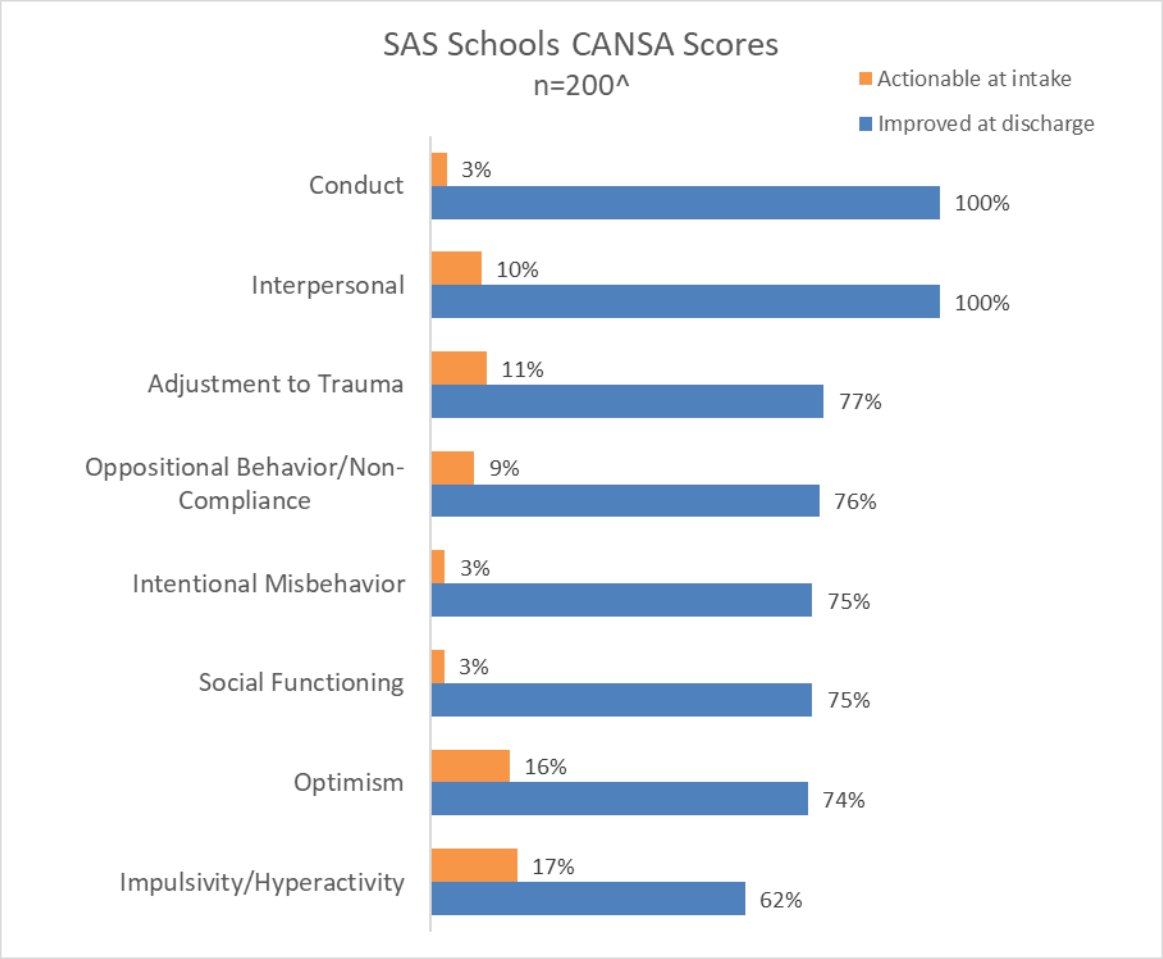


Calculations were based on participants with complete data for both pre and post assessments (n=322)
Conduct and Intentional misbehavior calculations were scored on a smaller subset based on age (6+) (n=321)

To establish a single measure of overall change across the three-year period, an index was created by summing the difference between intake and discharge for each of the eight domains. Sixty percent (60%) of the participants had a lower score (improved) at discharge compared to the initial assessment at intake.

Sow A Seed

Over the course of the three-year outcome evaluation period, Sow A Seed reported 594 student enrollments in their school-based services. The program collected 200 sets of intake and discharge CANSA assessments. In the figure below, the orange bars show what portion of students had actionable needs at intake. The most prevalent needs included Impulsivity (17% of students) and Optimism (16% of students). The blue bars show the rate of improvement for those students showing actionable need. Domains with the highest rate of improvement include Conduct and Interpersonal domains, where relatively small numbers of clients had needs, but all 100% saw improvement. The domain presenting the biggest challenge appears to be impulsivity, where 17% of students had actionable needs and 62% of those with needs demonstrated improvement.



^ In the first year of collecting assessments, some domains were missing from the Sow A Seed instrument. The impact of this issue was that the number of students assessed on each domain ranged from 139 to 200 (the denominator used to calculate the orange bar)

To establish a single measure of overall change across the three-year period, an index was created by summing the difference between intake and discharge for each of the eight domains. Sixty-four percent (64%) of the participants had a lower score (improved) at discharge compared to the initial assessment at intake.

Cost/Benefit Analysis

The following table shows several key indicators of performance for the School Based Interventions project (based on invoiced amounts), including costs of the project, cost per participant, and cost per individual who graduated or who showed improvement.

The project cost $1,630 per individual served and $2,203 per individual who showed improvement.

School Based Interventions				
Expenditure/Benefit FY 2023/24				
	CAPC	Parents By Choice	Sow a Seed	Total
*Program Expenditures^*	*$461,307*	*$254,959*	*$217,661*	*$933,927*
Unduplicated individuals served	208	196	169	573
Expenditures per individual served	*$2,218*	*$1,301*	*$1,288*	*$1,630*
% of discharge assessments showing improved overall score*	88%	55%	69%	74%
Expenditure per individual who showed improvement	*$2,520*	*$2,365*	*$1,867*	*$2,203*

^Based on invoiced amounts

*FY23/24 Index of eight domain scores: % with overall lower score at discharge

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbances to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, if any are made, and BHS compared referral information to electronic health records to track linkages to service. School Based Intervention programs did not identify individuals needing a higher level of care; thus no referrals were made.

Timely Access to Services for Underserved Populations Strategy

PEI reporting requirements ask for details about referrals to mental health treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[18]. This school-based program did not identify individuals needing a higher level of care; no referrals were made.

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

Intervention

Early Intervention to Treat Psychosis (TEIR)

Project Description

The Telecare Early Intervention and Recovery Services (TEIR) Project provides an integrated set of promising practices intended to slow the progression of psychosis. The project follows the evidence-based Portland Identification and Early Referral (PIER) model. The project goal is to identify and provide treatment to individuals who have experienced their first psychotic episode in the past two years or who are showing prodromal symptoms of psychosis in order to prevent disability and the onset of the acute stage of illness.

Project Outputs

In FY 2023/24, the TEIR Project provided early intervention services to a total of 88 unduplicated individuals who received an average of 116 hours of service.

The following table shows that over the course of the year 65 individuals were found eligible for TEIR through psychosis screenings and 41 completed the enrollment SIPS assessment. Among these, 29 were admitted to the program to begin receiving services.

Telecare Early Intervention and Recovery Services (TEIR)	
Outputs FY 2023/24	
Number of consumers found eligible for TEIR	65
Number of early psychosis screenings completed (SIPS assessment)	41
Number of admissions	29
Total unduplicated count of individuals receiving early intervention	88
Number of family members who participated in program*	46
Total numbers of contacts	7,745
Average number of contacts per individual served	88
Average hours per individual	116

*estimate based on average quarterly participation

Outputs across three years

The table below shows key outputs across the past three years. Although the number of admissions had a dip in FY22/23, the number of individuals served has remained stable (average of 80 per year). The number of contacts and hours per individual has increased over the three year period .

Telecare Early Intervention and Recovery Services (TEIR)				
Outputs: Three Year Comparison				
	FY21/22	FY22/23	FY23/24	Yearly Average
Number of early psychosis screenings completed (SIPS assessment)	n/a	16	41	29
Number of admissions	30	15	29	25
Total unduplicated count of individuals receiving early intervention	75	77	88	80
Total numbers of contacts	4,660	6,073	7,745	6,159
Average number of contacts per individual served	62	79	88	76
Total minutes of service	385,843	509,669	614,794	503,435
Average minutes per individual	5,145	6,619	6,986	6,250
Average hours per individual	86	110	116	104

Demographics

Demographic forms were collected at the time of screening for eligibility for services. Based on the information provided in the demographic forms collected[19] (n=64), the program population can broadly be described as young adults under the age of 26, with 40% identifying as male, 53% female, and the balance (7%) identifying as transgender, non-binary, questioning, or another gender identity. TEIR participants are racially and ethnically diverse; 36% identified as Black or African American and 36% identified as Hispanic or Latino.

Demographic tables from 2023/24 are included in the appendix to this report.

[19] Up to 56% of participants declined to answer any given demographic question.

Participant Outcomes

The TEIR program tracked progress toward outcomes two ways: program completion rates and Reduction in Prodromal Symptoms.

Program completion rates

TEIR intends to maximize the number of participants who discharge from services having completed program objectives. The table below shows the TEIR records of discharge status for each of 52 clients discharged during the three-year period. A total of 22 discharged clients completed program objectives or otherwise transitioned successfully to another program (42%).

Telecare Early Intervention and Recovery Services (TEIR)		
Program completion rates Discharges during FY 2021/22, 2022/23, 2023/24		
	Count	%
Completed program objectives - did not transition to another mental health program	10	19%
Completed program objectives - transitioned to a lower level of care with BHS	5	10%
Completed program objectives - transitioned to a lower level of care with a community-based resource	7	13%
Did not complete program objectives - voluntarily dropped out of program and did not seamlessly transition to another mental health program	4	8%
Did not complete program objectives - discharged to higher level of care (e.g., IMD/Locked)	4	8%
Did not complete program objectives - discharged to jail or prison	0	0%
Moved out of the area	8	15%
Can't find client/lost to services	9	17%
Realization that client does not meet minimum program requirements (i.e., no psychosis)	0	0%
Other	2	4%
Missing	3	6%
Total discharges	**52**	

Reduction in Prodromal Symptoms (SIPS/SOPS)

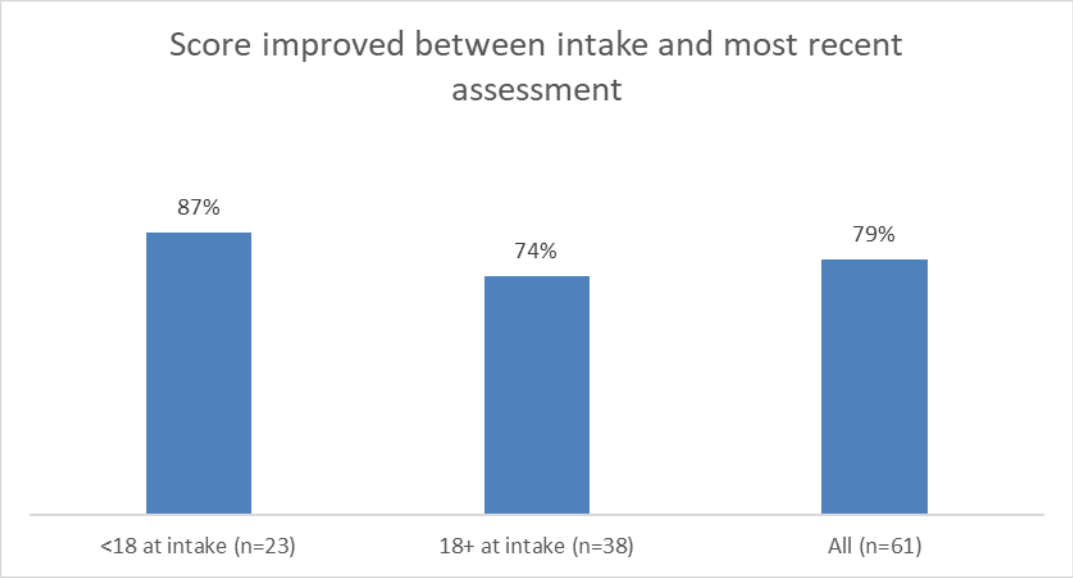
TEIR participants were assessed using the Structured Interview for Psychosis –Risk Syndromes (SIPS) and Scale for the Assessment of Prodromal Symptoms (SOPS), referred to briefly as SIPS/SOPS. TEIR assesses clients at intake using SIPS and then assesses them every six months of program involvement using the SOPS. The findings from the ongoing assessment should guide therapeutic planning and goals.

The table below shows that there were 61 clients with at least one SOPS conducted in the three-year evaluation period. These assessments were compared to their corresponding SIPS from their intake period (forming a pre/post methodology)[20]. Analysis found that on average clients improved their scores by 4.8 points. Seventy-nine percent saw a change in score to indicate improvement.

Telecare Early Intervention and Recovery Services (TEIR)					
Reduction in Prodromal Symptoms -Three Years FY 2021/22, 2022/23, 2023/24					
Instrument: Structured Interview for Psychosis –Risk Syndromes (SIPS)/ Scale for the Assessment of Prodromal Symptoms (SOPS)					
Number of Clients with a matched Pre and Post n=61					
	Intake (SIPS)	Most recent Assessment (SOPS)	Time Range between SIPS and SOPS (months)	Change in Score	% showing reduced score
Min	0	0	2.3	-8	79%
Max	22	21	71.4	14	
Average	13.1	8.2	29.1	4.8	
Stnd. Deviation	5.0	5.4	5.4	17.0	

[20] Although TEIR was already using the SIPS/SOPS protocol prior to this period, they began tracking the scores as a part of the outcomes evaluation during FY22/23.

Program leaders are interested in the impacts of age at time of enrollment on outcomes. Preliminary exploration of the data showed that clients who started receiving services before the age of 18 were more likely to show improvement over time (87% vs 74% of those who began at age 18 or older). It is noted that in some cases those who start at an earlier age may end up spending more time in the program, which may also explain the differential outcomes.



Cost/Benefit Analysis

The following table shows key indicators of performance for the TEIR program (based on invoiced amounts), including costs of the project, cost per participant, and cost per individual who showed improved outcomes.

The TEIR program cost $18,238 per individual served, or $23,686 per participant with demonstrated improvement.

Telecare Early Intervention and Recovery Services (TEIR)	
Expenditure/Benefit FY 2023/24	
Program Expenditures	*$1,604,965*
Unduplicated individuals served	88
Expenditures per individual served	*$18,238*
Percent who showed improvement*	79%
*Expenditure per individual who showed improvement**	$23,086

*As defined under Participant Outcomes and extrapolated from an existing sample of participants with matching pre and post scores

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, if any are made, and BHS compares referral information to electronic health records to track linkages to service.

The following is a summary of data on mental health treatment referrals from the TEIR program during the 2023/24 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for five individuals, all of which were mental health referrals for treatment provided, funded, administered, or overseen by County mental health programs.
- One (25%) was known to have engaged in treatment within sixty days. This individual was linked to service two days after the referral.

Timely Access to Services for Underserved Populations Strategy

PEI reporting requirements ask for details about referrals to mental health treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[21]. None of the referrals from TEIR in FY23-24 were made on behalf of these populations.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the TEIR program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

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

Community Trauma Services for Adults

Project Description

Community Trauma Services for Adults (Trauma Services) serves adults who have trauma history and traumatic stress symptoms. The focus is on individuals from low-income communities and communities of color where systemic oppression and social determinants of health have resulted in negative life outcomes. The project goal is to alleviate symptoms, reduce negative outcomes, and improve life functioning for individuals with emerging, mild, or moderate PTSD or related stress disorders.

The Trauma Services Project was delivered by three community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC)
- El Concilio
- Vietnamese Voluntary Foundation, Inc. (VIVO)

Project Outputs

In the 2023/24 fiscal year, the Trauma Services project served a total of 272 individuals with some an average of 11 hours of service per individual. Approximately 20% of the participants received individual therapy and 61% received rehabilitation. The majority of time (59%) was dedicated to services other than individual therapy and rehabilitation.

Trauma Services	
Outputs FY 2023/24	
	Total
All services	
Unduplicated count of individuals	272
Average minutes per individual	657
Average hours per individual	11.0
Service time disaggregated	
Individual Therapy	
Unduplicated count of individuals	54
% of individuals who received individual therapy	20%
Project time dedicated to therapy (as a percentage of total minutes)	11%
Average hours per individual	5.8
Rehabilitation service*	
Unduplicated count of individuals	165
% of individuals who received rehabilitative services	61%
Project time dedicated to rehab (as a percentage of total minutes)	31%
Average hours per individual	5.6
Other clinical service time^	
Unduplicated count of individuals	260

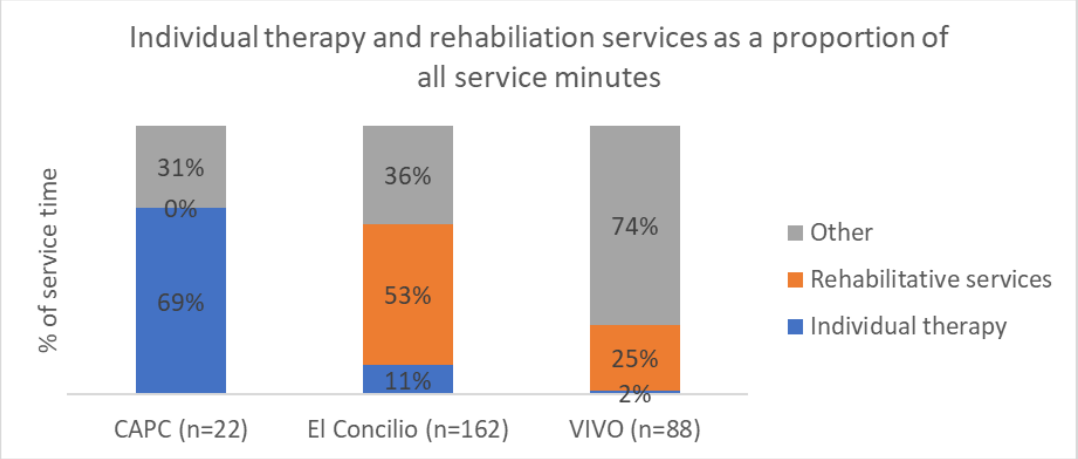
% of individuals who received rehabilitative services	96%
Project time dedicated to other services (as a percentage of total minutes)	59%
Average hours per individual	6.7

*Includes Psychosocial Rehabilitation and Psychosocial Rehab Group
^Includes Engagement, Plan Development, Case Management, Evaluation

Each program ended up serving a different number of participants. CAPC served the fewest (22); VIVO served 88, and El Concilio served 172. VIVO provided the most intensive services, an average of 20.6 hours per participant whereas El Concilio provided the least intensive, only 5.5 hours. CAPC provided 12.1 hours of service per participant. The providers offered different models of implementation. This is illustrated in the figure below, which shows the proportion of service time dedicated to therapy, rehabilitation, and non-therapeutic time by each provider.

- CAPC participants were primarily referred through other CAPC programs, resulting in targeted and appropriate screenings. Eighteen of their 22 screened referrals received individual therapy, comprising 69% of all service minutes. This model of implementation adhered closely to the program design.
- El Concilio screened a high number of individuals (162) and referred 137 of them (85%) to higher levels of care. Of those served by the program following a screening, 86 (53%) received rehabilitation services and 27 (17%) received individual therapy.[22]
- VIVO screened 88 individuals, most of whom (79) received what was coded as rehabilitative services, though chart reviews revealed that a majority of rehabilitation time was spent connecting participants to community resources rather than providing true psychosocial education and rehabilitation. Only 9 individuals received therapy and only two percent of service minutes were dedicated to therapy. The Department recognizes the unique trauma-related mental health needs of Asian ethnic groups residing in San Joaquin County. VIVO explained that many of their constituents refuse to go to treatment for various reasons including language barriers, immigration fears, etc. While VIVO operates much needed programming intended to help its base assimilate into American culture and flourish, this project's funding requires that programs support individuals with emergent mental illness. Unfortunately, VIVO's model of implementation departed significantly from the program design, which had higher expectations for therapeutic services to address PTSD symptoms, thus the program was discontinued at the end of Fiscal Year 2023-24.

[22] These figures are duplicated counts because individuals may have received services prior to being referred.



Outputs across three years

The table below shows key outputs across the two years of the project's history. The number of individuals served decreased in the second year. The number who received individual therapy dropped notably and the number who received rehabilitation services increased. Overall, the number of hours per individual went down.

