BEHAVIORAL HEALTH AND RECOVERY SERVICES
A Mental Health and Substance Use Disorder Services Organization

Ruben Imperial, MBA
Director

800 Scenic Drive, Modesto, CA 95350
Phone: 209-525-6225 Fax: 209-558-4326

June 24, 2021

California Department of Health Care Services
Program Outcomes, Evaluation & Reporting Section
Attention: MHSA
1500 Capitol Ave
Sacramento, CA 95399

Mental Health Services Oversight and Accountability Commission
Attention: Program Operations
1325 J Street, Suite 1700
Sacramento, CA 95814

RE: MHSA Three Year Program and Expenditure Plan FOR FISCAL YEARS 2020-2023 Annual Updates FOR FISCAL YEARS 2019-2020 and 2020-2021

Dear Colleagues,

Attached please find the Stanislaus County Behavioral Health and Recovery Services (SCBHRS) Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan for Fiscal Years 2020-2023 Annual Updates for Fiscal Years 2019-2020 and 2020-2021.

Per statute AB 1467, we are required to submit an MHSA Three Year Program and Expenditure Plan and Annual Updates to the California Department of Health Care Services (DHCS) as well as the Mental Health Services Oversight and Accountability Commission (MHSOAC). We would appreciate an acknowledgment that you have received this document.

This Three Year Program and Expenditure Plan and Annual Update was developed to include a progress report on all MHSA funded programs and projects. Additionally, this report provides details regarding the broader strategic planning process for SCBHRS over the next three years, which incorporates MHSA values, the BHRS mission and vision, and valuable input from community stakeholders. The Annual Update was posted for a 30-day review and comment period from April 1, 2021, to April 30, 2021. A public hearing was conducted by the Behavioral Health Board on May 27, 2021.

On June 15, 2021, the Stanislaus County Board of Supervisors adopted the Stanislaus County Behavioral Health and Recovery Services (SCBHRS) Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan for Fiscal Years 2020-2023 Annual Updates for Fiscal Years 2019-2020 and 2020-2021. It authorized the auditor controller to certify that the fiscal requirements had been met. The document was signed by the Assistant Auditor Controller on June 22, 2021.

If you have any questions, please do not hesitate to contact the MHSA Planning Office at (209) 525-6247.

Sincerely,

Ruben Imperial, MBA
Behavioral Health Director
CC: Martha Cisneros
Enclosure

THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
BOARD ACTION SUMMARY

DEPT: Behavioral Health & Recovery Services BOARD AGENDA:9.1
AGENDA DATE: June 15, 2021

SUBJECT:
Approval to Adopt the Mental Health Services Act Three Year Program and Expenditure Plan for Fiscal Years 2020-2023, Annual Updates for Fiscal Years 2019-2020 and 2020-2021, Early Psychosis Learning Health Care Network and Full Service Partnership Multi-County Collaborative Innovations Projects, and to Authorize Expenditure of Mental Health Services Act Funds for Innovations Projects

BOARD ACTION AS FOLLOWS: **RESOLUTION NO. 2021-0269**

On motion of Supervisor C. Condit **Seconded by Supervisor** B. Condit
and approved by the following vote,
Ayes: Supervisors: B. Condit, Withrow, Grewal, C. Condit, and Chairman Chiesa
Noes: Supervisors: None
Excused or Absent: Supervisors: None
Abstaining: Supervisor: None

1) **X** **Approved as recommended**
2) _____ **Denied**
3) _____ **Approved as amended**
4) _____ **Other:**

MOTION:

ATTEST: **ELIZABETH A. KING, Clerk**
Stanislaus County Board of Supervisors,
State of California

Elizabeth A King

File No.

THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
AGENDA ITEM

DEPT: Behavioral Health & Recovery Services BOARD AGENDA:9.1
AGENDA DATE: June 15, 2021

CONSENT ☐

CEO CONCURRENCE: YES 4/5 Vote Required: No

SUBJECT:

Approval to Adopt the Mental Health Services Act Three Year Program and Expenditure Plan for Fiscal Years 2020-2023, Annual Updates for Fiscal Years 2019-2020 and 2020-2021, Early Psychosis Learning Health Care Network and Full Service Partnership Multi-County Collaborative Innovations Projects, and to Authorize Expenditure of Mental Health Services Act Funds for Innovations Projects

STAFF RECOMMENDATION:

1. Adopt the Mental Health Services Act Three-Year Program and Expenditure Plan for Fiscal Years 2020-2023 and Annual Updates for Fiscal Years 2019-2020 and 2020-2021, reporting outcomes for Fiscal Years 2018-2019 and 2019-2020, respectively.
2. Adopt the Early Psychosis Learning Health Care Network and Full-Service Partnership Multi-County Collaborative Innovations Projects and authorize expenditure of MHSA Funds for Innovations Projects.
3. Authorize the Behavioral Health Director, or designee, to sign the County Compliance Certification and submit the Mental Health Services Act Three-Year Program and Expenditure Plan for Fiscal Years 2020-2023, Annual Updates for Fiscal Years 2019-2020 and 2020-2021, Early Psychosis Learning Health Care Network and Full-Service Partnership Multi-County Collaborative Innovations Projects to the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission.
4. Authorize the Auditor-Controller and the Behavioral Health Director, or their respective designees, to sign the Mental Health Services Act County Fiscal Accountability Certification certifying that the fiscal requirements have been met.

DISCUSSION:

Proposition 63, otherwise known as the Mental Health Services Act (MHSA), created a 1% tax on income more than $1 million to expand mental health services. It was designed to expand and transform California's behavioral health system to better serve individuals with, and at risk of, serious mental health issues, and their families. MHSA addresses a broad continuum of prevention, early intervention, and service needs and the necessary infrastructure, technology, and training elements that support the public behavioral health system.

Counties are responsible for ensuring compliance with Welfare and Institutions (W&I) Code Section 5892(a) and State guidance and allocate and expend funds in the following categories:

- Innovations – 5%
- Prevention and Early Intervention (PEI) – 19%
- Community Services and Supports (CSS) – 76%

To expend funds, the County must:

- Prepare a Three-Year Program and Expenditure Plan
- Gain approval of Plan through annual stakeholder process
- Spend in accordance with an approved Plan
- Prepare and submit MHSA Annual Revenue and Expenditure Reports (RER)

Funding is not tied to demand for services, is not guaranteed, and revenue can be volatile.

As the contracted Mental Health Plan (MHP) with the State of California, Behavioral Health and Recovery Services (BHRS) administers Stanislaus County's behavioral health services, and uses MHSA funding to provide integrated mental health and supportive services to adults and older adults with a serious mental illness (SMI) and to children and youth with a serious emotional disturbance (SED). BHRS also uses funding to strengthen prevention and early intervention efforts and to build a "help first" system of care to eliminate disparities and promote wellness, recovery and resiliency outcomes.

Over the last year, the Department completed the initial phase of strategic planning to address a substantive structural budget shortfall. At the same time, the MHSA stakeholder process unfolded, providing the Department the opportunity to inform the broader strategic plan with MHSA values and stakeholder input. BHRS took substantive steps towards further developing an integrated system, aligning Realignment and other funding streams with the interests and values of the MHSA. As an agency and community partner, BHRS is committed to strengthening Stanislaus County's public mental health system, across the spectrum of care.

On March 30, 2021, the Stanislaus County Board of Supervisors (BOS) accepted the Stanislaus County BHRS Strategic Plan and authorized the Behavioral Health Director to finalize the Mental Health Services Act Three-Year Program and Expenditure Plan for Fiscal Years 2020-2021, 2021-2022, and 2022-2023 for Board consideration that aligns program services with sustainable funding (Resolution 2021-0136).

BHRS is requesting approval of the following:

- MHSA Three-Year Program and Expenditure Plan ("Plan") for Fiscal Years 2020-2021, 2021-2022, and 2022-2023
- Annual Updates ("Update") for Fiscal Years 2019-2020 and 2020-2021, reporting results and outcomes for Fiscal Years 2018-2019 and 2019-2020, respectively
- Early Psychosis Learning Health Care Network and Full-Service Partnership Multi-County Collaborative Innovations Plans ("Innovations Plan") and to allow expenditure of MHSA Funds for Innovations Projects

Plans and Updates are developed with feedback from the MHSA Representative Stakeholder Steering Committee (RSSC). The Plan and Update development process must also include a 30-day public review/comment period and a public hearing conducted by the Stanislaus County Behavioral Health Board (Welfare and Institutions Code, Section 5848). Information on the community planning and local review processes can be found on pages 44-47, 240-243, 264-265, and 278-280 of the attached Plan.