Trauma Services			
Outputs: Two Year Comparison			
	FY22/23	FY23/24	Yearly Average
All services			
Unduplicated count of individuals	345	272	309
Total minutes	394,397	178,811	286,604
Average hours per individual	19.0	11.0	15.0
Service time disaggregated			
Individual Therapy			
Unduplicated count of individuals	93	54	74
Number of minutes	81,080	18,792	49,936
Average hours per individual	15.0	5.8	10.4
Rehabilitation service*			
Unduplicated count of individuals	82	165	124
Number of minutes	35,242	55,053	45,148
Average hours per individual	7.0	5.6	6.3
Other clinical service time^			
Unduplicated count of individuals	344	260	302
Number of minutes	278,075	104,966	191,521
Average hours per individual	13.0	6.7	9.9

*Includes Psychosocial Rehabilitation and Psychosocial Rehab Group

^Includes Engagement, Plan Development, Case Management, Evaluation"

Demographics

Demographic forms were collected upon intake or initiation of services. Based on the information provided in the demographic forms collected (n=220), the program population primarily consists of adults aged 26-59 (80%); an additional 11.5% were young adults aged 16-25 and the remaining 8% were 60+. Trauma Services participants are ethnically and racially diverse. Two-thirds (66%) who answered questions about their ethnic background identified themselves as Hispanic or Latino; most of these participants were served by El Concilio. Thirteen percent identified as Asian (13%); most of these individuals were served by VIVO. Seventy-three percent of participants were female (73%); this was higher at CAPC which has a focus on parents of young children.

Demographic tables from FY2023/24 are included in the appendix to this report.

Participant Outcomes

The Trauma Services project used the Los Angeles Symptom Checklist (LASC) to screen admitting participants. The LASC is a self-report measure of posttraumatic stress disorder (PTSD); programs use a five-point scale to evaluate how problematic each symptom is. Scores provide the program with a classification of full or partial PTSD, based on 17 PTSD symptoms that align with the DSM IV diagnosis of PTSD (e.g. nightmares, trouble trusting others, excessive jumpiness).The LASC also provides a global score of distress and adjustment problems based on the full list of 43 symptoms (e.g. difficulty holding a job, problems with authority, depression).

The Trauma Services project used the LASC at intake as a part of the screening process. The project design also intended that the LASC be used every six months to track progress. Program theory suggests that services should result in reduced symptomatology. Results from this two-year evaluation period are presented separately for each provider below.

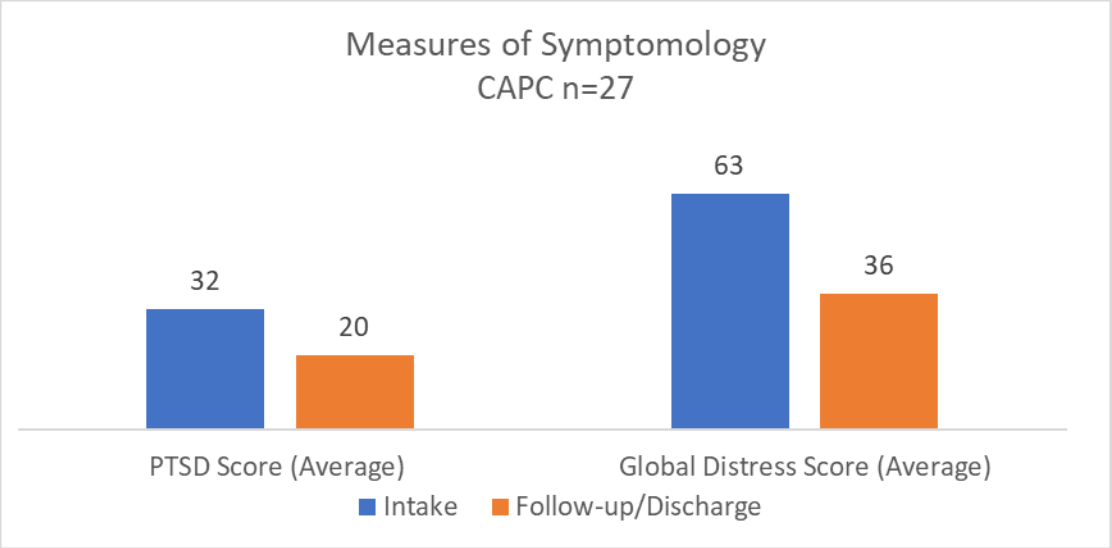
CAPC

Over the course of the two years of the CAPC Trauma Services program, CAPC delivered individual therapy services to 33 individuals. Program participants received an average of 20.2 services (22.4 hours of service). CAPC documented scores for 27 individuals who completed both an intake LASC and at least one follow-up LASC. This represents 73% of all clients served.

CAPC Services FY22/23, FY23/24			
Number of Matched Pre and Post : 27			
	Individuals Served	Average Hours	Average # of Services
All Services	37	22.4	20.2
Therapy or Rehab Services	33	16.1	11.5

A simple comparison of scores found that 96% of program participants with pre- and post-assessments showed at least a one-point improvement in their total PTSD score.

The figure below shows that the average PTSD score dropped from 32 to 20.The Global Distress Score also decreased from 63 to 36. Both of these changes are statistically significant.[23]



[23] PTSD Score, significant change t(26)=7.362, p=0.00
Global Distress Score, significant change t(26)=7.629, p=0.00

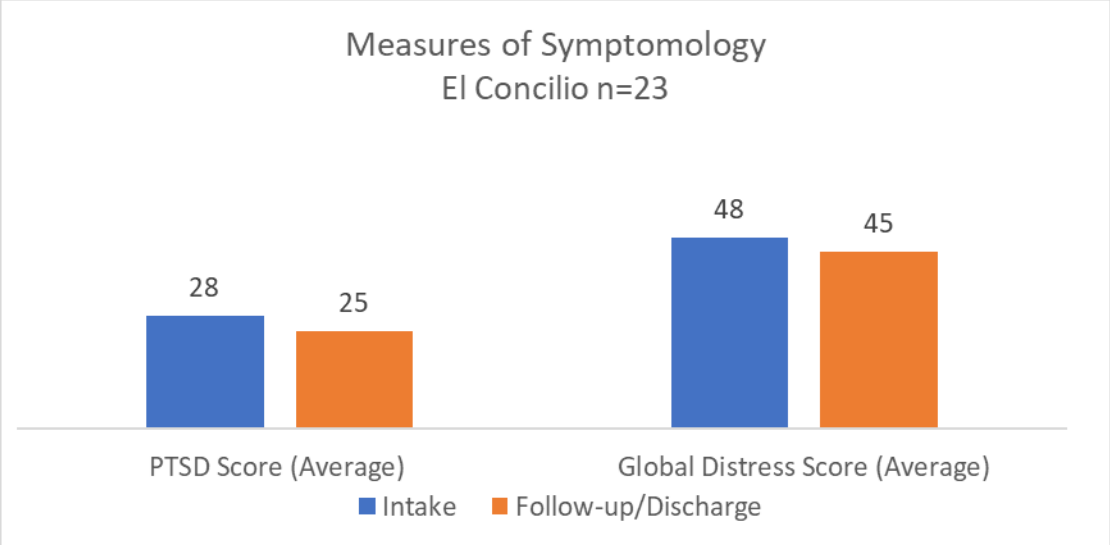
El Concilio

Over the course of the two years of the El Concilio Trauma Services program, El Concilio delivered services to 372 individuals; 137 of these individuals received therapy or rehab services. Participants who engaged in therapy and/or rehab received an average of 8.2 services (9.1 hours). El Concilio documented scores for 23 participants who completed both an intake LASC and at least one follow-up LASC. This represents 17% of the individuals engaged in therapeutic services.

El Concilio Services FY22/23, FY23/24			
Number of Matched Pre and Post : 23			
	Individuals Served	Average Hours	Average # of Services
All Services	372	7.6	8.5
Therapy or Rehab Services	137	9.1	8.2

A simple comparison of scores found that 57% of El Concilio participants with pre- and post-assessments showed at least a one-point improvement in their total PTSD score.

The figure below shows that the average PTSD score dropped from 28 to 25.The Global Distress Score also decreased from 48 to 45. Neither of these changes are statistically significant. [24]



[24]

PTSD Score, no significant change t(22)=0.929, p=0.363
Global Distress Score, No significant change t(22)=0.463, p=0.648

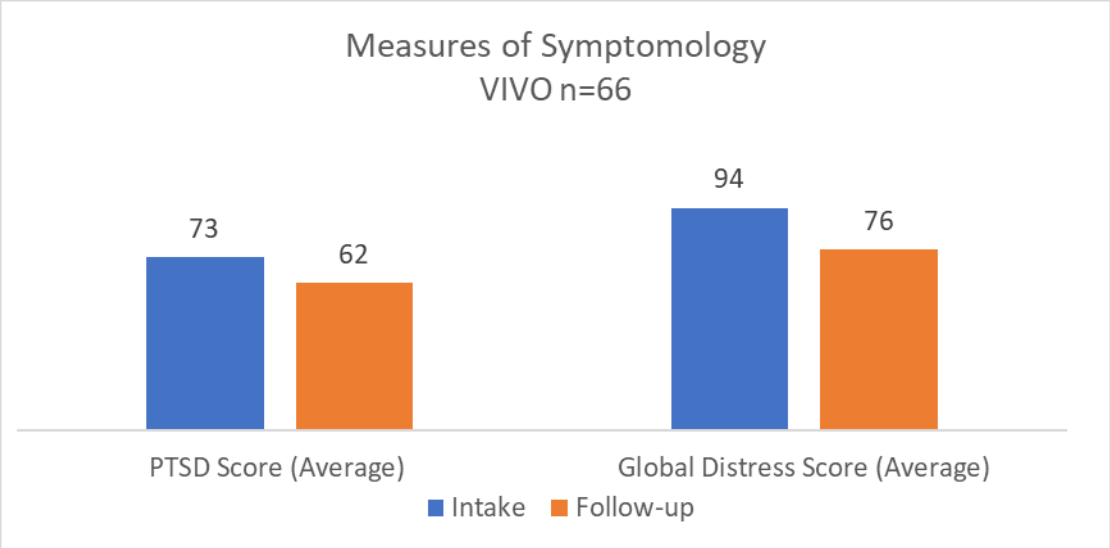
VIVO

Over the course of the two years of the VIVO Trauma Services program, VIVO delivered services to 99 individuals. Program participants received an average of 51.3 services (41.5 hours of service). VIVO documented scores for 66 clients who completed both an intake LASC and at least one follow-up LASC. This represents 73% if clients engaged in therapy or rehabilitative services.

VIVO Services FY22/23, FY23/24			
Number of Matched Pre and Post : 66			
	Individuals Served	Average Hours	Average # of Services
All Services	99	41.5	51.3
Therapy or Rehab Services	91	10.5	15.0

A simple comparison of scores found that 92% of clients with pre and post assessments showed at least a one-point improvement in their total PTSD score.

The figure below shows that the average PTSD score dropped from 73 to 62.The Global Distress Score also decreased from 94 to 76. Both of these changes are statistically significant.[25] To the degree that VIVO's program contributed to the improvement in scores, it appears that the benefits derived mostly from case management rather than trauma therapy and rehabilitation services.



[25] PTSD Score, significant change t(65)=10.057, p=0.00
Global Distress Score, significant change t(65)=10.6, p=0.00

Cost/Benefit Analysis

The Trauma Services project cost $2,160 per individual served and $2,512 estimated per individual who showed improvement.

Trauma Services				
Expenditure/Benefit FY 2023/24				
	CAPC	El Concilio	VIVO	Trauma Services Total
*Program Expenditures^*	*$62,253*	*$189,334*	*$336,000*	*$587,588*
Unduplicated individuals served	22	162	88	272
Expenditures per individual served	*$2,830*	*$1,169*	*$3,818*	*$2,160*
Percent who showed improvement* (based on matched pre and post assessments)	96% (n=27)	54% (n=23)	92% (n=66)	86% (n=116)
*Expenditure per individual who showed improvement**	*$2,948*	*$2,164*	*$4,150*	*$2,512*

^based on invoiced amounts
*As defined under Participant Outcomes for both FY22/23 and FY23/24 and extrapolated from existing sample of participants with matching pre and post scores

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, if any are made, and BHS compared referral information to electronic health records to track linkages to service, where possible.

The following is a summary of data on mental health treatment referrals from the Trauma Services program during the 2023/24 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for 153 individuals, 150 of which were mental health referrals for treatment provided, funded, administered, or overseen by County mental health programs. Most of these—139 referrals—were made by El Concilio's Trauma Services program into higher levels of treatment also provided by El Concilio.
- The average duration of untreated mental illness was 31 months (roughly 2.5 years).
- Of the 150 County-referred individuals, 106 (71%) were known to have engaged in treatment within sixty days. Among these individuals who linked to service, the average duration between referral and service was 7 days.

Trauma Services				
Access and Linkage to Treatment Strategy FY 2023/24				
	CAPC	El Concilio	VIVO	Trauma Services Total
Referrals to MH treatment				
Individuals referred	1	139	13	153
Duration of untreated mental illness (months)				
Average	5.0	33.0	23.2	30.8
Standard deviation	-	33.0	10.9	30.4
(Count of cases with duration data, used to calculate average and SD)	1	43	9	36
Linkages to county administered MH treatment				
Individuals referred to county MH treatment	1	139	10	150
# Engaged*	0	101	5	106
% Engaged	-	73%	50%	71%
Calendar days between referral and service				
Average	-	7.1	6.0	7.0
Standard deviation	-	9.9	11.7	10.0

*Engaged in a service within 60 days after referral

Timely Access to Services for Underserved Populations Strategy

PEI reporting requirements ask for details about referrals to mental health treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[26]. Below is a brief summary of the findings.

- Seventy-five percent (75%) of referrals were made on behalf of **Latino/Hispanic** individuals (from El Concilio).
- Ten percent (10%) of referrals were made on behalf of **Asian and Pacific Islander** individuals (most of these were through VIVO).

More detailed referral and linkage data for underserved populations are included in the supplemental file.

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

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Trauma Services programs encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

Outreach for Increasing Recognition of Early Signs of Mental Illness

NAMI Provider Education

Project Description

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

Provider Education is a free, 15-hour program of in-service training taught by a team consisting of an adult with a mental health condition, a family member, and a mental health professional who is also a family member or has a mental health condition themselves.

Project Outputs

NAMI delivered two multi-session Provider Education classes to 32 Behavioral Health Providers. This is fairly similar to outputs in the past three years (roughly 2-3 classes, 15-30 participants).

Outreach for Increasing Recognition of Early Signs of Mental Illness				
Outputs: Three Year Comparison				
	FY21/22	FY22/23	FY23/24	Yearly Average
Number of Provider Education Classes	3	2	2	2
Number of potential responders (participants)	28	15	32	25

Demographic tables from 2023/24 are included in the supplemental file.

Cost/Benefit Analysis

The following table shows the cost (based on county expenditure reports) for both the *Outreach for Early Recognition (OER) Program* and the *Stigma and Discrimination Reduction (SDR) Program* combined; and the total number of individuals who received training in each of the two programs. The average cost per individual trained in either OER or SDR programming was $153.

Outreach for Increasing Recognition of Early Signs of Mental Illness and Stigma and Discrimination Reduction	
Expenditure/Benefit FY 2023/24	
Program Expenditures (OER and SDR combined)	*$36,927*
Total individuals trained in Stigma and Discrimination Reduction programming (IOOV, F2F, P2P) (See next section)	209
Total individuals trained in Outreach for Early Recognition	32
Total number of individuals trained	241
Expenditure per individual trained	*$153*

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness to medically necessary care and treatment. For this reason, programs were asked to document mental health referrals, if any are made, and BHS compared referral information to electronic health records to track linkages to service.

This program reported no referrals to a higher level of mental health treatment .

Timely Access to Services for Underserved Populations Strategy

The program reported no mental health or PEI referrals to either of the populations identified as underserved[27].

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

Stigma and Discrimination Reduction

NAMI Stigma and Discrimination Reduction Program

Project Description

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

Project Outputs

A total of 209 individuals were reached through the Stigma and Discrimination Reduction Project in FY 2023/24. The following table shows the type and number of each training/workshop offered and the number of individuals reached.

NAMI Stigma and Discrimination Reduction Program		
Outputs FY 2023/24		
	Number of trainings/ workshops	Number of individuals reached
In Our Own Voice (IOOV) 60 to 90-minute presentations by two trained speakers describing personal experiences living with mental health challenges and achieving recovery	27	180
Family to Family (F2F) 12-session educational program for family members of adults living with mental illness taught by trained teachers who are also family members.	1	11
Peer to Peer (P2P) 10-session classes to help adults living with mental illness challenges achieve and maintain wellness taught by Peer Mentors living in recovery	2	18
TOTAL	30	209

Outputs across three years

The number of trainings has declined slightly and the number of participants has fluctuated.

NAMI Stigma and Discrimination Reduction Program				
Outputs: Three Year Comparison				
	FY21/22	FY22/23	FY23/24	Yearly Average
In Our Own Voice (IOOV)				
Trainings	45	28	27	33
Participants	266	113	180	186

Family to Family (F2F)				
Trainings	3	1	1	2
Participants	38	9	11	19
Peer to Peer (P2P)				
Trainings	2	3	2	2
Participants	20	31	18	23
TOTAL				
Trainings	50	32	30	37
Participants	324	153	209	229

Demographics

Demographic information was collected at the time of the class, either through paper-based forms or a web-based survey. Based on the information provided in the demographic forms collected[28] (n=202), over half of the participants were adults aged 26 to 59 (65%) and female (57%). Among participants who reported their race or ethnicity, 46% identified as Hispanic or Latino. Seven percent (7%) indicated they are homeless/unhoused.

Demographic tables from 2023/24 are included in the appendix to this report.

[28] Up to 13% of participants declined to answer any given demographic question.

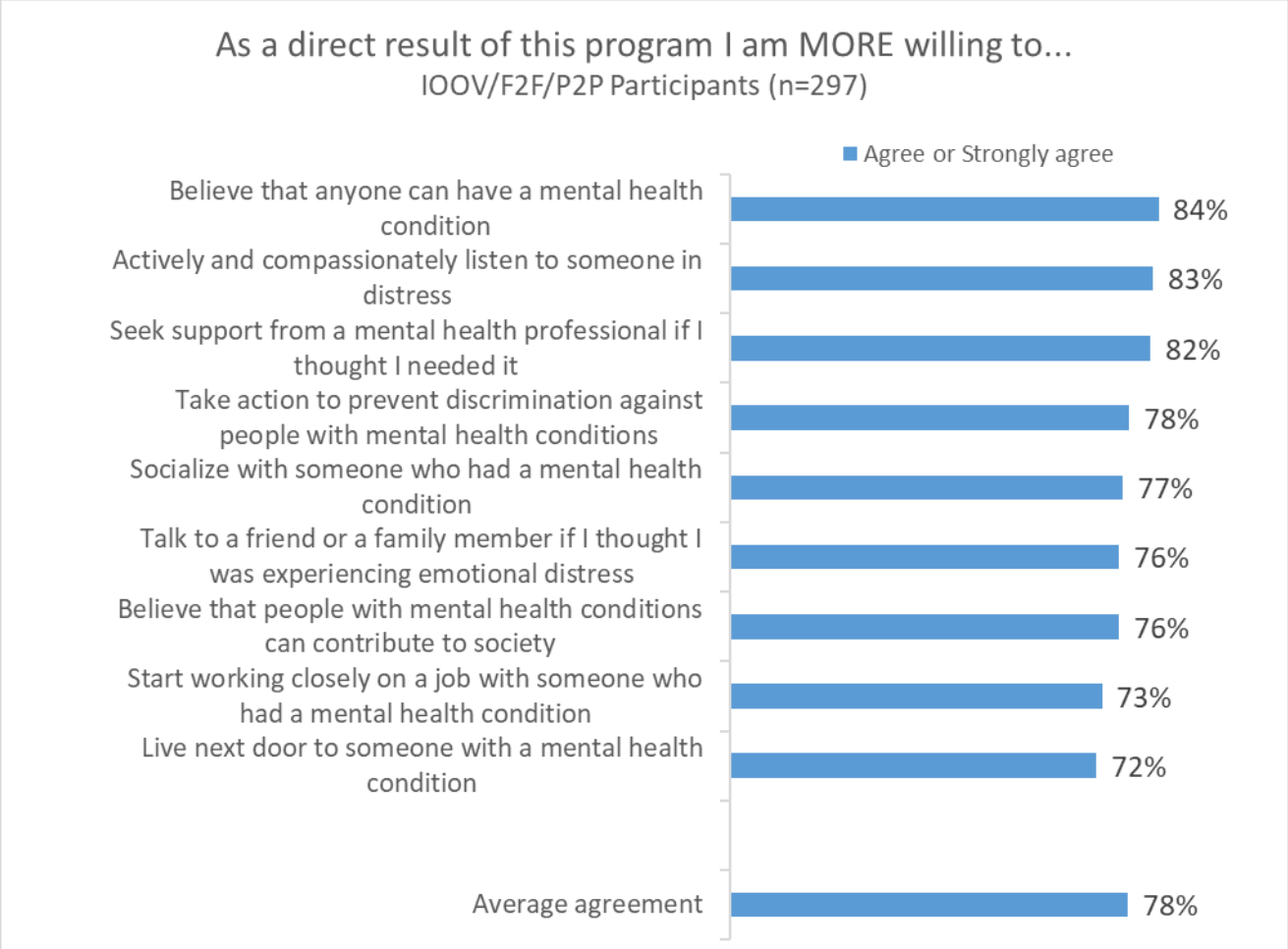
Participant Outcomes

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

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

To measure this, NAMI facilitators distributed evaluation surveys with a set of nine retrospective Likert Scale items asking participants to rate the degree to which their attitudes had shifted as a result of the program. Surveys were distributed at the conclusion of classes and trainings. Over the three-year evaluation period, NAMI collected 298 surveys[29].

Most participants indicated favorable shifts in attitudes. A majority said that because of programming they are more willing to actively listen to someone in distress (83%) and believe that anyone can have a mental health condition (84%).



[29] IOOV n=237 | F2F n=14 | P2P n=46

To arrive at a single attitudinal metric, a mean score was calculated from the survey items. On average, 78% of participants acknowledged improved attitudes, knowledge and/or behavior related to mental illness and seeking mental health services.

Cost/Benefit Analysis

The following table shows the cost (based on county expenditure reports) for both the *Outreach for Early Recognition (OER) Program* and the *Stigma and Discrimination Reduction (SDR) Program* combined; and the total number of individuals who received training in each of the two programs. The average cost per individual trained in either OER or SDR programming was $236.

Stigma and Discrimination Reduction and Outreach for Increasing Recognition of Early Signs of Mental Illness	
Expenditure/Benefit FY 2023/24	
Program Expenditures (OER and SDR combined)	*$36,927*
Total individuals trained in Stigma and Discrimination Reduction programming (IOOV, F2F, P2P)	209
Total individuals trained in Outreach for Early Recognition (See tab 8a)	32
Total number of individuals trained	241
Expenditure per individual trained	*$153*

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness to medically necessary care and treatment. For this reason, programs were asked to document mental health referrals, if any are made, and BHS compared referral information to electronic health records to track linkages to service.

This program reported no referrals to a higher level of mental health treatment .

Timely Access to Services for Underserved Populations Strategy

The program reported no mental health or PEI referrals to either of the populations identified as underserved[30].

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

Suicide Prevention

Suicide Prevention In Schools

Project Description

The CAPC-led project involved the evidence-based Yellow Ribbon (YR) Suicide Education Campaign and ancillary Be a Link Adult Gatekeeper and Ask 4 Help Youth Gatekeeper Trainings. In addition, CAPC provided SafeTALK workshops to youth over age 15 to assist in the recognition of individuals with suicidal thoughts and to connect them to mental health resources. The Suicide Prevention Project also provided depression screenings, referrals, and school-based depression support groups.

Project Outputs

In the 2023/24 fiscal year, the Suicide Prevention Project reached 6,396 participants at 15 schools. The following table presents a detailed breakdown of the number of individuals reached by various program activities. The Yellow Ribbon Campaign was the largest component, reaching 5,510 students.

Suicide Prevention in Schools	
Outputs FY 2023/24	
Total reached (duplicated count)	7,052
Total reached (unduplicated count)	6,396
Yellow Ribbon Campaign Messaging	5,510
Be a Link® Adult Gatekeeper Training	564
Ask 4 Help® Youth Gatekeeper Training	325
SafeTalk Training	322
Depression Screening	298
CAST Support Group Participants	23
Break Free from Depression Support Group Participants	10

Outputs across three years

The table below shows key outputs across the three year evaluation period. The number of individuals has decreased slightly each year.

Suicide Prevention in Schools				
Outputs: Three Year Comparison				
	FY21/22	FY22/23	FY23/24	Yearly Average
Total reached (duplicated count)	9,176	7,211	7,052	**7,813**
Total reached (unduplicated count)	8,444	6,460	6,396	**7,100**
Yellow Ribbon Campaign Messaging	7,772	5,947	5,510	**6,410**
Be a Link® Adult Gatekeeper Training	478	292	564	**445**

Ask 4 Help® Youth Gatekeeper Training	273	394	325	**331**
SafeTalk Training	194	221	322	**246**
Depression Screening	400	328	298	**342**
CAST Support Group	26	n/a	23	**25**
Break Free from Depression	33	29	10	**24**

Demographics

Demographic information was collected at the time of the service, either through paper-based forms or a web-based survey. Based on the information provided[31](n=7,707), the program population can broadly be described as racially and ethnically diverse. Just over half (56%) of participants in the presentations identified themselves as Hispanic or Latino. Thirteen percent (13%) identified as Asian, 7% Black or African American, 27% white, and 25% indicated more than one race.

Complete demographic tables from FY2023/24 are included in the appendix to this report.

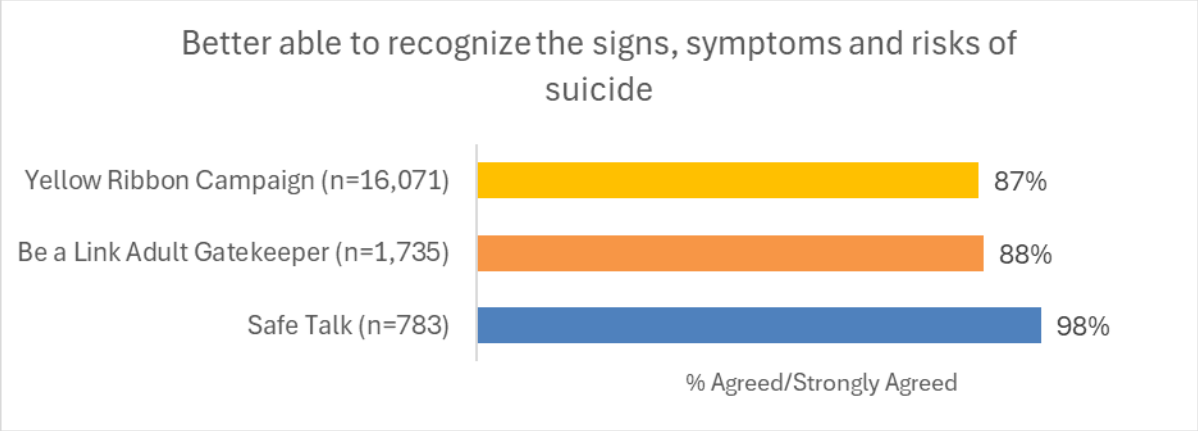
Participant Outcomes

The overall goal of the program is to reduce stigma associated with help-seeking behavior and to identify and refer individuals at risk for self-harming and suicidal behaviors. The Suicide Prevention Project evaluated their progress towards three intended outcomes: (a) increased knowledge of warning signs, symptoms and risks; (b) knowledge about professional and peer resources available to help people at risk of suicide; and (c) knowledge of how to intervene. During the three-year evaluation period, the project was able to collect surveys from 18,589 participants.

Increased knowledge of warning signs, symptoms and risks

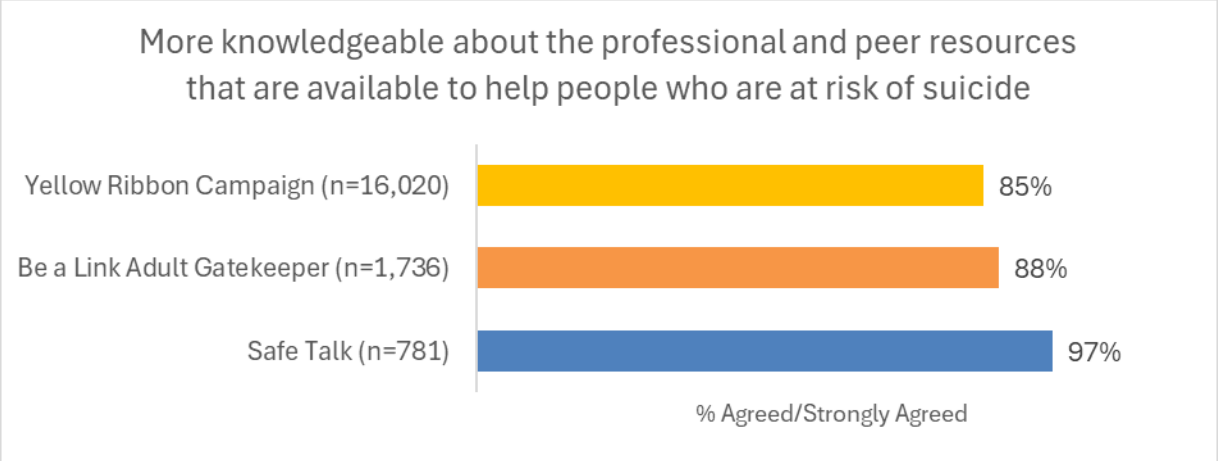
Participants were asked to indicate, as a result of the training, the extent to which they were better able to recognize the signs, symptoms and risks of suicide. The figure below shows that a solid majority (87%) of students participating in the Yellow Ribbon Campaign *agreed* or *strongly agreed* that they were better able to recognize the symptoms and risks of suicide. Adults reported a similar assessment (88% felt better prepared). An even larger portion felt this way after participating in Safe Talk (98%).

[31] This narrative description is based on the number of participants who provided a response to each demographic category. Up to 20% of participants declined to answer any given demographic question.



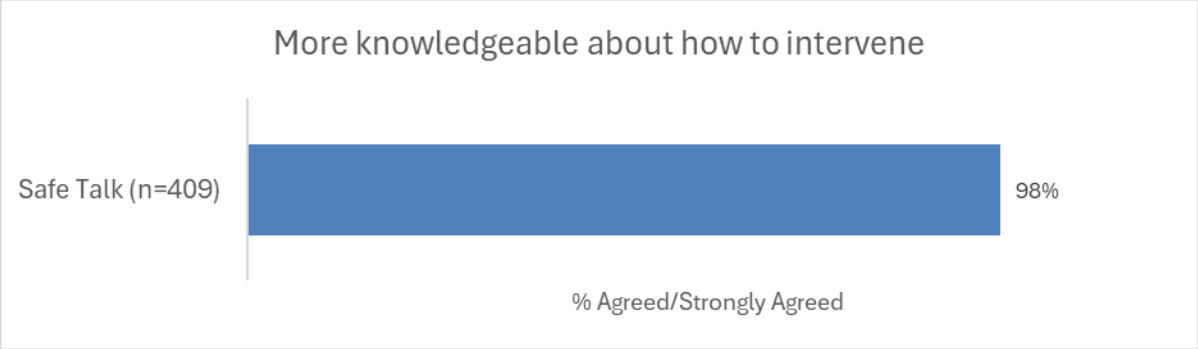
Increased understanding of how to ask for help

Suicide Prevention programming is intended to increase awareness about professional and peer resources that are available to help people who are at risk of suicide. The figure below shows that 85% of students in the Yellow Ribbon Campaign *agreed* or *strongly agreed* that they were more knowledgeable about resources available for people who are at risk of suicide. A slightly larger proportion (88%) of participants in Be a Link felt this way, and it was nearly unanimous among the participants in SafeTalk (97%).



Increased knowledge about how to intervene

SafeTALK is a 3-hour training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. The vast majority (98%) *agreed* or *strongly agreed* that they were more knowledgeable about how to intervene as a result of the training.



Cost/Benefit Analysis

The following table shows several key indicators of performance. The programs cumulatively cost $99 per individual served or $115 per participant who demonstrated improvement in intended outcomes.

Suicide Prevention	
Expenditure/Benefit FY 2023/24	
*Program Expenditures^*	*$630,508*
Total Reached	6,396
Expenditure per individual served	*$99*
Percent who showed improvement/positive change*	86%
*Expenditure per individual who showed improvement/positive change**	*$115*

^Based on invoiced amounts
*As defined under Participant Outcomes

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbance to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, if any are made, and BHS compared referral information to electronic health records to track linkages to service.

The following is a summary of data on mental health treatment referrals from the Suicide Prevention Individual Screenings during the 2023/24 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The Suicide Prevention project made referrals for 65 participants to mental health treatment. Eighteen (18) of the mental health referrals were for treatment provided, funded, administered, or overseen by County mental health programs.
- The average duration of untreated mental illness was 12.9 months.
- Of the 18 County-referred individuals, 7 (39%) were known to have engaged in treatment, defined as receiving services within 60 days.
- On average, the first mental health service was 18 days after referral.

Suicide Prevention in Schools	
Access and Linkage to Treatment Strategy FY 2023/24	
	Suicide Prevention (Individual Screening)
Referrals to MH treatment	
Individuals referred	65
Duration of untreated mental illness (months)	-
Average	12.9
Standard deviation	15.0
# of cases with duration data	20
Linkages to county administered MH treatment	
Individuals referred to county MH treatment	18
# Engaged*	7
% Engaged	39%
Calendar days between referral and service	-
Average	18
Standard deviation	18.4

*Engaged in a service within 60 days after referral

n/a= data not available

Timely Access to Services for Underserved Populations Strategy

PEI reporting requirements ask for details about referrals to mental health treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[32]. Below is a brief summary of the findings.

- During the 2023/24 fiscal year, the Suicide Prevention Project referred 101 **Hispanic/Latino** individuals to mental health treatment or another PEI program; this represents 53% of the Suicide Prevention Project's 189 referrals.
- During the 2023/24 fiscal year, the Suicide Prevention Project referred 15 **Asian and Pacific Islander** individuals to mental health treatment or another PEI program; this represents 8% of all referrals.
- More detailed referral and linkage data for underserved populations are included in the supplemental file.

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

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Suicide Prevention Project encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment, and PEI programs; and how to document referrals per State regulations. In addition, Mental Health Specialists engaged with school contacts to ensure they were receiving referrals and connecting with students. Depending on the severity of symptoms, project staff followed up within one week, and again at 30, 60, and 90-day intervals in order to ensure connection to appropriate services.

Access and Linkage to Treatment

Whole Person Care

Project Description

This project provides match funding for San Joaquin County's Whole Person Care Project, approved by DHCS in 2016. The purpose of San Joaquin County's Public Health and Behavioral Health integrated Whole Person Care project is to test interventions and create a care management infrastructure to better support individuals who are at high risk of untreated mental illness and are high utilizers of health care services. Program services target those who over-utilize emergency department services, have a mental health and/or substance use disorder, or are homeless or at risk for homelessness upon discharge from an institution.

The project involves outreach and engagement by a Homeless Outreach Team who seek to build rapport, provide non Medi-Cal reimbursed services such as transportation to appointments, meals, and other supports to stabilize individuals until they are ready for services, then screens and links them to treatment, as needed.

Project Outputs

In the 2023/24 fiscal year, the WPC project served 107 individuals, 42 of whom continued services from the prior fiscal year and 65 who initiated services in 2023/24. On average, individuals received 11 service contacts and 14 hours of service.

Whole Person Care (WPC)	
Outputs FY 2023/24	
Total unduplicated individuals served*	107
Individuals admitted during fiscal year	65
Total numbers of contacts	1,133
Average number of contacts per individual served	11
Total minutes of service	92,072
Average minutes per individual	860
Average hours per individual	14

Outputs across three years

The table below shows that the number of individuals served has fluctuated slightly.

Whole Person Care (WPC)				
Outputs: Three Year Comparison				
	FY21/22	FY22/23	FY23/24	Yearly Average
Total unduplicated individuals served	154	82	107	114
Individuals admitted during fiscal year	65	21	65	50
Total numbers of contacts	2,324	1,201	1,133	1,553

Contacts per individual served	15	15	11	13
Total minutes of service	134,023	98,949	92,072	108,348
Average minutes per individual	870	1,207	860	979
Average hours per individual	15	20	14	16

Demographics

Demographic forms were collected at the time of initiating services. Based on the information provided in the demographic forms collected[33] (n=51), the program population can broadly be described as adults (69% aged 26-59), with 63% identifying as female. WPC participants are racially and ethnically diverse; 37% identified as Black or African American and 29% identified as Hispanic or Latino. Ninety-six percent of WPC clients are homeless.

Complete demographic tables from 2023/24 are included in the appendix to this report.

Cost/Benefit Analysis

The following table shows the costs of the project and cost per individual served (based on county expenditure reports). In FY2023/24 the Whole Person Care program cost $10,738 per individual served.

Whole Person Care (WPC)	
Expenditure/Benefit FY 2023/24	
*Program Expenditures^*	*$1,148,942*
Unduplicated individuals served	107
Expenditures per individual served	$10,738

^based on county expenditure reports

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, and BHS compared referral information to electronic health records to track linkages to service.

As a matter of practice, 100% of new clients who received a service from Whole Person Care were engaged in discussions about referrals to various services. The following is a summary of data on mental health treatment referrals[34] documented by the WPC program during the 2023/24 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

[33] Up to 20% of participants declined to answer any given demographic question.
[34] Because of interconnected nature between mental health and substance use treatment in this population, referrals to SUD treatment were included in counts of mental health referrals

- The project documented referrals for 49 individuals to treatment provided, funded, administered, or overseen by County programs.
- Of the 49 County-referred individuals, 30 (61%) were known to have engaged in treatment, defined as attending at least one mental health service within 60 days.
- The average interval between referral and treatment was 10.8 days.

Whole Person Care (WPC)	
Access and Linkage to Treatment Strategy FY 2023/24	
Referrals to MH treatment	
Individuals referred	49
Duration of untreated mental illness (months)	
Average	93.1
Standard deviation	174.3
(Count of cases with duration data, used to calculate average and SD)	38
Linkages to county administered MH treatment	
Individuals referred to county MH treatment	49
# Engaged*	30
% Engaged	61%
Calendar days between referral and service	
Average	10.8
Standard deviation	16.9

*Engaged in a service within 60 days of referral

Timely Access to Services for Underserved Populations Strategy

PEI reporting requirements ask for details about referrals to mental health treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[35]. Below is a brief summary of the findings for these two populations. Complete data tables are included in the supplemental file.

- Twenty-seven percent (24%) of referrals were made on behalf of **Latino/Hispanic** individuals. Half of these individuals were known to have been linked to services (6 out of 12, 50%).

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

- One of the referrals (2%) were made on behalf of **Asian/Pacific Islander** individuals, though they were not known to have received services based on that referral.

Because Whole Person Care works closely with unhoused clients, we also looked at timely access for that group as an underserved population. The table below shows that 46 of the 49 referrals were for clients known to be homeless, representing 94% of all mental health referrals.

A total of 29 of these individuals were known to have engaged in treatment, with an average interval of 11 days between referral and service.

Whole Person Care (WPC)	
Timely Access to Services for Underserved Populations FY 2023/24	
Individuals referred to MH treatment or PEI	49
Underserved population: Homeless	
Individuals (in underserved population) referred to MH treatment or PEI	46
Proportion of referrals to MH treatment or PEI	94%
Individuals referred to county administered MH treatment	46
Referred individuals who engaged with county administered MH treatment	29
Interval between referral and treatment (days)	
Average	11.0
Standard deviation	17.1

*Engaged in a service within 60 days of referral

More detailed referral and linkage data for underserved populations are included in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Whole Person Care program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations. Additionally, WPC case managers provide warm handoffs to help clients link to services to which they are referred.

Conclusion

Voters passed Proposition 1, commonly known as Behavioral Health Services Act in March 2024, resulting in significant amends the Mental Health Services Act (MHSA) passed by voters in 2004. The new Act restructures funding allocations, expands services to include substance use disorder treatment and prioritizes services for persons with serious mental illness, including Full Service Partnerships (FSPs) and housing.