In March of 2020, Governor Newsom implemented a mandatory Stay-At-Home Order due to the Coronavirus Disease 2019 (COVID-19). Although BHRS was among many public agencies to be considered "essential" and staff continued to provide treatment and other supportive services, large gatherings and in-person public meetings were restricted which hindered the Department's ability to convene the required community planning and local review process to develop the 2020-2023 Plan and 2019-2020 Update.

In June of 2020, the California Department of Health Care Services released Information Notice 20-040, which provided counties with guidance on the Assembly Bill (AB) 81 statutory requirements of Mental Health Services Act (MHSA) funds to address immediate needs during the COVID-19 Public Health Emergency. This guidance also allowed counties to extend the effective timeframe of currently approved Plans or Updates to include Fiscal Year 2020-2021. The extension allowed BHRS to continue to operate programs and services reported in the Fiscal Year 2019-2020 Revenue and Expenditure Report (RER) into Fiscal Year 2020-2021 and provided for the submission of the Plan and Update prior to July 1, 2021.

Three-Year Program and Expenditure Plan (2020-2023)

As outlined in the BHRS Strategic Plan and approved by the Board of Supervisors, many programs will be concluded at the end of Fiscal Year 2020-2021 in order to align program operations and services with sustainable funding to prioritize behavioral health treatment services going forward. The list of these programs can be found on pages 12-13 of the attachment. Also outlined in the BHRS Strategic Plan, many new programs will be added in Fiscal Year 2021-2022. The list of programs being added can be found on pages 13-20 of the attached Plan.

The Plan summarizes the progress in implementing all services and activities. New or proposed changes to services or programs are included in each reporting component section.

Annual Updates for Fiscal Years 2019-2020 and 2020-2021

These Updates summarize what was new or different for each fiscal year reported, the challenges and strategies to mitigate them, and essential data and analysis that identifies not only demographics and outcomes, but also the connection to MHSA regulations.

Data and outcomes for each program funded by MHSA in Fiscal Years 2018-2019 and 2019-2020 are found on pages 48-236 of the attached Plan.

Innovation Project Recommendations

Innovation is one of five components of the Mental Health Services Act (MHSA). It provides funds to evaluate new approaches in mental health. The projects are intended to contribute to learning and address unmet needs, rather than having a primary focus on providing services.

As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community. Innovation projects are developed through input from community planning processes and are reflective of the unmet need identified by inclusive and diverse stakeholder input. Innovation funding makes it possible to try out new approaches, gather data, define, and measure the success of the new approach or practice without taking funds away from other necessary services. Since January 2010, Stanislaus County has conducted community planning for Innovation funding that resulted in the development of 17 new projects to date.

Stanislaus and other counties continuously must deal with the issue of the Innovation funding reverting due to the lengthy planning, approval, and implementation process, amongst other challenges. As the COVID-19 pandemic unfolded locally, the Department realized that the selection, development, and implementation of Innovation projects through the normal community planning process was not viable. Stanislaus and the other counties facing this issue were encouraged by the Mental Health Services Oversight and Accountability Commission (MHSOAC) to explore alignment with Innovation projects already approved by the MHSOAC to reduce the approval process timeline. BHRS quickly identified that two multi-county collaborative Innovation projects provided by the MHSOAC aligned very well with insights from stakeholder input on the BHRS system as a whole, and one aligned well with BHRS efforts to create a more robust stakeholder process for future Innovations proposals.

To explore this further and to ensure stakeholder support on these Innovation projects, BHRS conducted an informational session that detailed each project proposed as well as allowed time for discussion and questions surrounding these projects. The informational session for proposed Innovations projects was held on December 29, 2020. Following the informational session, stakeholders were invited to the RSSC meeting on January 15, 2021 to formally measure the level of support to move forward and pursue the proposed Innovation projects. After engaging in small group discussion and large group feedback discussion, RSSC members were surveyed utilizing the gradients of agreement scale; a scale utilized to measure the level of agreement and support towards a proposal. BHRS provided a one through five scale, with one representing non-acceptance of the proposed project and five noting complete and full acceptance. RSSC members identified fours and fives as their measurement during this meeting. The meeting concluded with agreement to move forward with both proposed Innovations projects.