As a result, PEI programs will now be included in a larger category of Behavioral Health Services and Supports, and funding previously dedicated to Prevention and Early Intervention will now be shared among programs that treat individuals with serious mental illness and cooccurring disorders, as well as those that provide workforce education and innovations to address behavioral health. Additionally, the administration of certain prevention services will transition to state-level agencies. Consequently, Counties across the state are reassessing and reducing PEI budgets, and as possible identifying alternative sources of revenue. The following are recommendations based on the evaluation.

Recommendations

- **Skill-Building for Parents and Guardians:** CAPC, Parents by Choice, and Catholic Charities have provided consistently high-quality parenting classes to at-risk parents for over a decade. Due to reallocation of resources, including the shifting of a certain proportion of PEI funds from counties to state-administered programs, we see no path forward for this project within the evolving funding structure. Our understanding is that certain PEI funds will be reallocated to county public health departments, and parenting programs will likely go out to bid. Local experience, strong evaluation reports, and positive references from program managers will help these programs continue to provide excellent services with other sources of funds.

- **Mentoring Transitional Age Youth:** Similar to Skill-Building for Parents and Guardians, CAPC and PREVAIL (formally Women's Center Youth and Family Services) have been providing prevention-oriented services to at-risk youth for numerous years. Based on the three-year evaluation, CAPC has served more participants and been more successful at graduating those who've met self-identified goals (93-84% completion rate vs 78-59% for PREVAIL). Improvements in CANSA scores between intake and discharge, likewise, were greater for CAPC. Our intention is not to cast doubt on the quality of PREVAIL's services, but rather to say that the CAPC is more effective at reaching youth who can benefit and has more capacity to affectively apply the evidence-based practice with these youth.

  Due to the contraction of PEI funding and in order to reduce administrative burden, it is the evaluator's perspective that we recommend ending the PREVAIL contract. We also recommend that CAPC employ a hybrid model: in addition, serving youth qualifying for Prevention services, begin providing Early Intervention services to those youth who

quality, thus leveraging Medi-Cal revenue. It is our perception that a large proportion of these youth would qualify for EPSDT or SMHS. It is also most certainly true that there are many other youth within the community who would qualify, including those referred by BHS.

- **Community Trauma Services for Adults:** El Concilio's Trauma program provided low-intensity services, averaging 5.5 hours per participant, in FY 2023/24. Only 11% of services involved individual therapy. Only 23 (17%) of the 137 individuals who participated in the program between FY 2022/23 and FY 2023/24 remained in treatment long enough for a follow-up LASC, and of those, pre/post improvements in PTSD scores were not statistically significant.

  It was also noted that the majority of FY2023/24 participants—129 out of 162 (86%)—were referred to higher levels of treatment, also provided by El Concilio. Therefore, the evaluator believes this program serves more of an *Access and Linkage to Treatment* or *Timely Services for Underserved Populations* function. Services delivered within these PEI components do not require demonstration of symptom alleviation (i.e., pre/post assessment).

  If the program wishes to remain Early Intervention, and continue to bill for Medi-Cal services, it should target patients with high levels of PTSD symptoms and, rather than referring them to more generalized treatment programs, provide more intensive, targeted, and longer-term clinical services aimed at preventing worsening PTSD symptoms.

- **TEIR:** The TEIR program provides intensive services to highly vulnerable youth and young adults. Out of all youth FSPs, TEIR provides the highest number of minutes per week per client and generates the greatest amount of Medi-Cal revenue. However, due to staffing transitions, this program has had consistent difficulty tracking and reporting outcome data. This casts a shadow on their effectiveness, in spite of anecdotal reports of successful client outcomes.

  Starting July 2027, SJCBHS will begin implementing the evidence-based Coordinated Specialty Care (CSC) and will need to demonstrate robust fidelity. BHS may be able to expand the current Telecare contract to include this EBP. In order to consider such expansion, we recommend that Telecare identify selective management-level staff who have data reporting and evaluation expertise who can support this program as well as any expansion.

- **School-Based Suicide Prevention:** CAPC has delivered suicide prevention workshops and intensive education to thousands of students in 15 high schools and several hundred community members within the county. Nonetheless there many more high schools in

the area, and over one hundred thousand students. The quality of CAPC programming is high, but not always well-received by school administrators, due to classroom interruptions. And while students report greater knowledge following training, community impact of suicide prevention programming is difficult if not impossible, to measure.

Since the launch of MHSA, CalAIM clarified that it is the schools' role to provide mild to moderate behavioral health treatment. Further, Children and Youth Behavioral Health Initiative (CYBHI) funds whole person-oriented school-based services, which may provide a more targeted approach, including screening, assessment and treatment. In 2023/24, the Suicide Prevention program provided only 298 screenings and involved only 33 students in depression support groups. We recommend cautiously ending the School-Based Suicide Prevention Project as school personnel report increasing expertise in the subject matter.

- **CARES** provides screening and trauma-informed services intended for children and youth with mild to moderate mental health symptoms, and their families using family education curricula. Nonetheless many child participants qualify for treatment under EPSDT guidelines and would benefit from more intensive evidence-based clinical therapies provided by a team of skilled providers. By shifting to a hybrid Prevention and Early Intervention program, CARES could match trauma-exposed children with the most appropriate treatment options as well as leverage Medi-Cal revenue for those children who qualify, advancing the goal of preventing the development of more severe and persistent behavioral health challenges. To this effect, Children and Youth Services (CYS) has already initiated on-site Medi-Cal certification review with DHCS.

- **NAMI's Provider Education and Stigma and Discrimination Reduction Programs:** NAMI of San Joaquin County has implemented four different curriculums targeting consumers, family members, providers, and the community at large. Retrospective evaluation surveys show favorable shifts in attitudes and knowledge about mental health among the 150 or so participants trained each year. The NAMI project is small due to insufficient staff and volunteer capacity to outreach and educate participants, and so, the ratio of oversight and evaluation to service delivery is very high. In spite of community presence, the programs have not generated any referrals to BHS, and trainings predominantly target existing clients, and thus outside the scope of prevention or early intervention programming intentions. Since BHSA funding for prevention and early intervention increasingly prioritize children and youth, individuals with co-occurring substance use disorders, and more robust outcome evaluation, we recommend ending this project and integrating NAMI trainings into the Wellness Centers' scopes of work.

- **Children 0-5:** Victor Community Counseling Services has been operating the Children 0-5 contract for one year. The project arose in response to a need, identified in MHSA

community meetings, for services for this population. However, Victor has not been able to attract as many children and caregivers as was anticipated. Due to a shortage of demand and an inability to identify children and families eligible for Prevention services, we recommend ending the program. The need can be met through programs that target very young children, as offered by Public health, as well as VMRC (Valley Mountain Regional Center), First Five of San Joaquin, Family Resource Center, and others.

- **Whole Person Care:** Under the Whole Person Care project umbrella, BHS outreach workers provide a vital bridge to behavioral health treatment and other necessary services for reluctant severely mentally ill unhoused and underhoused community members. Under CalAIM, many of these services can claim Medi-Cal reimbursement; thus the program should bill Medi-Cal when appropriate. Whole Person Care is currently an *Access and Linkage to Treatment* program, but if it begins providing more intensive services it might better be classified as either *Early Intervention* or a non-PEI-funded SMHS. And, given its short-term intention—to connect people to ongoing care—it is perhaps better for WPC to avoid the outcome measurement requirements of PEI.

  On a separate note, gathering PEI-required data from the Public Health Department has proven challenging because of various and uncoordinated reporting requirements from PH's multiple WPC funding streams, as well as logistical challenges coordinating health data between departments. If possible, we recommend using different, less cumbersome funding streams to support Public Health's effort to link members to mental health treatment.

Appendix: Demographic Tables

Skill-Building for Parents and Guardians

Methodological note: Data on demographic groups with fewer than 10 members in any program are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Skill-Building for Parents and Guardians				
Demographics FY 2023/24				
	CAPC-PC	CC-NPP	PBC - Triple P	Total Skill-building
Number of participants (unduplicated)	872	440	543	1,855
Number of demographic forms collected	932	468	470	1,870
Age				
0-15	X	X	X	X
16-25	36	10	29	75
26-59	623	411	286	1320
60 and older	42	15	12	69
Decline to answer	228	32	141	401
Race				
American Indian or Alaska Native	X	X	X	X
Asian	16	X	X	25
Black of African American	49	X	41	90
Native Hawaiian or other Pacific Islander	X	X	X	X
White	137	120	84	341
Other	394	153	135	682
More than one race	43	X	48	95
Decline to answer	286	191	151	628
Ethnicity				
Hispanic or Latino				
Caribbean	X	X	X	X
Central America	23	X	X	39
Mexican/Mexican-American	489	412	137	1038
Puerto Rican	X	X	X	X
South American	X	X	X	10
Other Hispanic or Latino	X	X	X	10
Non-Hispanic or Non-Latino				
African	30	X	29	59
Asian Indian/South Asian	X	X	X	13

Cambodian	X	X	X	X
Chinese	X	X	X	X
Eastern European	X	X	X	X
European	X	X	27	29
Filipino	X	X	X	12
Japanese	X	X	X	X
Korean	X	X	X	X
Middle Eastern	X	X	X	X
Vietnamese	X	X	X	X
Other Non-Hispanic or Latino	57	X	38	97
Other	X	X	X	X
More than one ethnicity	39	X	39	78
Decline to Answer	252	38	176	466
Primary language				
English	226	30	268	524
Spanish	465	408	53	926
Other	X	X	X	15
Decline to Answer	232	29	144	405
Sexual orientation				
Gay or Lesbian	X	X	X	13
Heterosexual or Straight	585	256	277	1118
Bisexual	X	X	17	23
Questioning or unsure of sexual orientation	X	X	X	X
Queer	X	X	X	X
Other	X	X	X	X
Decline to answer	332	199	170	701
N/A	X	11	X	11
Disability*				
Difficulty seeing	34	16	X	53
Difficulty hearing	11	X	X	15
A mental disability	36	X	16	52
A physical/mobility disability	31	X	13	45
A chronic health condition	22	X	X	37
Other Disability	17	X	15	32
Decline to answer	823	446	431	1700
No Disability	534	325	270	1129
Veteran status				
Yes	X	X	X	X
No	681	422	319	1422
Decline to answer	242	45	147	434
N/A	X	X	X	X

Sex assigned at birth				
Male	118	56	87	261
Female	585	385	238	1208
Decline to answer	229	27	145	401
Gender identity				
Male	117	57	86	260
Female	577	377	234	1188
Transgender	X	X	X	X
Genderqueer/Non-Binary	X	X	X	X
Questioning or unsure of gender identity	X	X	X	X
Other	X	X	X	X
Decline to answer	237	34	147	418
N/A	X	X	X	X
Homeless				
Yes	116	X	38	155
No	567	405	280	1252
Decline to answer	249	62	152	463

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

Mentoring for Transitional Age Youth

Methodological note: Data on demographic groups with fewer than 10 members in any program are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Mentoring for Transitional Age Youth			
Demographics FY 2023/24			
	CAPC	PREVAIL	Total TAY
Number enrolled	301	162	463
Number of demographic forms collected	289	166	455
Age			
0-15	X	X	X
16-25	270	166	436
26-59	X	X	X
60 and older	X	X	X
Decline to answer	18	X	18
Race			
American Indian or Alaska Native	X	X	X
Asian	17	X	20
Black of African American	36	47	83
Native Hawaiian or other Pacific Islander	X	X	X
White	67	31	98
Other	72	52	124
More than one race	67	27	94
Decline to answer	26	X	32
Ethnicity			
Hispanic or Latino			
Caribbean	X	X	X
Central America	X	X	X
Mexican/Mexican-American	127	74	201
Puerto Rican	X	X	X
South American	X	X	X
Other Hispanic or Latino	X	X	X
Non-Hispanic or Non-Latino			
African	25	17	42
Asian Indian/South Asian	X	X	X
Cambodian	X	X	X
Chinese	X	X	X
Eastern European	X	X	X
European	11	7	18
Filipino	10	X	10
Japanese	X	X	X

Korean	X	X	X
Middle Eastern	X	X	X
Vietnamese	X	X	X
Other Non-Hispanic or Latino	X	10	16
Other	12	X	12
More than one ethnicity	33	17	50
Decline to Answer	39	35	74
Primary language			
English	235	162	397
Spanish	34	X	38
Other	X	X	X
Decline to Answer	18	X	18
Sexual orientation			
Gay or Lesbian	12	X	21
Heterosexual or Straight	188	118	306
Bisexual	27	22	49
Questioning or unsure of sexual orientation	X	X	10
Queer	X	X	X
Other	10	X	14
Decline to answer	44	X	52
N/A	X	X	X
Disability*			
Difficulty seeing	13	X	15
Difficulty hearing	X	X	X
A mental disability	30	23	53
A physical/mobility disability	X	X	X
A chronic health condition	X	X	X
Other Disability	16	X	21
Decline to answer	34	36	70
No Disability	192	97	289
Veteran status			
Yes	X	X	X
No	268	159	427
Decline to answer	20	X	27
N/A	X	X	X
Sex assigned at birth			
Male	107	59	166
Female	163	105	268
Decline to answer	19	X	21
Gender identity			
Male	105	59	164

Female	154	101	255
Transgender	X	X	X
Genderqueer/Non-Binary	X	X	X
Questioning or unsure of gender identity	X	X	X
Other	X	X	X
Decline to answer	19	X	19
N/A	X	X	X
Homeless			
Yes	13	86	99
No	253	56	309
Decline to answer	23	24	47

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

Coping and Resilience Education Services (CARES)

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Coping and Resilience Education Services (CARES)	
Demographics FY 2023/24	
Number of participants who began services	268
Number of demographic forms collected	254
Age	
0-15	162
16-25	12
26-59	74
60 and older	X
Decline to answer	X
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	30
Native Hawaiian or other Pacific Islander	X
White	71
Other	79
More than one race	36
Decline to answer	30
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	153
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	19
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X
Filipino	X
Japanese	X
Korean	X

Middle Eastern	X
Vietnamese	X
Other Non-Hispanic or Latino	X
Other	X
More than one ethnicity	24
Decline to Answer	35
Primary language	
English	191
Spanish	60
Other	X
Decline to Answer	X
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	101
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Decline to answer	25
N/A	119
Disability*	
Difficulty seeing	14
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	X
Other Disability	X
Decline to answer	27
No Disability	192
Veteran status	
Yes	X
No	88
Decline to answer	X
N/A	162
Sex assigned at birth	
Male	110
Female	138
Decline to answer	X
Gender identity	
Male	31
Female	97

Transgender	X
Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Decline to answer	X
N/A	119
Homeless	
Yes	X
No	253
Decline to answer	X

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

Prevention Services for Children 0-5 and Caregivers (0 to 5)

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Prevention Services for Children 0-5 and Caregivers	
Demographics FY 2023/24	
Number of participants (unduplicated, including those rolled over from the previous year)	20
Number of demographic forms collected	19
Age	
0-15	19
16-25	X
26-59	X
60 and older	X
Decline to answer	X
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	X
Native Hawaiian or other Pacific Islander	X
White	X
Other	X
More than one race	X
Decline to answer	X
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	X
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	X
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X
Filipino	X
Japanese	X

Korean	X
Middle Eastern	X
Vietnamese	X
Other Non-Hispanic or Latino	X
Other	X
More than one ethnicity	X
Decline to Answer	X
Primary language	
English	10
Spanish	X
Other	X
Decline to Answer	X
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	X
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Decline to answer	X
N/A	19
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	X
Other Disability	X
Decline to answer	X
No Disability	17
Veteran status	
Yes	X
No	X
Decline to answer	X
N/A	19
Sex assigned at birth	
Male	13
Female	X
Decline to answer	X
Gender identity	
Male	X

Female	X
Transgender	X
Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Decline to answer	X
N/A	19
Homeless	
Yes	X
No	19
Decline to answer	X

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School Based Intervention for Children and Youth

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

School Based Interventions				
Demographics FY 2023/24				
	CAPC	Parents By Choice	Sow a Seed	Total
Number of participants (unduplicated)	208	196	169	573
Number of demographic forms collected	197	184	153	534
Age				
0-15	191	134	150	475
16-25	X	49	X	58
26-59	X	X	X	X
60 and older	X	X	X	X
Decline to answer	X	X	X	X
Race				
American Indian or Alaska Native	X	X	X	11
Asian	X	X	X	14
Black of African American	23	19	14	56
Native Hawaiian or other Pacific Islander	X	X	X	X
White	106	22	59	187
Other	39	100	37	176
More than one race	12	22	29	63
Decline to answer	10	11	X	27
Ethnicity				
Hispanic or Latino				
Caribbean	X	X	X	X
Central America	X	X	X	X
Mexican/Mexican-American	106	106	69	281
Puerto Rican	X	X	X	X
South American	X	X	X	X
Other Hispanic or Latino	X	X	10	19
Non-Hispanic or Non-Latino				
African	11	14	X	31
Asian Indian/South Asian	X	X	X	X
Cambodian	X	X	X	X
Chinese	X	X	X	X
Eastern European	X	X	X	X
European	X	X	X	X

Filipino	X	X	X	X
Japanese	X	X	X	X
Korean	X	X	X	X
Middle Eastern	X	X	X	X
Vietnamese	X	X	X	X
Other Non-Hispanic or Latino	44	23	X	74
Other	X	X	X	X
More than one ethnicity	10	24	X	42
Decline to Answer	14	X	34	53
Primary language				
English	177	147	95	419
Spanish	19	32	46	97
Other	X	X	X	X
Decline to Answer	X	X	10	10
Sexual orientation				
Gay or Lesbian	X	X	X	X
Heterosexual or Straight	43	103	32	178
Bisexual	X	18	X	20
Questioning or unsure of sexual orientation	X	X	X	X
Queer	X	X	X	X
Other	X	X	X	X
Decline to answer	X	X	X	X
N/A	152	47	115	314
Disability*				
Difficulty seeing	X	X	X	X
Difficulty hearing	X	X	X	X
A mental disability	X	X	X	X
A physical/mobility disability	X	X	X	X
A chronic health condition	X	X	X	X
Other Disability	0	13	X	16
Decline to answer	X	X	X	10
No Disability	196	164	140	500
Veteran status				
Yes	X	X	X	X
No	X	49	X	58
Decline to answer	X	X	X	X
N/A	191	134	150	475
Sex assigned at birth				
Male	121	56	91	268
Female	76	126	62	264

Decline to answer	X	X	X	X
Gender identity				
Male	26	38	18	82
Female	18	94	18	130
Transgender	X	X	X	X
Genderqueer/Non-Binary	X	X	X	X
Questioning or unsure of gender identity	X	X	X	X
Other	X	X	X	X
Decline to answer	X	X	X	X
N/A	152	47	115	314
Homeless				
Yes	X	X	X	X
No	197	183	151	531
Decline to answer	X	X	X	X

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Telecare Early Intervention and Recovery Services (TEIR)

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Telecare Early Intervention and Recovery Services (TEIR)	
Demographics FY 2023/24	
Number of participants (unduplicated, including those rolled over from the previous year)	88
Number of demographic forms collected	64
Age	
0-15	X
16-25	43
26-59	X
60 and older	X
Decline to answer	20
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	14
Native Hawaiian or other Pacific Islander	X
White	10
Other	X
More than one race	X
Decline to answer	25
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	13
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	11
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X
Filipino	X
Japanese	X

Korean	X
Middle Eastern	X
Vietnamese	X
Other Non-Hispanic or Latino	X
Other	X
More than one ethnicity	X
Decline to Answer	26
Primary language	
English	39
Spanish	X
Other	X
Decline to Answer	22
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	19
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Decline to answer	36
N/A	X
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	X
Other Disability	X
Decline to answer	24
No Disability	36
Veteran status	
Yes	X
No	40
Decline to answer	24
N/A	X
Sex assigned at birth	
Male	16
Female	22
Decline to answer	26
Gender identity	
Male	16

Female	21
Transgender	X
Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Decline to answer	24
N/A	X
Homeless	
Yes	X
No	36
Decline to answer	24

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Community Trauma Services for Adults

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Trauma Services				
Demographics FY 2023/24				
	CAPC	El Concilio	VIVO	Total
Total unduplicated count of individuals receiving services (SmartCare)	22	162	88	272
Total number screened (program records)	24	237	30	291
Number of demographic forms collected	23	168	29	220
Age				
0-15	X	X	X	X
16-25	1	23	1	25
26-59	21	139	16	176
60 and older	1	5	12	18
Decline to answer	X	1	X	1
Race				
American Indian or Alaska Native	1	X	X	1
Asian	X	X	27	27
Black of African American	X	X	X	12
Native Hawaiian or other Pacific Islander	X	X	X	X
White	X	21	X	31
Other	X	141	X	143
More than one race	X	X	X	X
Decline to answer	X	X	X	X
Ethnicity				
Hispanic or Latino				
Caribbean	X	X	X	X
Central America	X	X	X	X
Mexican/Mexican-American	X	132	X	141
Puerto Rican	X	X	X	X
South American	X	X	X	X
Other Hispanic or Latino	X	X	X	X
Non-Hispanic or Non-Latino				
African	X	X	X	X
Asian Indian/South Asian	X	X	X	X
Cambodian	X	X	X	X

Chinese	X	X	X	X
Eastern European	X	X	X	X
European	X	X	X	X
Filipino	X	X	X	X
Japanese	X	X	X	X
Korean	X	X	X	X
Middle Eastern	X	X	X	X
Vietnamese	X	X	X	X
Other Non-Hispanic or Latino	X	25	18	51
Other	X	X	X	X
More than one ethnicity	X	X	X	X
Decline to Answer	X	X	X	X
Primary language				
English	21	66	X	89
Spanish	X	101	X	103
Other	X	X	27	27
Decline to Answer	X	X	X	X
Sexual orientation				
Gay or Lesbian	X	X	X	X
Heterosexual or Straight	18	166	25	209
Bisexual	X	X	X	X
Questioning or unsure of sexual orientation	X	X	X	X
Queer	X	X	X	X
Other	X	X	X	X
Decline to answer	X	X	X	X
N/A	X	X	X	X
Disability*				
Difficulty seeing	X	X	X	X
Difficulty hearing	X	X	X	X
A mental disability	X	X	X	X
A physical/mobility disability	X	X	X	10
A chronic health condition	X	X	X	X
Other Disability	X	X	X	X
Decline to answer	X	X	12	13
No Disability	20	164	X	190
Veteran status				
Yes	X	X	X	X
No	23	166	28	217
Decline to answer	X	X	X	X

N/A	X	X	X	X
Sex assigned at birth				
Male	X	46	12	60
Female	21	121	17	159
Decline to answer	X	X	X	X
Gender identity				
Male	X	46	12	60
Female	21	120	17	158
Transgender	X	X	X	X
Genderqueer/Non-Binary	X	X	X	X
Questioning or unsure of gender identity	X	X	X	X
Other	X	X	X	X
Decline to answer	X	X	X	X
N/A	X	X	X	X
Homeless				
Yes	X	X	12	18
No	21	162	13	196
Decline to answer	X	X	X	X

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

NAMI Outreach for Increasing Recognition of Early Signs of Mental Illness

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Outreach for Increasing Recognition of Early Signs of Mental Illness	
Demographics FY 2023/24	
Number of participants	32
Number of demographic forms collected	28
Age	
0-15	X
16-25	X
26-59	23
60 and older	X
Decline to answer	X
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	X
Native Hawaiian or other Pacific Islander	X
White	10
Other	X
More than one race	X
Decline to answer	X
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	X
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	X
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X
Filipino	X
Japanese	X
Korean	X

Middle Eastern	X
Vietnamese	X
Other Non-Hispanic or Latino	X
Other	X
More than one ethnicity	X
Decline to Answer	X
Primary language	
English	23
Spanish	X
Other	X
Decline to Answer	X
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	23
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Decline to answer	X
N/A	X
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	X
Other Disability	X
Decline to answer	X
No Disability	22
Veteran status	
Yes	X
No	27
Decline to answer	X
N/A	X
Sex assigned at birth	
Male	X
Female	21
Decline to answer	X
Gender identity	
Male	X
Female	21

Transgender	X
Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Decline to answer	X
N/A	X
Homeless	
Yes	X
No	28
Decline to answer	X

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

NAMI Stigma and Discrimination Reduction Program

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

NAMI Stigma and Discrimination Reduction Program				
Demographics FY 2023/24				
	IOOV	F2F	P2P	Total
Number of participants (unduplicated)	180	11	18	209
Number of demographic forms collected	188	X	18	211
Age				
0-15	X	X	X	X
16-25	27	X	X	29
26-59	112	X	13	126
60 and older	29	X	X	36
Decline to answer	18	X	X	18
Race				
American Indian or Alaska Native	X	X	X	X
Asian	18	X	X	20
Black of African American	12	X	X	12
Native Hawaiian or other Pacific Islander	X	X	X	X
White	75	X	12	88
Other	18	X	X	22
More than one race	22	X	X	25
Decline to answer	40	X	X	41
Ethnicity				
Hispanic or Latino				
Caribbean	X	X	X	X
Central America	X	X	X	X
Mexican/Mexican-American	43	X	X	52
Puerto Rican	X	X	X	X
South American	X	X	X	X
Other Hispanic or Latino	X	X	X	X
Non-Hispanic or Non-Latino				
African	X	X	X	X
Asian Indian/South Asian	X	X	X	X
Cambodian	X	X	X	X
Chinese	X	X	X	X
Eastern European	X	X	X	X
European	15	X	X	17
Filipino	X	X	X	X
Japanese	X	X	X	X

Korean	X	X	X	X
Middle Eastern	X	X	X	X
Vietnamese	X	X	X	X
Other Non-Hispanic or Latino	X	X	X	X
Other	X	X	X	X
More than one ethnicity	22	X	X	24
Decline to Answer	71	X	X	75
Primary language				
English	156	X	17	177
Spanish	X	X	X	11
Other	X	X	X	X
Decline to Answer	16	X	X	16
Sexual orientation				
Gay or Lesbian	X	X	X	X
Heterosexual or Straight	138	X	10	152
Bisexual	X	X	X	10
Questioning or unsure of sexual orientation	X	X	X	X
Queer	X	X	X	X
Other	X	X	X	X
Decline to answer	13	X	X	16
N/A	13	X	X	13
Disability*				
Difficulty seeing	11	X	X	11
Difficulty hearing	X	X	X	X
A mental disability	46	X	X	51
A physical/mobility disability	22	X	X	26
A chronic health condition	23	X	X	30
Other Disability	X	X	X	X
Decline to answer	25	X	X	28
No Disability	96	X	X	105
Veteran status				
Yes	X	X	X	10
No	174	X	16	195
Decline to answer	X	X	X	X
N/A	X	X	X	X
Sex assigned at birth				
Male	80	X	X	85
Female	103	X	13	121
Decline to answer	X	X	X	X
Gender identity				

Male	75	X	X	79
Female	100	X	11	116
Transgender	X	X	X	X
Genderqueer/Non-Binary	X	X	X	X
Questioning or unsure of gender identity	X	X	X	X
Other	X	X	X	X
Decline to answer	X	X	X	X
N/A	X	X	X	X
Homeless				
Yes	14	X	X	14
No	162	X	18	185
Decline to answer	12	X	X	12

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

Suicide Prevention in Schools

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Suicide Prevention in Schools		
Demographics FY 2023/24		
	Presentations	Individual Screening
Number of participants (unduplicated)	6,396	298
Number of demographic forms collected (duplicated)	7,707	353
Age		
0-15	3,814	132
16-25	2,685	156
26-59	762	33
60 and older	41	X
Decline to answer	405	31
Race		
American Indian or Alaska Native	121	X
Asian	791	22
Black of African American	402	30
Native Hawaiian or other Pacific Islander	0	X
White	1,606	98
Other	1,518	90
More than one race	1,494	64
Decline to answer	1,775	43
Ethnicity		
Hispanic or Latino		
Caribbean	16	X
Central America	136	X
Mexican/Mexican-American	2713	155
Puerto Rican	65	X
South American	64	X
Other Hispanic or Latino	163	X
Non-Hispanic or Non-Latino		
African	229	17
Asian Indian/South Asian	141	X
Cambodian	88	X
Chinese	46	X
Eastern European	X	X
European	303	22
Filipino	235	13

Japanese	29	X
Korean	12	X
Middle Eastern	69	X
Vietnamese	70	X
Other Non-Hispanic or Latino	0	X
Other	352	X
More than one ethnicity	909	26
Decline to Answer	2,067	68
Primary language		
English	4,913	247
Spanish	1,259	62
Other	311	12
Decline to Answer	1,224	32
Sexual orientation		
Gay or Lesbian	192	16
Heterosexual or Straight	4,860	230
Bisexual	407	28
Questioning or unsure of sexual orientation	111	X
Queer	73	X
Other	121	X
Decline to answer	1,937	72
N/A	X	X
Disability*		
Difficulty seeing	342	12
Difficulty hearing	74	X
A mental disability	237	14
A physical/mobility disability	55	X
A chronic health condition	67	X
Other Disability	81	X
Decline to answer	1,600	53
No Disability	5,411	265
Veteran status		
Yes	25	X
No	2,949	187
Decline to answer	919	34
N/A	3,814	132
Sex assigned at birth		
Male	3,189	120
Female	3,850	199
Decline to answer	668	34
Gender identity		

Male	2,882	118
Female	3,443	187
Transgender	36	X
Genderqueer/Non-Binary	85	X
Questioning or unsure of gender identity	36	X
Other	21	X
Decline to answer	1,198	37
N/A	X	X
Homeless		
Yes	47	X
No	6,429	314
Decline to answer	1,231	37

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Whole Person Care

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Whole Person Care (WPC)	
Demographics FY 2023/24	
Number of demographic forms reported	51
Age	
0-15	X
16-25	X
26-59	35
60 and older	14
Missing/Decline to answer	X
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	19
Native Hawaiian or other Pacific Islander	X
White	24
Other	X
More than one race	X
Missing/Decline to answer	X
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	X
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	13
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X
Filipino	X
Japanese	X
Korean	X
Middle Eastern	X

Vietnamese	X
Other Non-Hispanic or Latino	X
Other	X
More than one ethnicity	X
Missing/Decline to answer	10
Primary language	
English	48
Spanish	X
Other	X
Missing/Decline to answer	X
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	46
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Missing/Decline to answer	X
N/A	X
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	19
A physical/mobility disability	10
A chronic health condition	11
Other Disability	X
Missing/Decline to answer	X
No Disability	15
Veteran status	
Yes	X
No	48
Missing/Decline to answer	X
Sex assigned at birth	
Male	19
Female	32
Missing/Decline to answer	X
Gender identity	
Male	19
Female	32
Transgender	X
Genderqueer/Non-Binary	X

Questioning or unsure of gender identity	X
Other	X
Missing/Decline to answer	X
N/A	X
Homeless	
Yes	48
No	X
Missing/Decline to answer	X

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

San Joaquin County

Semi-Statewide Enterprise Health Record

Multi-County Collaborative INN Project

Annual Innovative Project Report

Reporting Period: July 1, 2023 – June 30, 2024

Project Period: 02/01/2023 – 02/01/2028

SAN JOAQUIN COUNTY
Behavioral Health Services

In partnership with

CalMHSA
California Mental Health Services Authority

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Project Overview and Local Need

1. Please describe this Innovation project and its purpose.

This is a multi-county, scalable INN project that stems from a larger Semi-Statewide Enterprise Health Record (EHR) project CalMHSA is concurrently leading (the EHR Project). In fiscal year (FY) 2023-24, CalMHSA partnered with 23 California counties – collectively responsible for 27% of the state's Medi-Cal members – on the Semi-Statewide Enterprise Health Record project. In FY 2024-25, to date CalMHSA is partnering with 25 counties, collectively responsible for 35% of the state's Medi-Cal members.

This project is unique in that it engages counties to collaboratively design a lean and modern EHR to meet the needs of counties and the communities they serve.

The key principles of the EHR project include:

Enterprise Solution: Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of county behavioral health plans. This approach also facilitates data sharing between counties for patient treatment and payment purposes as patients move from one county to another.

Collective Learning and Scalable Solutions: Moving from solutions developed within individual counties to a semi-statewide cohort allows counties to achieve alignment, pool resources and bring forward scaled solutions to current problems, thus reducing waste, mitigating risk and improving quality.

Leveraging CalAIM: CalAIM implementation represents a transformative moment when primary components within the EHR are being re-designed (e.g., clinical documentation and Medi-Cal claiming), while data exchange and interoperability with physical health care — toward improving care coordination and client outcomes — are both required and supported by the State.

Lean and Human-Centered: Engaging with experts in human-centered design to reimagine the clinical workflow in a way that reduces "clicks" (the documentation burden), increases client safety and natively collects outcomes.

Interoperable: Typically, county behavioral health has, in response to state regulations, developed documentation that is out of alignment with data exchange standards. We are reimagining the clinical workflow, allowing critical information about the people we serve to be formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like health information exchanges).

2. Please describe how this project makes a change to an existing practice in the field of mental health, including but not limited to application to a different population.

This project will meet the general requirements by making a change to an existing practice in the field of mental health — specifically, the practice of documenting care in an EHR that meets the needs of the county's workforce and the clients they serve. This innovative project aims to transform the standard use of an electronic health record by standing up a semi-statewide behavioral health electronic health record in collaboration with a cohort of counties. This new EHR is responsive to identified provider needs and supports the spread of best practices among the participating counties. Optimizing the EHR to meet daily workflow needs of treating providers can enhance working conditions, increase efficiencies, and reduce burnout, ultimately improving the conditions under which direct client care is

provided. With the input of provider stakeholders and best practice experts in the field of human-centered design, the new EHR is being collaboratively and intentionally designed to improve the method and ease of documenting in the EHR as well as gathering and appropriately sharing pertinent clinical information from the EHR, which will promote less time spent on "treating the chart" and more time spent on "treating individuals" in need of care.

3. Please describe how this project impacts your County's local need(s).

Previous Response:
San Joaquin County's local needs have not significantly changed over the last project period; however, we do have a few updates regarding the EHR reporting activities.

Previous Response:

- *SmartCare will significantly Improve our ability to audit and comply with State regulations. The system will have functionality allowing the County to remove access to data entry for staff with expired licenses. Additionally, the County will be able to track access to client profiles to ensure files are not accessed erroneously. The County will have the ability to ensure clinical documentation groups are assigned appropriately.*
- *There's an anticipated reduction in the use of paper to gather necessary medical records to perform clinical operations.*
- *In future Iterations SmartCare will provide the County with greater granular data extraction leading to detailed reports. This should result in better clinical outcomes.*
- *As a cloud-based system SmartCare will make it much easier for the County to provide access to Community Based Organizations, reducing the overall amount of time it takes to onboard new vendors.*
- *SmartCare will provide considerable enhancements to security related to multi-factor authentication making It easier for I.S. staff to track and prevent cyberattacks. Supervisors we bill be able to finalize notes of staff out of extended leaves, a process we were unable to complete in our current EMR.*

Updated Response:

- The EHR is assisting in data collection for Care Court which Is an arduous task. Care Court provides community-based behavioral health services and supports to Californians living with schizophrenia spectrum or other psychotic disorders who meet health and safety criteria. It is a new civil court process where certain people, such as family members, first responders, and providers, may file a petition to the court to create a voluntary CARE agreement or a court-ordered CARE plan.
- The EHR is expected to assist with Data Collection Reporting. These forms are required for all clients in a Full Service Partnership and are designed to track client data.

- The EHR is completing our 274 reporting. The 274 standard is an Electronic Data Interchange standard selected by the DHCS to ensure provider network data submitted to DHCS is consistent, uniform, and aligns with national standards.
- We are able to scan in documents to the EHR which assist with sharing information across different providers in different locations.

Progress Update and Identified Changes

1. Please describe your project progress from July 1, 2023, through June 30, 2024.

San Joaquin County (SJC) is well beyond the Initial phases of Implementation of our new EHR. We have moved into figuring out how to best utilize every function of the new EHR.

SJC onboarded a contracted staff person to assist with the implementation of the EHR In March of 2024. As we need less assistance now, this position Is now part time. Her title Is SmartCare Project Manager and she assisted In monitoring our progress on resolving Issues within the EHR.

SJC also created a new Clinical Assistant Director position which was filled In April of 2024. This person works closely with the Business Office to ensure we are maximizing our billing potential. This person also serves as a liaison between the Business Office and the clinical teams.

Local CBO's have all been onboarded Into SmartCare with the exception of some NTP providers who continue to provide services via the batch upload process. When needed, SJCBHS has offered additional, on site trainings for CBO's.

We have utilized many CalMHSA supports including CalMHSA's Learning Management System for learning opportunities and the Power BI dashboards. We hope to gain more support from CalMHSA in regards to the DCR form reporting.

2. Has your county experienced any changes in project implementation and/or local need since the submission of your Appendix for MHSOAC approval? What is/are the reason(s) for this/these change(s)?

We have not experienced any changes during this reporting period, but we will have changes to report In the next reporting period as we signed a contract with CalMHSA to do Revenue Cycle Management effective 7/1/24.

3. How does this change/these changes noted in #2 above impact or modify your project plan and/or timeline?

N/A

CalMHSA's Internal Evaluation and Qualitative Analysis of the State of Electronic Health Records Across California Counties

CalMHSA partnered with IDEO, a global, human-centered design and research company with over 40 years of consulting experience working in social and government sectors. As reported in the 2023 Annual Report, IDEO conducted interviews with over 50 county staff, met with EHR and other analogous experts (e.g., digital storytellers, data visualization scientists and behavioral scientists), and completed an in-depth analysis of SmartCare to inform design strategies that align with user needs, promote transparent communication, augment decision-making and best practices and, through increased efficiency, reduce staff burnout and improve workforce retention. IDEO identified the following key needs in the previous project period:

- An improved EHR design that allows for a holistic view of patient data rather than siloed across different areas of the software
- Better facilitation of record keeping and sharing across the platform
- Improved utilization of automaticity and intentional pauses at moments to accurately capture structured data to reduce redundancy, disseminate key information and promote best practices while maintaining flexibility and trust amongst users
- Transparent dialogue and a disruption of bias patterns in the software so the data entered can promote equitable outcomes and care

During this project period, CalMHSA initiated or completed multiple initiatives that align with the needs identified by IDEO as well as the project aims / learning goals outlined in the subsequent section.

Data Automaticity: Toward the goal of reducing documentation burden and ensuring providers have current information available to support clinical decision making and care coordination, functionality was implemented that syncs clinical data across multiple documents within the EHR. For example:

- When a provider writes a progress note, they can add a newly identified problem to the client's problem list from within the note itself. The newly identified problem is automatically added to the client's problem list for viewing by others on the treatment team without the provider needing to duplicate the entry.
- A new psychiatry note was implemented, designed with county input (e.g., medical directors, nurses, prescribers, pharmacists). The note pulls recent and relevant data from other chart sources (e.g., current medications, labs, allergies, orders), allowing providers to access key medical information for clinical decision making. The note also allows providers to select what information is clinically relevant from recent session notes, allowing them to pull important medical information forward without having to retype.

EHR Functionality to Promote Client Safety and Clinical Best Practice:

- Client face sheets and reports (e.g., discharge, shift summaries, facility medication administration, medication reconciliation, appointments) were created that aggregate comprehensive data into a cohesive and holistic clinical presentation for providers.
- Mechanisms were implemented to ensure critical client information (e.g., legal holds, seclusion/restraints, medication reconciliation, drug interactions) are evaluated timely and routinely to enhance safeguards for patient rights and safety. For example, CalMHSA developed

mechanisms for counties to track a client's legal hold status, which was iteratively improved to incorporate DHCS guidance. Providers can review key information, such as when the legal hold was last reviewed and the review outcome, helping them understand the client's progression through legal hold process, promoting efficient and timely review to ensure the provision of clinically appropriate care.

Collective Dashboards: Multiple counties identified dashboarding as a local need to support activities such as workflow management, monitoring, and outcomes tracking. CalMHSA launched PowerBI dashboards in February 2024 that transform raw EHR aggregate (non-PHI) data into actionable insights for counties. They display county-specific data on key indicators (e.g., population demographics and diagnoses, service utilization, program enrollment/discharges, billing processes), which can be used to inform program planning/oversight, decision-making through an equity lens and benchmarking system performance. Counties can also compare their performance to other counties (e.g., of similar size or region) as well as aggregate performance across all counties using the EHR for statewide benchmarking.

EHR User Support: CalMHSA instituted multiple platforms to provide continuous support to counties across EHR user roles/disciplines (e.g., clinicians, prescribers, administrators, contract providers, quality management, front desk and billing staff). Some resources are available 24 hours a day, seven days a week to ensure counties have access to information on-demand, as needed.

Chatbot: CalMHSA implemented an innovative, AI-driven technology that provides on-demand information retrieval to respond to EHR user support questions (e.g., on EHR functionality, billing requirements, etc.). Staff can access the Chatbot on their home page dashboard when they login to the EHR. Chatbot was used continuously throughout FY 2023-24, averaging around 4,000 messages every month (approximately 47,000 messages total).