Proposed Innovations projects were posted for 30-day Public Review on April 21, 2021, during which time no public comment was received. Additionally, the Innovation Projects

were presented to the local Behavioral Health Board and a public hearing was held on May 27, 2021. The Department is recommending the following Innovations projects for consideration.

Early Psychosis Learning Health Care Network (LHCN) Innovations Project

BHRS currently has an early psychosis intervention program, LIFE Path operated by Sierra Vista Child and Family Services, which serves adolescents ages 14-25 and their families who have either qualified as clinically high risk (prodromal) or have experienced a first break within the past year. As part of the Early Psychosis Learning Healthcare Network Collaborative, BHRS and the LIFE Path program will benefit from sharing and learning with the multiple and diverse participating counties. LIFE Path will gain technical assistance; an effective early psychosis-specific data collection methodology; innovative treatment approaches; and a learning collaborative that will enhance the program's access to new research, clinical support, and solution-oriented ideas for programmatic challenges. By receiving this assistance and support, LIFE Path will be able to use the evidence-based practices to be more effective and efficient and will also improve engagement of participants and family members in treatment and recovery. The expectation is that LIFE Path will increase the number of referred individuals who move forward with the assessment process as well as those who are retained in treatment and recovery.

Full-Service Partnership Multi-County Collaborative Innovations Project

BHRS has identified the need to use and share meaningful data in a clear and engaging way to better understand if Full-Service Partnership (FSP) programs are truly resulting in positive recovery outcomes for the clients served. The proposed Innovation Project will address Stanislaus County BHRS's FSP program challenges and needs through a thorough and inclusive approach. The project will support BHRS in implementing improvements in how we design, provide, and continuously improve FSP programs in the following ways:

- Create shared understanding of current FSP programs – who the programs are serving, how they are serving them, and what data is being collected to yield outcome measurement.
- Include stakeholders in the identification of FSP program strengths and areas of improvement.
- Identify problem statements that can be used to create FSP programs that are data and outcome oriented.
- Develop and support data collection, analysis, and presentation processes that allows BHRS to identify disparities through demographics and outcomes data, as well as ensure individual clients are connected to appropriate and customized services to increase positive outcomes.
- Identify and define FSP program outcome goals and develop meaningful performance measures to track progress towards goals; concurrently develop sustainable processes for using the data for continuous tracking and improvement.
- Clarify, streamline, and improve design and practices within FSP programs to better serve our County's FSP population and subpopulations.
- Leverage other counties' processes, learning, and best practices while participating in the Multi-County FSP Innovation Project.

POLICY ISSUE:

Per MHSA regulation, Counties must prepare and submit a Three-Year Program and Expenditure Plan (Plan) and Annual Updates (Update), adopted by the County's Board of Supervisors, to the Mental Health Services Oversight and Accountability Commission (MHSOAC) and the Department of Health Care Services (DHCS) within 30 days of adoption (Welfare and Institutions Code, Section 5847 (a)). All expenditures of MHSA funds for mental health programs in a County must be consistent with a currently approved Plan or Update (Welfare and Institutions Code, Section 5892(g)).

All Plans and Updates are required to include:

- Certification by the County Mental Health Director to ensure County compliance with pertinent regulations, laws, and status of the Mental Health Services Act, including stakeholder engagement and non-supplantation requirements; and
- Certification by the County Mental Health Director and the County Auditor-Controller that the County has complied with any fiscal accountability requirements and that all expenditures are consistent with the Mental Health Services Act.

FISCAL IMPACT:

The programs described in the Plan are funded by the Mental Health Services Act revenues, which leverage Medi-Cal Federal Financial Participation (FFP) and several other funding streams to maximize services provided to the community. To support all MHSA components and programs, $56 million in appropriations, $49.4 million in estimated revenue and $6.6 million in the use of fund balance were included in the BHRS 2021-2022 Proposed Budget. BHRS will avoid Innovation funding reversion by the timely approval and submission of the two proposed Innovation Projects. If these plans are not approved, $1,346,811 of Innovation funding will revert on June 30, 2021.

BOARD OF SUPERVISORS' PRIORITY:

The recommended actions are consistent with the Board of Supervisors' priorities of *Supporting Community Health* and *Delivering Efficient Public Services and Community Infrastructure* by providing mental health and substance use disorder services in the community through vendor partnerships.

STAFFING IMPACT:

The continuation of services described in the attached Plan and Update will be facilitated by existing BHRS staffing and resources.

CONTACT PERSON:

Ruben Imperial, MBA (209) 525-6205
Director, Behavioral Health and Recovery Services

ATTACHMENT(S):

1. 2020-2023 Mental Health Services Act 3-Year Plan, Annual Updates, and Innovations Projects

STANISLAUS COUNTY
MENTAL HEALTH SERVICES ACT
THREE YEAR PROGRAM AND EXPENDITURE PLAN
FOR FISCAL YEARS 2020-2023 AND ANNUAL UPDATES
FOR FISCAL YEARS 2019-2020 AND 2020-2021

Behavioral Health and
Recovery Services

WELLNESS • RECOVERY • RESILIENCE

Table of Contents

Introduction

Components

Comment Form

COUNTY COMPLIANCE CERTIFICATION

County: Stanislaus

County Mental Health Director	Project Lead
Name: Ruben Imperial, MBA Telephone Number: 209-525-6225 E-mail: Rimperial@stanbhrs.org	Name: Martha Cisneros, MPA Telephone Number: 209-525-6247 E-mail: mcisneros@stanbhrs.org
Mailing Address: Stanislaus County Behavioral Health and Recovery Services 800 Scenic Drive Modesto, CA 95350	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this annual update/plan update. Mental Health Services Act (MHSA) 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.

This Plan Update has been developed with the participation of stakeholders, in accordance with Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft FY 2019-2020 Plan Update was circulated to representatives of stakeholder interests and any interested party for 30 days for public review and comment. All input has been considered with adjustments made, as appropriate.

A.B. 100 (Committee on Budget – 2011) significantly amended the Mental Health Services Act to streamline the approval processes of programs developed. Among other changes, A.B. 100 deleted the requirement that the three year plan and updates be approved by the Department of Health Care Services (DHCS) after review and comment by the Mental Health Services Oversight and Accountability Commission (MHSOAC). In light of this change, the goal of this update is to provide stakeholders with meaningful information about the status of local programs and expenditures.

A.B. 1467 (Committee on Budget – 2012) significantly amended the Mental Health Services Act (MHSA) which requires Three-Year Plans and Annual Updates to be adopted by the County Board of Supervisors; requires the Board of Supervisors to authorize the Behavioral Health Director to submit the Annual Plan Update to the Mental Health Services Oversight and Accountability Commission (MHSOAC); and requires the Board of Supervisors to authorize the Auditor-Controller to certify that the County has complied with any fiscal accountability requirements and that all expenditures are consistent with the requirements of the Mental Health Services Act.

The information provided for each work plan is true and correct.

All documents in the attached Three Year Program & Expenditure Plan 2020-2023 and Annual Updates FY 2019-2020 and FY 2020-2021, are true and correct.

Ruben Imperial _____ 6/18/2021

Mental Health Director/Designee (PRINT) Signature Date

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Stanislaus

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

Local Mental Health Director	County Auditor-Controller/ City Financial Officer
Name: Ruben Imperial, MBA Telephone Number: (209) 525-6225 E-mail: RImperial@stanbhrs.org	Name: Kashmir Gill Telephone Number: (209) 525-7507 E-mail: GillK@stancounty.com
Local Mental Health Mailing Address: 800 Scenic Drive Modesto, CA 95350	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report 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.