EHR Knowledge Base Website: CalMHSA published and maintains a county-facing website that includes training materials, user guides, FAQs and tools to support counties in using the EHR. Website analytics for nine months in FY 2023-24 show active engagement:

- 36,000 active users viewed 425,000 website pages. The average number of pages viewed per user was approximately 12, and the average active engagement time spent on the site per session was around 5.7 minutes.
- Around 22,000 documents were downloaded by around 4,400 users, with two of the most common files being EHR Essentials (1,700 downloads, 1,200 users) and Clinical Workflow (1,100 downloads, 826 users). The average number of download events per user was around five.
- The top ranked page paths were Clinical Documentation (32,000 views) and Billing Documentation (14,000 views).

Helpdesk: The Helpdesk is available 7 a.m. to 7 p.m. (PST), Monday through Friday, to respond to user needs and requests. Helpdesk utilization data show active county engagement with this

resource in FY 2023-24. During the initial EHR rollout in quarter 1, the total number of tickets (approximately 6,700) was nearly three times the remaining quarterly totals and then stabilized in quarters 2 through 4 (averaging around 2,100 tickets per quarter). This pattern suggests users benefitted most from Helpdesk support when the system was new.

County Shared Decision-Making Meetings: CalMHSA began facilitating shared decision-making meetings in quarter 3 of FY 2023-24 to obtain county input on improvements/ developments to the EHR system. Between March and June 2024, CalMHSA hosted five meetings on various topics (patient portal, crisis stabilization billing, supervisor document review processes, tracking client grievances and appeals, and EHR development prioritization). On average, around 55 individuals across 20 counties attended these meetings. Shared decision-making strategies will continue to be used to guide development efforts over time.

Meta-Tagging: In FY 2023-24, CalMHSA began working with counties to implement program meta-tagging, which is a process where counties define key attributes of each program such as service populations and intended outcomes. Meta-tagging allows counties to group programs with similar attributes – once fully adopted, it can be used for program planning as well as tracking outcomes across comparable programs within and between counties. As part of the initial rollout, meta-tagging has been used to streamline certain billing processes:

- Meta-tagging enabled CalMHSA to accurately identify the types of services provided through the programs and ensure appropriate billing codes and modifiers are applied. This process ensures precise billing and alleviates the need for counties to manually attach programs to rate schedules. Automating this task significantly reduced the time and inefficiency associated with updating potentially hundreds of rate records per program.
- CalMHSA developed an innovative process that integrates the service tables and rate schedules published by DHCS with each county's specific meta-tagging. This results in a comprehensive set of rate records that is automatically uploaded into the county's SmartCare environments via a script. This streamlined approach significantly reduces the time required to implement critical billing updates, ensuring counties can operate more efficiently and effectively.

Evaluation Data/Learning Goals/Project Aims

CalMHSA contracted with the RAND Corporation to conduct a comprehensive evaluation of the project. RAND selected evidence-based EHR metrics grounded in measurement science that are precise, reliable and valid. To ensure a systematic evaluation of the migration to the new EHR platform, RAND is employing two measurement approaches:

1. A pre-post **user survey to measure user experience and satisfaction** of existing EHRs and the new EHR across all participating counties.
2. Pre-post **task-based usability testing** to obtain objective measures of EHR usage and burden (as measured by the length of time required to complete specific, common tasks in the EHR) before and after the migration to the new EHR.

The pre-phase measurements were collected and reported in the 2023 Annual Report. The timeline for completing the post-phase measurements was extended due to multiple DHCS policy changes that impacted county operations during this project period (e.g., documentation reform, payment reform), which contributed to an extended EHR implementation period. RAND will complete the post-EHR migration measurements and evaluation of project aims/learning goals outlined below at a future date. The evaluation will eventually allow for an assessment of how the transition to the new EHR resulted in changes to usability and user satisfaction.

Learning Goals/Project Aims
Quality ▪ Comprehensiveness of client care ▪ Efficiency of clinical practice ▪ Interactions within the health care team ▪ Clinician access to up-to-date knowledge
Safety/Privacy ▪ Avoiding errors (i.e., drug interaction) ▪ Ability to use clinical data for safety ▪ Personal and professional privacy
Satisfaction ▪ Ease of use ▪ Clinician's stress level ▪ Rapport between clinicians and clients ▪ Client's satisfaction with the quality of care they receive ▪ Interface quality
Outcomes ▪ Communication between clinicians and staff ▪ Analyzing outcomes of care ▪ System usefulness ▪ Information quality

Program Information for Individuals Served

This project focuses on transforming current EHR systems and processes counties use for the provision of behavioral health services. Accordingly, we have not estimated the number of individuals expected to be served annually. As noted previously, the participating counties in the Semi-Statewide Enterprise Health Record project are collectively responsible for serving the population of Medi-Cal members who need specialty mental health and/or substance use disorder treatment services among approximately 35% California's Medi-Cal members.

Regarding specific project information on individuals to served, this project focuses on transforming the current EHR *system and the processes* California counties use for the provision of behavioral health services rather than directly testing an innovative approach to *service delivery.*

Budget and Annual Expenditures

All expenditures in this table were funded with MHSA Innovation funds.

Personnel		
Classification (Job Title)	***Job Description and FTE***	***Costs Incurred So Far***
MHSA Coordinator	*.05-.15 – MHSA Coordinator will provide oversight and manage the implementation of the new Semi-Statewide EHR system to include stakeholder engagement and collaboration within our county.*	*$11,506.68*
Clinical Assistant Director	*.05-.10 – Deputy Director of Administration will provide senior level oversight in the implementation of the new Semi-Statewide EHR system in our county*	*$9,894.05*
Department Applications Analyst IV	*.05-.20 – Department Applications Analyst IV will provide I.S. Project Lead support of the new Semi-Statewide EHR system in our county.*	*$20,471.93*

Department Information Systems Analyst IV	*.05-.20 – Department Information Systems Analyst IV will provide I.S. Project Lead support of the new Semi-Statewide EHR system in our county.*	*$18,786.66*
Department Information Systems Analyst II	*.05-.10 – Department Information Systems Analyst II will provide I.S. Project support of the new Semi-Statewide EHR system in our county.*	*$57,063.60*
Management Analyst III	*.05-.15 – Management Analyst III will provide billing system analysis of the new Semi-Statewide EHR system in our county.*	*$16,846.05*
Accountant III/Management Analyst II	*.05-.10 – Accountant III will provide billing system analysis support of the new Semi-Statewide EHR system in our county.*	*$14,216.23*
Payroll Taxes and Benefits	***Description of Benefits***	***Cost***
MHSA Coordinator	*Including: unemployment insurance, retirement, social security, life insurance, health insurance, dental insurance, and vision care*	*$7,989.93*

Clinical Assistant Director	*Including: unemployment insurance, retirement, social security, life insurance, health insurance, dental insurance, and vision care*	*$6,145.20*
Department Applications Analyst IV	*Including: unemployment insurance, retirement, social security, life insurance, health insurance, dental insurance, and vision care*	*$16,795.58*
Department Information Systems Analyst IV	*Including: unemployment insurance, retirement, social security, life insurance, health insurance, dental insurance, and vision care*	*$14,228.52*
Department Information Systems Analyst II	*Including: unemployment insurance, retirement, social security, life insurance, health insurance, dental insurance, and vision care*	*$5,706.36*
Management Analyst III	*Including: unemployment insurance, retirement, social security, life insurance, health insurance, dental insurance, and vision care*	*$10,783.06*
Accountant III/Management Analyst II	*Including: unemployment insurance, retirement, social security, life insurance, health insurance, dental insurance, and vision care*	*$9,557.80*
Operating Expenses – Direct Costs		
Travel		$11.55

Consultation/Contract Expenses		
Contract	*Participation Agreement for EHR*	*$1,081,825*
Contract	*Participant Contingency Budget*	*$0*
Evaluation Costs (If not already described or identified above -if so remove this line).		
Evaluation Costs	*RAND Evaluation*	*$0*
Indirect Costs		
Indirect Costs	*10% indirect costs*	*$129,717*
Total Direct Costs		*$1,297,172*
Total Budget		***$1,426,889***

Commented [AA1]: Why is this zero? This was $815,906 in the originally submitted proposal.

Commented [AA2]: This should be $500,000. RAND costs need to be included.

Helpful Items to Note:

- *If your county's budget has changed since submitting your Appendix, please make sure to address this change in the Progress Update and Identified Changes section of the report template.*
- *Please make sure to include any evaluation costs (e.g., RAND).*

XII. Appendix: Community Planning Documents

2024-25 MHSA Community Meeting Flyer

2024-25 MHSA Consumer/Family Member Focus Groups Flyer

2024-25 MHSA Community Training and Planning Presentation

MHSA Community Planning Stakeholder Demographic Form/Results Summary

MHSA Consumer & Stakeholder Surveys and Results Summary

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Behavioral Health Services
A Division of Health Care Services Agency

Genevieve G. Valentine, LMFT, BHS Director
Fay Vieira, LMFT, BHS Assistant Director- Clinical
Cara Dunn, BHS Assistant Director- Administrative

San Joaquin County mhsa

Transforming Mental Health Services

Consumer/Family Member Community Planning Focus Groups
Mental Health Services Act (MHSA)

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

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

Please join us at one of the following consumer and family member focused community meetings to discuss the needs and opportunities to strengthen mental health services in San Joaquin County. These meetings will include a brief training on the stakeholder process, an update on how MHSA funds are currently being used, as well as a chance to share your opinion and recommendations on how to enhance programs and services. Your feedback is needed to inform the 2025-26 Annual Update to the 2023-2026 Three Year Program and Expenditure Plan.

We are counting on your voice to help guide us!

Wellness Center **Tuesday, August 6, 2024** **9:30 A.M. – 11 A.M.** **1109 N. California St.** **Stockton, CA 95202**	**Gipson Center** **Thursday, August 8, 2024** **1:30 P.M. – 3 P.M.** **405 E. Pine St.** **Stockton, CA 95204**

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

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Transformando

Los Servicios de Salud Mental

Grupos de Enfoque de Planificación Comunitaria para Consumidores y Miembros de la Familia Ley de Servicios de Salud Mental (MHSA)

La Ley de Servicios de Salud Mental (MHSA), tiene como objetivo transformar la asistencia de salud mental pública para niños, jóvenes, adultos y adultos de la tercera edad. La MHSA proporciona asignaciones de fondos para servicios comunitarios de salud mental en cinco áreas de programas:

- Servicios y Apoyos Comunitarios (CSS)
- Prevención e Intervención Temprana (PEI)
- Educación y Capacitación Laboral (WET)
- Obras de Infraestructura y Necesidades Tecnológicas (CF/TN)
- Innovación (INN)

Por favor, acompáñenos en una de las siguientes reuniones comunitarias enfocadas en los consumidores y miembros de la familia para hablar sobre las necesidades y oportunidades para fortalecer los servicios de salud mental en el Condado de San Joaquín. Estas reuniones incluirán una capacitación breve sobre el proceso de las partes interesadas, un informe sobre cómo se utilizan actualmente los fondos de la MHSA, así como la oportunidad de compartir su opinión y recomendaciones acerca de cómo mejorar los programas y servicios. Su opinión es necesaria para informar la Actualización Anual 2025-26 del Programa Trienal y Plan de Gastos 2023-2026.

¡Contamos con su voz para ayudar a guiarnos!

Centro: **Wellness Center** **martes, 6 de agosto, 2024** **9:30 A.M. – 11:30 A.M.** **1109 N. California St.** **Stockton, CA 95202**	Centro: **Gipson Center** **jueves, 8 de agosto, 2024** **9:30 A.M. – 11:30 A.M.** **405 E. Pine St.** **Stockton, CA 95204**

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Favor de colocar esta invitación en una ubicación pública y distribúyala a través de sus listas de correo. Gracias por compartir esta invitación.

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San Joaquin County mhsa
MENTAL HEALTH SERVICE ACT
Stakeholders' Information Site

Transforming Mental Health Services

Behavioral Health Services
A Division of Health Care Services Agency

Genevieve G. Valentine, LMFT, BHS Director
Fay Vieira, LMFT, BHS Assistant Director – Clinical
Cara Dunn, BHS Assistant Director

August 2024 Community Planning Meetings
Mental Health Services Act (MHSA)

Tuesday, August 20, 2024	Thursday, August 22, 2024	Tuesday, August 27, 2024	Wednesday, August 28, 2024
2:00 P.M. – 4:00 P.M.	1:00 P.M. – 3:00 P.M.	2:00 P.M. – 4:00 P.M.	9:00 A.M.– 11:00 A. M.
Larch Clover Community Center	**Lodi Public Library**	**El Concilio (Zoom) Spanish Session**	**General Meeting (Zoom)**
11157 W. Larch Rd. Tracy, CA 95304	201 W. Locusts St. Lodi, CA 95240	**Phone:** (669) 444-9171 **Meeting ID:** 991 1771 0384 **Passcode:** 012747	**Phone**: (669) 444-9171 **Meeting ID:** 991 1771 0384 **Passcode**: 012747

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

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

Please join us at one of the following community meetings to discuss the needs and opportunities to strengthen mental health services in San Joaquin County. These meetings will include brief training on the stakeholder process, an update on how MHSA funds are currently being used, as well as a chance to share your opinion and recommendations on how to enhance programs and services. Your feedback is needed to inform the 2025-2026 Annual Update to the 2023-2026 Three Year Program and Expenditure Plan.

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San Joaquin County mhsa MENTAL HEALTH SERVICE ACT Stakeholders' Information Site

Transformando Los Servicios de Salud de Mental

Behavioral Health Services
A Division of Health Care Services Agency

Genevieve G. Valentine, LMFT, BHS Director
Fay Vieira, LMFT, BHS Assistant Director – Clinical
Cara Dunn, BHS Assistant Director

Agosto 2024 Reuniones Comunitarias de Planificación
Ley de Servicios de Salud Mental (MHSA)

Martes, 20 de Agosto, 2024	**Jueves, 22 de Agosto, 2024**	**Martes, 27 de Agosto, 2024**	**Miércoles, 28 de Agosto, 2024**
2:00 P.M. – 4:00 P.M.	1:00 P.M. – 3:00 P.M.	2:00 P.M. – 4:00 P.M.	9:00 A.M.– 11:00 A. M.
Centro Comunitario Larch Clover 11157 W. Larch Rd. Tracy, CA 95304	**Biblioteca Pública de Lodi** 201 W. Locust St. Lodi, CA 95240	**El Concilio (Zoom)** **Sesión en español** **Tel:** (669) 444-9171 **ID de la reunión:** 991 1771 0384 **Clave:** 012747	**Reunión General (Zoom)** **Tel**: (669) 444-9171 **ID de la reunión:** 991 1771 0384 **Clave**: 012747

La Ley de Servicios de Salud Mental (MHSA) tiene como objetivo transformar la asistencia de salud mental pública para niños, jóvenes, adultos y adultos de la tercera edad. La MHSA proporciona asignaciones de fondos para servicios comunitarios de salud mental en cinco áreas de programas:

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Educación y Capacitación Laboral (WET)
Obras de Infraestructura y Necesidades Tecnológicas (CF/TN)
Innovación (INN)

Por favor acompáñenos en una de las siguientes reuniones comunitarias para hablar sobre las necesidades y oportunidades para fortalecer los servicios de salud mental en el Condado de San Joaquín. Estas reuniones incluirán una breve capacitación sobre el proceso de las partes interesadas, un informe sobre cómo se utilizan actualmente los fondos de la MHSA, así como la oportunidad de compartir su opinión y recomendaciones sobre cómo mejorar los programas y servicios. Su opinión es necesaria para informar la Actualización Anual 2025-26 del Programa Trienal y Plan de Gastos 2023-2026.

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MENTAL HEALTH SERVICE ACT
Stakeholders' Information Site

Transforming Mental Health Services

Behavioral Health Services
A Division of Health Care Services Agency

Genevieve G. Valentine, LMFT, BHS Director
Fay Vieira, LMFT, BHS Assistant Director – Clinical
Cara Dunn, BHS Assistant Director

September 2024 Community Planning Meetings
Mental Health Services Act (MHSA)

Monday, September 9, 2024	Tuesday, September 10, 2024	Wednesday, September 11, 2024	Wednesday, September 18, 2024	Friday, September 27, 2024
3:00 P.M. – 4:30 P.M.	4:00 P.M. – 6:00 P.M.	2:00 P.M. – 4:00 P.M.	5:00 P.M. – 7:00 P.M.	1:00 P.M. – 3:00 P.M.
BHS Consortium (Zoom)	**General Meeting (Zoom)**	**Weston Ranch Branch Library**	**Behavioral Health Advisory Board**	**Manteca Public Library**
Phone: (669) 444-9171 **Meeting ID**: 991 1771 0384 **Passcode**: 012747	**Phone**: (669) 444-9171 **Meeting ID**: 991 1771 0384 **Passcode**: 012747	453 W. French Camp Rd. Stockton, CA 95206	1212 N. California St. Stockton, CA 95202 Conference Room B & C	320 W. Center St. Manteca, CA 95336

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

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San Joaquin County mhsa MENTAL HEALTH SERVICE ACT

Transformando
Los Servicios de Salud de Mental

Behavioral Health Services
A Division of Health Care Services Agency

Genevieve G. Valentine, LMFT, BHS Director
Fay Vieira, LMFT, BHS Assistant Director – Clinical
Cara Dunn, BHS Assistant Director

Septiembre 2024 Reuniones Comunitarias de Planificación
Ley de Servicios de Salud Mental (MHSA)

Lunes, 9 de Septiembre, 2024	Martes, 10 de Septiembre, 2024	Miércoles, 11 de Septiembre, 2024	Miércoles, 18 de Septiembre, 2024	Viernes, 27 de Septiembre, 2024
3:00 P.M. – 4:30 P.M.	4:00 P.M. – 6:00 P.M.	2:00 P.M. – 4:00 P.M.	5:00 P.M. – 7:00 P.M.	1:00 P.M. – 3:00 P.M.
Consorcio BHS (Zoom)	**Reunión General (Zoom)**	**Biblioteca Filial de Weston Ranch**	**Consejo Consultivo de Salud Conductual**	**Biblioteca Pública de Manteca**
Tel: (669) 444-9171 **ID de reunión**: 991 1771 0384 **Clave**: 012747	**Tel**: (669) 444-9171 **ID de reunión**: 991 1771 0384 **Clave**: 012747	453 W. French Camp Rd. Stockton, CA 95206	1212 N. California St. Stockton, CA 95202 Salas de Conferencia B y C	320 W. Center St. Manteca, CA 95336

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Welcome to 2024-25 MHSA Community Planning

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- Please sign in by providing name and email address in ZOOM Chat Box
- Please complete Survey Monkey Demographics (link in the chat box)
- Meeting will be recorded for transcribing purposes

1

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San Joaquin County Behavioral Health Services
Mental Health Services Act – Overview and Planning

Community Program Planning for the 2025-26 MHSA
Annual Update to the 2023-26 MHSA Three Year Plan

2

Part 1: Overview of BHS

WELCOME AND INTRODUCTIONS
BHS MISSION, VISION, AND VALUES

SAN JOAQUIN COUNTY

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Mission and Vision

Mission Statement

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

Vision Statement

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

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Core Values

SERVICE:

We are dedicated to serving our community through the promotion of behavioral health and wellness.

RESPECT:

We value diverse experiences, beliefs, and backgrounds and strive in our interactions to keep everyone's dignity intact.

RECOVERY:

We share a belief that all individuals can find a path towards health and well-being.

INTEGRITY:

Our values guide us as individuals and as an organization to be responsive and trustworthy.

Providing our clients with the same quality of care that we all would want our families to receive.

5

Part 2: Community Training on Mental Health Services Act

OVERVIEW OF MHSA
COMMUNITY INVESTMENT
STAKEHOLDER INPUT

6

Mental Health Services Act (MHSA)

Purpose of MHSA Funding

- Expand and enhance mental health services for individuals with serious mental illness.
- Provide prevention and early intervention services for those at risk of developing a mental illness.
- Promote innovative solutions that will advance the field of mental health.
- Strengthen the personnel, technology, and facilities through which services are offered.