Ruben Imperial
Local Mental Health Director (PRINT)

Signature 6/18/2021
Date

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated December 23, 2020, for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a). in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Kashmir Gill
County Auditor Controller / City Financial Officer (PRINT)

Signature 6/22/21
Date

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

Message from the Director

Over the last year, Stanislaus County Behavioral Health & Recovery Services (SCBHRS) has been challenged. One day we were all going about our daily lives, working, going to school, staying connected with loved ones or just trying to make the best of everyday. The next day, we all, as a community, stopped what we were doing, and began to isolate to do our part to slow the spread of COVID-19. This was challenging. Our work stopped, our plans were canceled, and services provided to our community began to look very different.

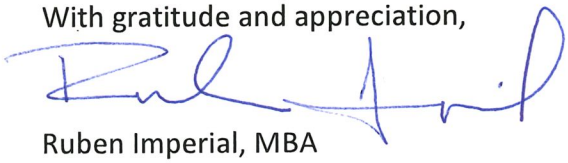
Despite this, our SCBHRS team, County staff and contract providers, and community partners pulled together and made the best of a very uncertain situation. Dedication to providing quality prevention, early intervention, and treatment services for the most vulnerable, under-served and under-represented community members was and still is our priority.

Although the world around us stopped, our local city, county and state governments did not. Our city, county and state officials provided relief and aid to counties, and in some cases extended deadlines and workflows so that services could remain open and current despite daily changes in direction.

There is no way that I can provide this annual MHSA Message From The Director without providing my utmost gratitude to our community, stakeholders, contractors, providers and staff, for coming together to ensure the continuity of behavioral health services for our community throughout this challenging time.

This years' Three Year Program and Expenditure Plan (Plan) for Fiscal Years 2020-2023 and Annual Updates for Fiscal Years 2019-2020 and 2020-2021 (Update) not only reflects where we have been, but a hopeful pathway forward. This pathway has brought us to a behavioral health system strengthened by the resilience gained in overcoming the challenges of the COVID-19 pandemic, a workforce that is more skilled in using new telehealth treatment tools and have become accustomed to remote work, and a renewed and deepened commitment to the provision of essential treatment services by dedicated behavioral health workforce in our community.

With gratitude and appreciation,



Ruben Imperial, MBA
Behavioral Health Director

Executive Summary

MHSA Purpose:

A mental illness is a disease that causes mild to severe disturbances in thought and/or behavior, resulting in an inability to cope with life's ordinary demands and routines. According to the National Alliance on Mental Illness (NAMI), one in five adults in the United States experience a mental illness and 1 in 25 (10 million) adults live with a serious mental illness.

In Stanislaus County, funding from the Mental Health Services Act (MHSA) is helping Stanislaus County Behavioral Health and Recovery Services (SCBHRS or referred to as the Department) address this important issue by expanding and strengthening prevention, early intervention and treatment programs for people living with mental illness. True to the aim of MHSA, SCBHRS is building a "help first" system of care to eliminate disparities, and promote wellness, recovery, and resiliency outcomes.

SCBHRS has a proud history of providing behavioral health services for the Stanislaus community. The Department administers the County's behavioral health services, providing integrated mental health services to adults and older adults with a serious mental illness (SMI) and to children and youth with a serious emotional disturbance (SED). SCBHRS also provides substance use disorder (SUD) services for adults and adolescents, supportive services, prevention and early intervention services, and serves as Stanislaus County's Public Guardian.

Data Considerations:

The Three Year Program and Expenditure Plan for Fiscal Years (FY) 2020-2023 (Plan) and Annual Update (Update) for FY 2019-2020 and FY 2020-2021, contain data submissions and updates for FY 2018-2019 and 2019-2020. The FY 2018-2019 data informs the Update for FY 2019-2020, and the FY 2019-2020 data informs the Update for FY 2020-2021. FY 2020-2021 data submissions and updates are not included in this Update since this fiscal year will not yet be complete at the time this report will be submitted. Rather, FY 2020-2021 data will be reflected in the Update for FY 2021-2022. Data is reported in arrears, after the completion of the Annual Revenue and Expenditure Report (ARER).

Timeline for Reporting:

In March of 2020, Governor Newsom implemented a mandatory Stay-At-Home Order due to the Coronavirus Disease 2019 (Covid-19). Although SCBHRS was amongst many public agencies to be considered "essential" and staff continued to provide treatment services, large gatherings and in-person public meetings were restricted which hindered the department's ability to convene the required community planning and local review process to develop the Plan and Update.

In May of 2020, Governor Newsom provided a plan to lift the mandatory COVID-19 Stay-At-Home Order in three phases depending on the number of positive cases reported in each county. At that time, Stanislaus County experienced an increase in positive tests and hospitalizations, which placed further restrictions on Stanislaus County that impeded the Department's ability to engage stakeholders in a meaningful community planning and local review process as required by MHSA statute.

For this reason, SCBHRS convened two web-based video streaming meetings in June of 2020. Both meetings were specifically aimed at communicating to the community of stakeholders, consumers, and key partners on the MHSA process, and of BHRS' intent to apply for an extension for the submission of the Three Year Program and Expenditure Plan and Annual Updates. These meetings also served as a forum to discuss how SCBHRS intended to build a more robust community planning and local review process under the added conditions of online platforms and other video-based streaming software.

In June of 2020 Governor Newsom released Behavioral Health Information Notice 20-040. It served the purpose of providing counties with guidance on the Assembly Bill (AB) 81 statutory requirements of Mental Health Services Act (MHSA) funds to address immediate needs during the COVID-19 Public Health Emergency.

Under Welfare and Institution (W&I) Code section 5847(h), a county that is unable to complete and submit a Three-Year Program and Expenditure Plan (Plan) or annual update (Update) for FY 2020-2021 due to the COVID-19 Public Health Emergency may extend the effective timeframe of its currently approved Plan or Update to include FY 2020-2021 and submit a Plan or Update to the Mental Health Services Oversight and Accountability Commission and the State Department of Health Care Services (DHCS) by July 1, 2021.

SCBHRS completed the required MHSA Three Year Program and Expenditure Plan and Annual Update Extension FY 2020-21 Form 5510 and submitted to the State Department of Health Care Services (DHCS) on August 30, 2020. Form 5510 was received and noted by DHCS following the submission date. The form 5510 was filed and can be viewed for the required MHSA Three Year Program and Expenditure Plan and Annual Update on the DHCS' website; MHSA Fiscal Oversight.

The extension allowed for SCBHRS to continue to operate programs and services reported in the ARER into FY 2020-2021, the first year of the Three Year Program and Expenditure Plan for Fiscal Years 2020-2023 and Annual Update. Additionally, the extensions provided by AB 81, to submit the Plan and Update in 2021, gave SCBHRS the opportunity to strengthen the community and stakeholder engagement processes as well as deploy in a broader Department wide strategic planning process.

MHSA Three Year Program and Expenditure Plan for Fiscal Years 2020-2023 and Annual Update for Fiscal Years 2019-2020 and 2020-2021 Report Structure:

The Plan and Update reflect SCBHRS' ongoing work to fulfill the promise of Proposition 63 approved by California voters in 2004. Over the last year, the Department completed the initial phase of strategic planning to address a substantive structural budget shortfall. At the same time, the MHSA stakeholder process unfolded, providing the Department the opportunity to inform the broader strategic plan with MHSA values and stakeholder input.

SCBHRS took substantive steps towards further developing an integrated system, aligning Realignment and other funding streams with the interests and values of the MHSA. As an agency and community partner, SCBHRS is committed to strengthening Stanislaus County's public mental health system, across the spectrum of care. Our Plan and Update provides and features updates to programs and services in all service delivery components of MHSA for FY 2018-2019 and 2019-2020. These updates summarize what was new or different for each fiscal year reported, the challenges and strategies to mitigate them, and essential data and analysis that identifies not only demographics and outcomes, but also the connection to MHSA regulations.

New or proposed changes to services or programs have been added to each reporting component section as related to the funding terms and regulations required by the ARER for each reporting fiscal year.

Due to the broader strategic planning efforts conducted by SCBHRS as a Department, and the integration with MHSA, an overview of the Departments' Strategic Plan is provided below. This information will also serve as a foundation for future Plans and Updates.

Stanislaus County Behavioral Health and Recovery Services Strategic Plan

For the past several years, operating costs to maintain current service levels have exceeded anticipated revenue, and the Department has relied upon the use of available fund balance to continue to maintain existing services. Demand for adult residential mental health and psychiatric hospital treatment remains high, while costs have continually outpaced available revenue. Impacts resulting from the COVID-19 pandemic, including a decline in Realignment and Mental Health Services Act (MSHA) funding in FY 2019-2020, have exacerbated these challenges.