Common Acronyms

(MHSA) Mental Health Services Act, Prop. 63

(CSS) Community Services and Supports
(PEI) Prevention and Early Intervention
(INN) Innovation
(WET) Workforce Education and Training
(CFTN) Capital Facilities and Technology

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MHSA Core Principles

- **Client/family driven**
- **Cultural competence**
- **Community collaboration**
- **Service integration**
- **Focus on recovery, wellness, and resilience**
- **Serving the unserved and underserved**

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2023 MHSA SHOWCASE – 2023-24 – MHSA Community Planning Kickoff

Thursday, October 5, 2023 – BHS Campus -

- 350 Attendees (209 Previous Year)
- 265 Surveys Completed (129 Previous Year)
- 31% of attendees identified as Consumer and/or Family Member

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2023-24 Planning Session Attendance

13 Community Planning Events (October/November) + 5 Stakeholder Feedback Presentations = 18 Total Meetings

- Wellness Center, Gipson Center (Consumer/Family Member Focus)
- 7 Face-to-Face Sessions
  - Lodi, Tracy, Manteca, Behavioral Health Advisory Board, Garden Acres (East Stockton), Kennedy Community Center (South Stockton) and Catholic Charities (Spanish/Central Stockton)
- 4 General Zoom Sessions
  - Consortium and 3 General Zoom Calls
- Total Attendees: 143 + Stakeholder Meetings Below (80) = 223

• Consortium	12/13/23–	18 Attendees
• CAC	12/22/23–	5 Attendees
• BHAB	12/20/23 –	18 Attendees
• Cultural Competency Committee – 1/9/23 –		8 Attendees
• BHS Managers Meeting – 1/18/23 -		31 Attendees
		80 Attendees

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2023-24 Planning Session Demographics

Age Range		Gender Identity		Sexual Orientation		Primary Language		Race/Ethnicity		Consumer Affliation	
18-25	16.00%	Female	72.00%	Heterosexual	79.71%	English	84.00%	Native American	4.35%	Consumer	47.83%
26-59	71.00%	Male	27.00%	LGBTQI	14.49%	Spanish	10.14%	African American	24.64%	Family Member	43.48%
60 and Older	14.00%	Transgender	1.00%	Prefer Not To Answer	5.80%	Other	5.80%	Latino/Hispanic	30.43%	None of the above	30.43%
								Southeast Asian	8.70%		
								Other Asian/Pacific Islander	1.45%		
								White/Caucasian	26.09%		
								Mixed Race	4.35%		

Stakeholder Affiliation-

- Community Based Mental Health Service Providers
- Community Based Non-Mental Health Providers
- Advocates
- Children & Family Service Providers
- K-12 Education Providers
- Veterans Services
- Senior Services
- Law Enforcement
- Hospital/Health Care Providers
- BHS (MH and SUD) Services Staff
- Behavioral Health Board
- Public Health

SAN JOAQUIN COUNTY

Stakeholder Themes = MHSA PLANNING Priorities in the 2023-2026 Three Year Plan

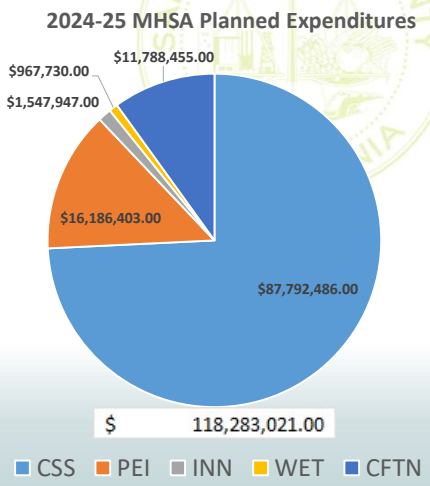
- **ACCESS TO TREATMENT & HOUSING STABLITY**
- **BEHAVIORAL HEALTH AND JUSTICE COLLABORATIONS**
- **COMMUNITY PARTNERSHIPS WITH CULTURALLY FOCUSED BEHAVIORAL HEALTH CARE**

SAN JOAQUIN COUNTY

MHSA Programming in San Joaquin County

Program Areas

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



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13

13

MHSA planning benefits from community stakeholder input

- Consumers, family members, providers, and Community
- Review programs and make recommendations
- Input for improvements outlined in Annual Update
- Plan reviewed (30 days) & public hearing at Behavioral Health Board

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Part 3: Planning Discussion

GROUP BRAINSTORM
- WHAT WORKS?
- WHAT NEEDS IMPROVEMENT?

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Community Program Planning

Purpose: *To assess the mental health needs of the entire community, including those that are currently served, and those that are unserved, underserved, or inappropriately served.*

Feedback Requested:

1) What is working?
2) What needs improvement?
3) How can we better serve underserved/unserved consumers in San Joaquin County?

Definitions:

Gap or Need – Services do not exist,or does not exist for a specific population.

Issue or Concern – Services exist, but there is an issue or concern to be addressed.

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Planning Activities for the Annual Update

- **Community Planning Meetings (including face-to-face)**
  - Lodi, Tracy, Manteca, Weston Ranch, Stockton (August/September 2024)
  - Consumer/Family Member Focus Groups (August 2024)
  - Zoom Call Meetings including Spanish Speaking Sessions (August/September 2024)
- **Stakeholder & Consumer / Family Members Surveys (October 2024)**
- **MHSA Showcase – October 3, 2024**
- **Key Informant Interviews (October/November 2024)**
- **Stakeholder Feedback Meetings (October/November 2024)**
- **BHSA – ROADSHOW in 5 largest Cities**
- **Draft Plan for 30-day Public Review (December 2024/January 2025)**
- **Public Hearing (January/February 2025)**
- **Presentation to the Board of Supervisors (February/March 2025)**

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Collecting your Feedback!

- **Please make sure to:**
  - Sign-in to the meeting via the chat .
  - Complete the linked demographic form (SurveyMonkey).
  - Complete the confidential stakeholder feedback form (SurveyMonkey).
  - Consider sending additional feedback, suggestions or ideas to:

Mail:

MHSA Comments
c/o MHSA Coordinator
1212 N. California St.
Stockton CA 95202

E-mail:

mhsacomments@sjcbhs.org

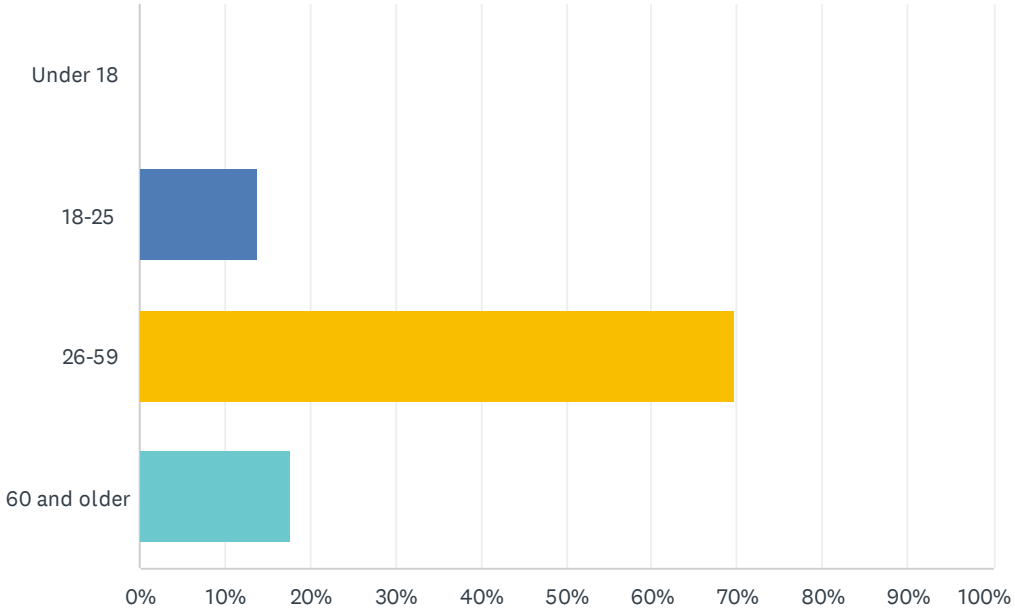
18

Angelo Balmaceda
MHSA Coordinator
abalmaceda@sjcbhs.org

19

Q1 Please indicate your age range.

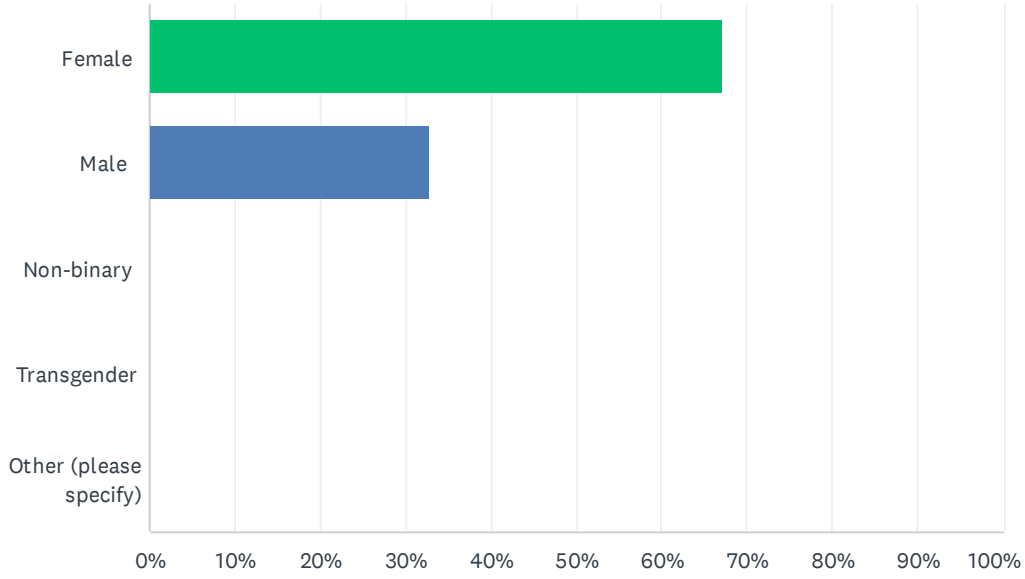
Answered: 79 Skipped: 0



ANSWER CHOICES	RESPONSES	
Under 18	0.00%	0
18-25	13.92%	11
26-59	69.62%	55
60 and older	17.72%	14
Total Respondents: 79		

Q2 What is your gender identity?

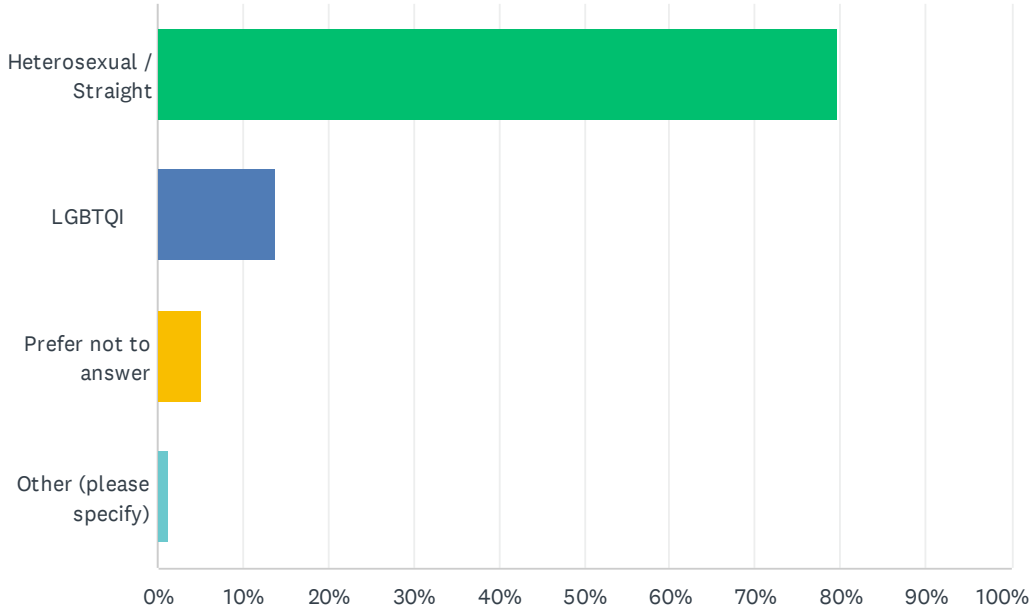
Answered: 79 Skipped: 0



ANSWER CHOICES	RESPONSES	
Female	67.09%	53
Male	32.91%	26
Non-binary	0.00%	0
Transgender	0.00%	0
Other (please specify)	0.00%	0
TOTAL		79

Q3 What is your sexual orientation?

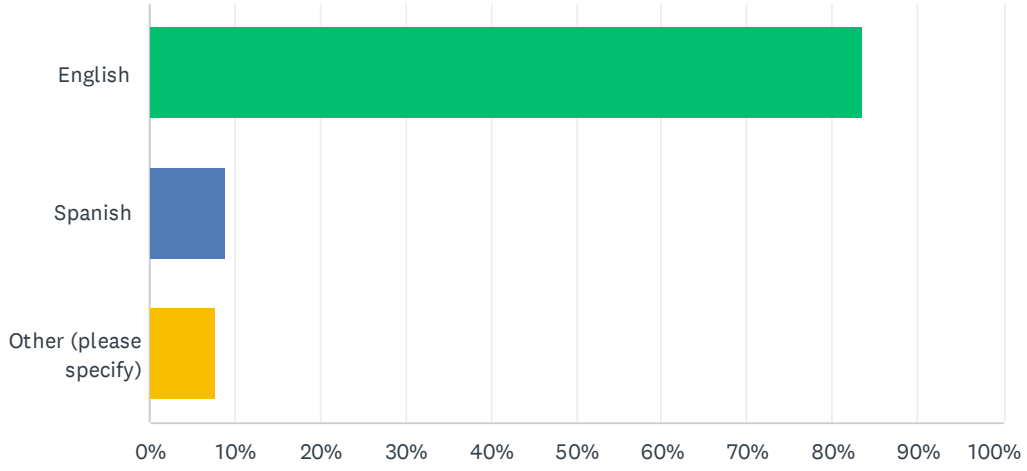
Answered: 79 Skipped: 0



ANSWER CHOICES	RESPONSES	
Heterosexual / Straight	79.75%	63
LGBTQI	13.92%	11
Prefer not to answer	5.06%	4
Other (please specify)	1.27%	1
TOTAL		79

Q4 What is the primary language spoken in your home?

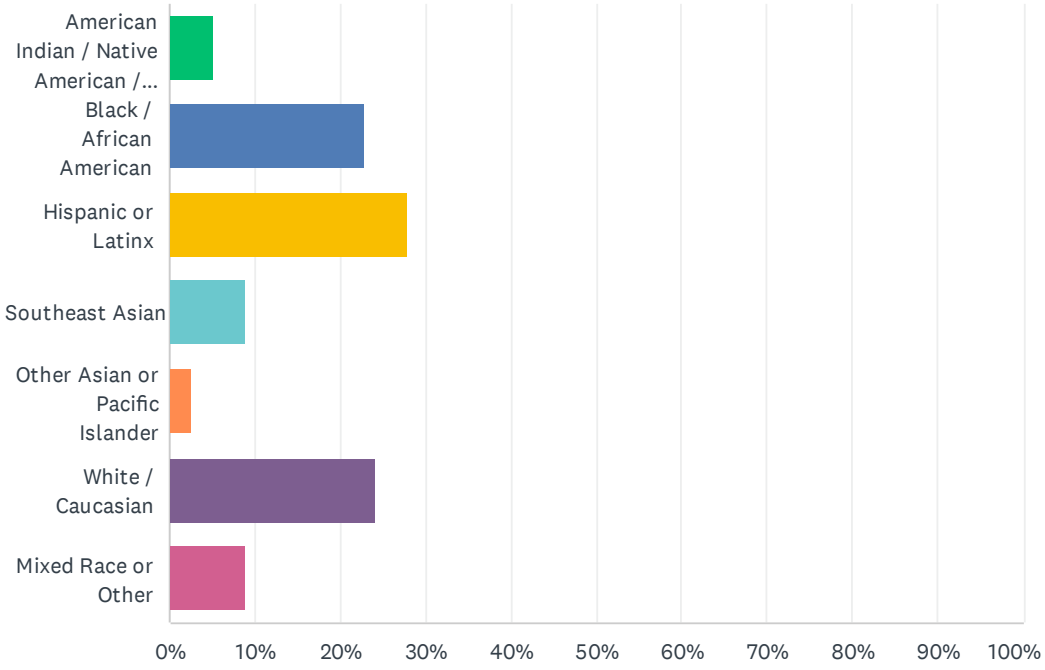
Answered: 79 Skipped: 0



ANSWER CHOICES	RESPONSES	
English	83.54%	66
Spanish	8.86%	7
Other (please specify)	7.59%	6
TOTAL		79

Q5 What is your race or ethnicity?

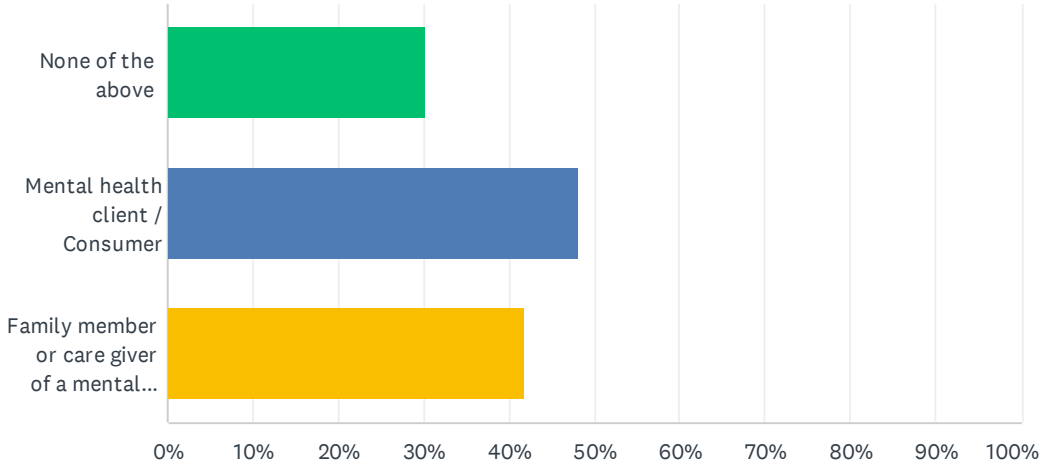
Answered: 79 Skipped: 0



ANSWER CHOICES	RESPONSES	
American Indian / Native American / First Nations (including Hawaiian and Alaskan Native)	5.06%	4
Black / African American	22.78%	18
Hispanic or Latinx	27.85%	22
Southeast Asian	8.86%	7
Other Asian or Pacific Islander	2.53%	2
White / Caucasian	24.05%	19
Mixed Race or Other	8.86%	7
TOTAL		79

Q6 Consumer Affiliation (if applicable)

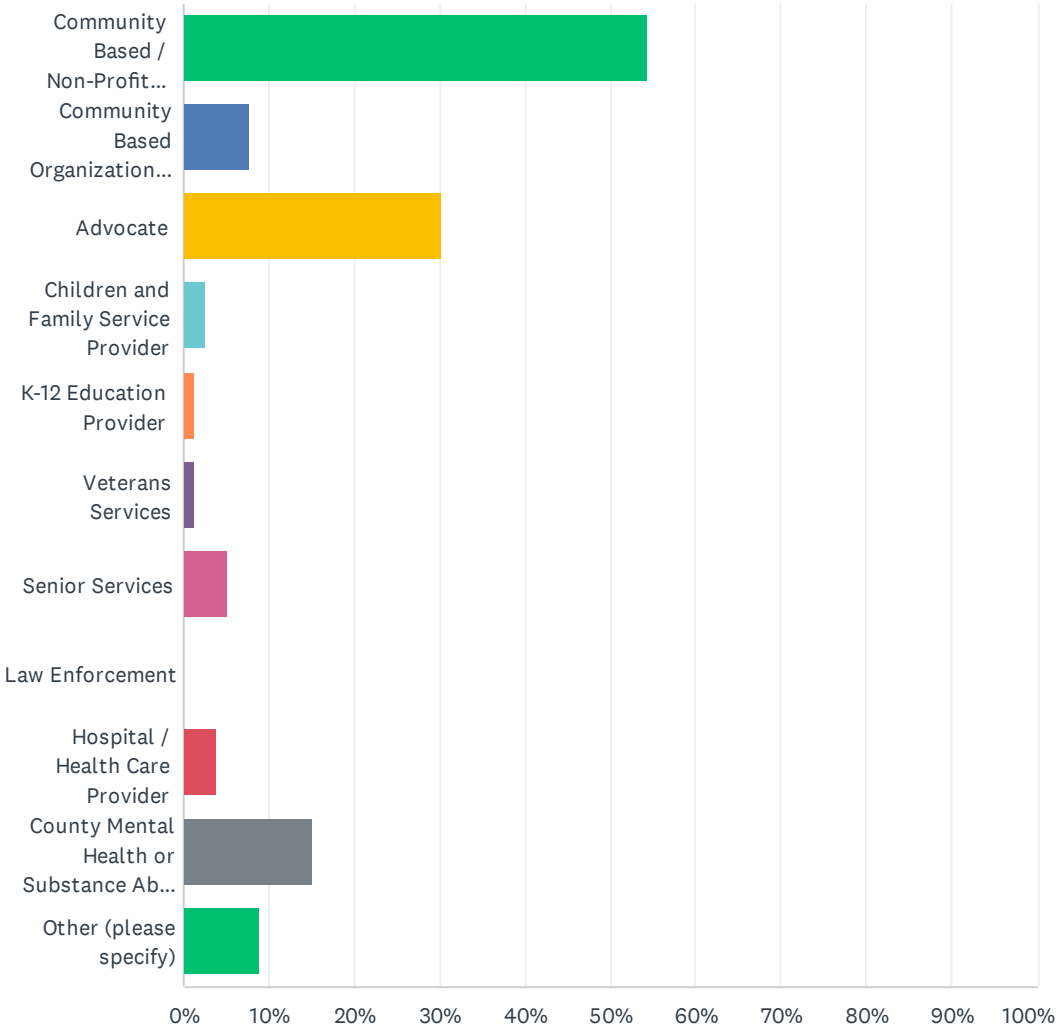
Answered: 79 Skipped: 0



ANSWER CHOICES	RESPONSES	
None of the above	30.38%	24
Mental health client / Consumer	48.10%	38
Family member or care giver of a mental health consumer	41.77%	33
Total Respondents: 79		

Q7 Stakeholder Affiliation (check all that apply)

Answered: 79 Skipped: 0



ANSWER CHOICES	RESPONSES	
Community Based / Non-Profit Mental Health Services Provider	54.43%	43
Community Based Organization (Not-Mental Health Services Provider)	7.59%	6
Advocate	30.38%	24
Children and Family Service Provider	2.53%	2
K-12 Education Provider	1.27%	1
Veterans Services	1.27%	1
Senior Services	5.06%	4
Law Enforcement	0.00%	0
Hospital / Health Care Provider	3.80%	3
County Mental Health or Substance Abuse Services Staff	15.19%	12
Other (please specify)	8.86%	7
Total Respondents: 79		

What is working well at San Joaquin County Behavioral Health?	What needs improvement at San Joaquin County Behavioral Health?	How can we better serve consumers in San Joaquin County?
1. Access 2. Outreach 3. Whole Person Care	51/50 holds and early releases!	Access care
Suicide prevention services	Linkage to appropriate services	Access is great for connecting SAS and mhs
Services are timely	More therapy	Access to care
Accessibility	Doing a great job, strive every day to be better	Access to housing
Staff case managers	Assessments	Address the issues in San Joaquin County
Collaboration among agencies	Facilities	Advertise in different areas
Community based programs	Wait time for certain services/programs	Advertise warmline on all SJC vehicles
Staff client relationships	Timeliness of appointment times/more accessible placements	Advertise/promote at Downtown w/flyers and advocate
Easy to call	Childcare assistance	All nutrition fitness and wrap around services
Culturally appreciative	More bilingual services out in the community	Another office in Stockton or bigger
Assessing information on young people	More events to share	Awareness
Bringing awareness of mental health	Linkage to counseling services	Be available more
Knowledge of resources	Housing	Be aware and available
Mobile crisis	Medication v therapy, "double dipping" when someone needs both	Be more open to people with different needs
Outreach team	Ability to get consumers in faster	Be more reliable
Communication and support	More employees.	Better communication
Supportive management	I just would like to have more time with therapy	Better communication at conservator's office
Staff does their best to help clients	Staff attitude	Better entry access
Medication	Collaboration between agencies	Better facilities
Referral coordination could be better	Response time	Better facilities and more therapists and parking
The staff	IT department is overworked and understaffed	Better pay for employee retention.
Services provided and friendly staff	Parking, treatment rooms to be more welcoming	Better system. Hire people specifically to go through referrals
Therapy treatment	You need more clinical licensed staff to meet the needs of youth experiencing trauma.	By doing more outreach
Staff is great	Medi-Cal reps stationed at BHS to assist clients with completing applications.	By enlisting more providers
Re-entry programs	A lot of things	By making it more known about the services there are
The people are great a lot of nice depts	More housing funds for TAY youth	Childcare assistance
Everything is great at the time.	Hotline/access	Community outreach
Human Resources	More care for lower level issues	Continue doing what you're doing and ensure funding stays in SJC to continue services and programs. Funding is essential! Ask the community about what they need.
The classes I attend	Access to housing	Continue to be in partnership with outside agencies
Getting access to mental health appointments in a timely manner	More resources for OAS dept	Continue to bring awareness
Collaboration with other agencies	Communication	Cultural competency trainings for LGBTQ+ clients
Getting a variety of clients	Intake process, access in hours open, more locations, more resources	Cultural mental health services
CARES program for youth	More convenience	Decrease transportation barriers
Staff	Appointment availability	Do more events so the community can be more aware of the resources in the County
Nice staff	Attitudes of employees and genuine	Do more outreach programs
The services	The therapy services	Doing great
Some of crisis services	Access to all regardless of health insurance	Drop in centers for youth, childcare for appointments
My staff	Doing well	Easier access, more promoting services
24 Hour services	SUD treatment access, more workers	Enhance mobile crisis unit
Community outreach	Mobile crisis support	Everything is going well.
Great providers	More workers	Expand programs and services
The ease of accessing services	To be more time efficient	Expand Reach
Being scheduled within 10 days	Unsure	Expand service to more locations
The therapists are good	More staff	Expanding emergency services
Communication	Diversity of classes	Focus on young adults
Referrals to different services	More communication and understanding of staff programs	Follow ups w/referrals and providers, increase pay for programs funded by BHS. High case managers=low pay
The community meetings and public awareness	Adult services	Have a better follow up system
More clinicians in SUD	Communication	Have a directory
Appointments	More people from the streets	Have a directory of services
I am enrolled in BHS services but just started so it's hard to say	Dual diagnosis program	Have events for the community
Translators	The resources they give	Have more compassion/empathy
Therapy and great psychiatrist	Cultural competency, interpretation and LGBTQ+ safe spaces	Have more parking and programs and a nicer building the campus now looks really old and worn down and the parking lot that is already really hard to park in has had almost half the lot gone for over three months now and the work needs to get done ASAP
The fast service of referrals	Add more square footage	Have more programs
Staff	Mobile crisis	Having all teams be aware of all resources
Social Workers	Coordination with housing	Having mental health Services on school services
Teams, co-response within a different department	Staff-a lot of people don't know what programs there are in the County and they work for the County.	Having my employees
All of it	Staff understanding MH effects of individuals on campus	Help everyone
Being conscious of diversity	More staff for programs	Hire more case managers
All of the programs and services. There's something for everyone.	More face to face Dr. appointments	Hosting fairs in the lower income communities
The therapists and all that	Advertisement	Housing
The BHOW's are excellent	Advertisement and accessibility for parents of children with autism	I have never used the services
The services and where to get them	Cultural services	I think they already are doing a great job in the community
Their willingness to assist you no matter what	The attitude	I think you guys do a fine job
Access and the many resources that are advertised	Access to services	Improve staffing, advocate on social media

Connection to services	Answering calls	Include security in competency to help clients
Knowledgeable staff	The time to service individuals it sometimes takes too long	It was hard to get the ball rolling for services. I'm trying to learn more about the programs and no one really knows about it
Services provided are beneficial to the clients	Public relations	Kinder approach
Great event today	Collaboration	Language it is difficult to get language appropriate staff
Good services, competent clinicians and staff.	Clarification of programs	Make a TV Corner show
Great	Medi-Cal representation	Make it easier for parents who have lost a child
Exciting every day	Timeliness	Make sure they know about BHS Services
The diversity of the staff members at BHS	Access process	Making it easy to access services
The staff is always ready to help	Being more open ot family that are scared of getting help	More accessible things
Some programs are okay	Ease of access	More advertising of community services
The help the individuals receive	Nothing at this time	More advertising of services.
The programs for kids and older adults	Unknown	More affordable housing
Expanding programs	Options for more cultural groups	more agencies
Some of the programs	Better access	More awareness
Being culturally exclusive to everyone. Makes you feel welcomed	Clients state that there are times when its hard for them to connect to services they need directly	More clinics
Resources provided to families	Interoperability	More communication
I used to work at CYS	Management of no shows	More community-oriented events, ex. Christmas functions, parties, etc.
Variety of services	Culturally appropriate services	More customer service
The mobile crisis unit	More employees	More employees
The specialty services, reducing disparities	Open-Ended Response	More employees to be available
Offers age related services that are free	A lot of things, the building is old and the parking is bad	More exposure
Taking care of your mind	The promotion of how many services there are	More facilities
Timeliness	Access line and scheduling appointments	More facilities
Open-Ended Response	Availability	More food pantry
The staff at BHS are very helpful	Collaboration with other health agencies	More grants for OAS dept
The fact that they meet their clients where they are at in the community; very beneficial to their clients	Coordinate with PCP more	More groups
All the services clients have received have been very helpful	Easier access	More groups
Everything, I'm in counseling	Easier access to services, easier linkage	More health care service
Staff	Empathy	More homeless outreach and housing help
Getting my meds. I like my Dr.	Employment opportunity	More housing
Do not work there	HHS needs referrals from worker or building downtown	More humans
Networking among agencies	I have never used the services	More locations
All services being provided	I'm a community provider and my clients inform me that their mental health referrals go nowhere, no one reaches out to them or follows up on referrals	More marketing
A lot of good communication	Making appointments, attitudes in crisis	More marketing about resources
A lot of good communication of services	Maybe more timely access to services and more frequent client interaction	More medically assisted services
Almost anyone can access services	More agreements for out of reach services and locations	More mobile crisis
Staff is friendly	More compassion and cultural competency	More offices in Stockton, South areas
There are some good programs	More doctors	More outreach
The access to psychiatry, counseling, nurses, clinicians, transportation services, mobile crisis, and inpatient care	More events	More outreach
The amount of resources	More housing	More outreach
The amount of services there are for underserved populations	More medi-cal eligibility and insurance specialist to support clients	More outreach in schools
A lot of programs for people with MediCal	More Mental Health Specialists	More outreach to the community
Haven't actually used services from SJC BHS just saw the event and wanted to stop by	More mobile services	More parking at 1212
Events like this	More resources	More programs, more therapists
Meeting the client where they are	More services after hours	More programs/funding for homeless services
All resources	More Spanish resources, different languages	More providers
The communication	More staff to assist	More resources, especially housing, parental resources, and job apps
Getting the word out in the community of the resources	More therapy rooms	More services
Mobile crisis	Need better response from access referrals	More services and locations
Crisis and the warm line	No programs for people without insurance	More services for clients unable to leave their home or with mobility issues
All great programs, wish it was more widespread	Not much, they are super nice	More staff
Great staff	nothing really	More staff
The crisis help line	Organization of the departments	More staff
The crisis team is very responsive. The unit is very great. HAT supervisor is amazing (Sasha)	Parking. There is not enough parking for staff and clients. This may deter clients from attending appointments	More staff
The staff does their best to accommodate clients	Personable employees	More staff
Multiple options for care	Phone calls constantly bounced around	More staff
The diversity of the services	Provide Medi-Cal reps for the clients in completing to assist applications	More staff
The variety of programs/services	Access line	More staff in the community
Case workers	Access to therapy services	More staff.
Some of the programs are really good and useful	Better clarity of services	More substance use and temporary housing services
Referring clients to BHS is very easy, the process is fluid	Better clarity on services that they offer-the wide range	More TAY Programs
After hours team	Better/more time for team building	More therapist
All the different resources in the community	Crisis related to suicidal threats	More tools for Hispanic population
The staff is informative of the services offered	Everything good	More tools to Hispanic population
They care	Follow up is hard	More variety of services to transport

They are working well with partner recovery programs with transition and meeting our needs
Being well
Providing services that are offered
The access to services
The referral system has been working great
Therapy services
The availability of services
Accessibility and access/point of entry providing both SUD and mental health services as a starting point
The warm line
Events and other stuff
I have never used their services
Kindness of employees
The consistent people that are working with my daughter
The different programs they offer at BHS
The diversity programs offered throughout behavioral health
Collaborations between health providers and case managers
Triage system
Case Management Services
The help we give to all
The mental health services, specifically Family Ties as we hold our groups there
Care
Amount of resources is plentiful
Access to services
All the programs
Collaboration
From homeless to a home, got me a nice place to live for 4 years now, Amen.
This has been an awesome experience
The staff care!
I like that they are attentive and I've actually been getting the treatment I've been needing
Scheduling
More services and access to services.
More intervention programs
Yes
I hope to find out
Collaboration with community
Keeping the same case worker

Getting care
Linkage or comms with hospitals and FSPS
More access to services for those who may fall through the cracks, for example homeless residents, special needs individuals, and the elderly populations
More clinicians
More clinicians, more County vehicles
More communication and staff allowing go out there for any client
More employees
More outreach
More pop up shops and more resources for BH. Provide more services for families that have no insurance
More resources for low income
More services
More services for LGBTQ
More services to people with different needs
More therapy and case management
Places for those who receive services and are unhoused
Referral process
Resources
Scheduling
Staff
Staff
Takes too much time for referrals to go through especially independent therapy
Timely appointments
Too much paperwork, not enough case managers
Transportation
Turn around time for access referrals
Unconscious bias, stereotyping, free mental health services without insurance
Wait times
Wait times
We need more anonymous grief groups
Yes

More workers
No wrong door
None
Nothing
Offer more preventative services in education programs
Outreach
Outreach
Outreach and resources
Outreach to all communities/unhoused communities
Outreach to marginalized communities
Outreach with homeless
Outreaches
Patience is they key
People in jails make services more available
Post suicide grief groups
Provide more parking spaces; schedule times to suit working families
Provide more therapy
Put out flyers
Quicker services
Quicker turn around
Reach out to children at skate parks
Reaching out to feel better
Reducing barriers to TX
Rides
Safe camp site
Send out flyers in all PO boxes
Staff
Staff
Telecare services
The services I get are pretty great I can't complain
The time to connect anyone looking for services
The whole assessment and linkage process
Timeliness, more cultural competence
Treat them as people
Work with other medical coverage
Yes
You are awesome
You're doing great
You're great

What gaps in services exist or do you not see existing for a specific population?	Are there any issues or concerns with existing services that need to be addressed?
Not enough care	Just an access point
More transgender services	Housing unsheltered individuals
Children, school age/adolescents, 55+	Clearer systems for working with other Counties
Outpatient connections	See 9
Clients with severe mental health needs	Follow up care after patient is discharged from crisis houses such as counseling.
Autism sensory issues that prevent access	No show cancellations, favoring clients scheduled
I think mental health is taking great action in the population I see a lot of changes in the past couple of years	Observation
Not enough clinicians or therapists. Clients have verbally expressed lack of rapport building and feeling rushed and unheard	Like I said more face to face
People who are less severe	Having enough staff to meet the needs of the community
Not enough resources for Native American community	No concerns at this time
Follow up on homeless population	No not at this time
Don't see any	Clear systems for working with other Counties
No services for undocumented	Childcare assistance
Understanding people of color	Need to spend less time on SmartCare program and more time with people
Substance abuse programs	Behaviors related to special needs (autism, etc.)
Marginalized groups	Parking
Homeless population-more engagement	Autism help
Not being able to have access to mental health for the unserved	Approach situations with care
Housing help	0-5 years mental health
Treatment to homelessness	Yes lack of LGBTQ programs
No LGBTQI+ programs specifically for this community	Accessibility for unhoused people
Yes	More
Teen/youth in school programs	Poor communication
Maybe more services for youth/family intervention	Not enough services geared toward people of color
Adult ADHD no help for this	More facilities
Unsure	Unsure
Homeless population in getting them housed	More therapy for HAT program
Suicidal and homeless having a place to go	Yes
I don't know	Transportation; ease of access
Homeless population	Parking lot is a mess with the dark gray Toyota tacoma and other big trucks blocking driveways
Short staffed.	Not sure
When services are handed off to another agency	No shows to appointments
Need inpatient crisis facility for kids	Follow-through, rapport building
Face to face therapy	Referral turnaround time
TAY	Unsure
Access for Latino AA	More advocacy for homeless population
More SUD AND Mental Health treatment combined.	Speed of the clients getting service
Warm handoff to outside community resources	Transportation
Language barriers	Limited resources in the Tracy area. Many youths are underserved
Native American services	Nothing I know of
We have very few programs for kids or children	Need more detox
Transportation	More access to interpreters
Childcare assistance	More case managers
Less manpower	Just have a better attitude with clients that are mentally ill and homeless
Just when clients miss their appointment	Don't know
Inpatient and outpatient outgoing	Follow ups
Mental health services for the Latinx community-bridging that gap of generational misinformation and mistrust	A lot too many to name
Lack of programs	More staff
Autism, intellectual disability	Need more employees
Ages 25-59	I don’t know
We more people that have both mental and substance abuse issues	It seems like there is often no difference in service providers
Availability on weekends for working families; children at school during day	BHS employees need to have more information on all the programs available (ex. the restart program)
Staff	Timeliness
LGBTQ	More care managers
Native Americans	See above

Time

Substance abuse

Timeliness

Immigrant that do not have children. Sometimes with chindrwn and school a lot of reaources are more easily available but there are a lot of immigrant that can t have access to service due to not knowing

The limited access to mental health services

Team building among business all around staff.

Think about it

Native American

Services for different cultures, religions, etc. More accessibility for those hard of hearing

More youth OAS programs

Not enough community knowledge of the services available.

SUD-withdrawal management

For migrants

Focus more on homeless people

Providing a way for consumers to write down their preferred/chosen name

Not enough services geared towards people of color

Open-Ended Response

Diversity

Substance use for minors

Unknown

Unsure

Dual diagnosis. We talk about but don't have resources or materials

No direction and many employees don't seem to know what there is for people

People of color are often “invisible”, would like to see more education to end stigma

Difficulty if no insurance or Medi-Cal

Resources for TAY youth

I don't see gaps

Representation of clients in courts-conservators do not do enough advocate

I don't see a women's group for Forensic dept.

Ambassadors downtown for referral

18 years to adult, for parents trying to advocate for 18 year old young adults

Housing for homeless with no income

Alternatives to therapy

Substance abuse

Clinics

More facilities

The basic needs the individual requires such as documents and housing

Length of time waiting to receive services

See #7. Continue to support families, even after they have been in crisis. Follow up care is essential.

Transportation

Not enough help and people don't want to meet in person and not enough zoom groups

DV services

All are connected, you have options

Dual diagnosis

I believe ages 12-16 are currently being underserved. Lack of mental health resources/programs for that age

I have not seen that

Latin language assistance (bi-lingual assistance)

Not enough Spanish resources

TAY youth having to meet specific criteria based on the barriers (foster parenting, etc.) to get any housing support

Continuity of care after emergency services

TAY FSP

Transportation to appointments

Not that I can think of

Just need more places for people to grieve

More groups

There are not any major issues, this is a helpful community

Staff

Not everyone acknowledges mental health. Not everyone is aware of the signs of mental health

More kid programs

More therapists

Not so much but help more people

Too many to count at this time

Not enough providers for the youth

Bonding and caring

LGBTQ+ services should be across the board

Turn around time for accessing referrals

Yes too many to list

We need more bilingual services

Already mentioned

Communication between agencies and collaboration

Not enough ways to access services

Short staffed.

Space for therapy

There are no issues or concerns that I am aware of

More Native American services
More tools for migrants
Employment assistance for low income

Substance abuse with minors

Don't know
Housing for mental health clients

None, you're doing great

Between crisis and connecting to outpatient
Gaps in connection to reassignment of clients
Not as many for Asian populations

Consistent help for youth when parents can't travel or are not involved

Diversity in crisis unit.
Staff

Children's services

Connection to SUD services
Housing
Housing, 0-5 years mental health services
Client between crisis and lower level of care
SAS trans persons
The lack of patient services representatives, there use to be some years ago but they are not available anymore
Language barriers
Transport
Services often vary due to funding we want more consistency and more priority for homeless