To balance the FY 2020-2021 Adopted Final Budget, BHRS relied upon $9.2 million in anticipated salary savings from holding 61 positions vacant in mental health programs. SCBHRS also relied upon the use of $16.3 million in mental health fund balance and County General Fund "glide path" of $3.5 million, for a total of $19.8 million in one-time funds, to balance the FY 2020-2021 budget for mental health programs in order to continue to provide services to the community. SCBHRS has been working closely with the Stanislaus County Chief Executive Office to clearly identify the most urgent needs and explore funding options to address critical adjustments required to mitigate these challenges and move forward with a strategic, efficient plan to provide services effectively with limited resources. Mental Health and MHSA programs cannot be sustained under the threat of these combined impacts without implementing new strategies that bring expenses in

line with revenue. These strategies must align resources to meet federal and state standards to avoid potential fines and penalties for non-compliance, while addressing critical treatment needs in the community.

On November 24, 2020, the Stanislaus County Board of Supervisors authorized SCBHRS to conduct stakeholder processes and gather community input to complete a program review, plans and recommendations that align program operations and services with sustainable funding (Resolution 2020-0631) to:

- Prioritize behavioral health treatment services as designated in the Core Treatment Model (CTM) to maximize the number of clients served and leverage federal/state funding.
- Maintain compliance with federal/state network adequacy standards.
- Create efficiencies by standardizing team structures and consolidating administrative functions.

As the behavioral health plan administrator, SCBHRS is recommending a restructure of operations and a redirection and reprioritization of resources to provide critical treatment services to those most in need. The aim of these recommendations is to stabilize and transition SCBHRS fiscal plan to operate within annual allocations, minimizing the use of fund balance for on-going operations. The goal is also to emerge from the fiscal and health crisis focused on strengthening the Department's capability to provide behavioral health care to support the existing caseloads of clients and provide clarity on what resources will be needed to support the community's behavioral health needs into the future.

This plan proposes to direct resources to a treatment team structure, which is designed to maximize staffing and supervision ratios on each team based on the level of care required and supported with an efficient management, supportive services, and administrative structure. Resources such as shelter and housing for SCBHRS clients have been incorporated where funding allows.

On March 30, 2021, the Stanislaus County Board of Supervisors (BOS) accepted the SCBHRS Strategic Plan that aligns program operations and services with sustainable funding to prioritize behavioral health treatment services to maximize the number of clients served and leverage federal and state funding, maintain compliance with network adequacy standards, and create efficiencies by standardizing team structures and consolidating administrative structures. The BOS authorized SCBHRS to make the necessary adjustments to contracted service levels, execute staffing reassignments, negotiate new agreements, and modify existing agreements as outlined in the SCBHRS Strategic Plan to support full implementation by July 1, 2021. They also authorized the Behavioral Health Director to finalize the Mental Health Services Act Three-Year Program and Expenditure Plan for Fiscal Years 2020-2021, 2021-2022, and 2022-2023 for Board consideration in May that aligns program services with sustainable funding (Resolution 2021-0136).

FY 2018-2019 Programs Added or Expanded

Community Services and Supports (CSS):

- FSP 09 – Assisted Outpatient Treatment added
- GSD 09 – Short Term Residential Therapeutic Program added
- GSD 10 – Crisis Residential Unit added

Prevention:

- Child and Youth Resiliency added
- Afghan Path Toward Wellness added

CalHFA Housing:

- Housing Project Added – A specific project was not identified; however, funds were earmarked for future use.

FY 2018-2019 Programs Concluded

Innovations (INN):

- INN 16 – Co-Occurring Disorders Project concluded as INN project and adopted as a Full Service Partnership Program for FY 2019-2020.

FY 2019-2020 Programs Added or Expanded

Community Services and Supports (CSS):

- FSP 10 – Co-Occurring Disorders Program added
- GSD 09 –Short Term Residential Therapeutic Programs Expanded to add a third provider
- O&E 02 – Housing Program – Garden Gate Respite Expanded:
    - Placement capacity in Transitional Board and Care facilities
    - Emergency Shelter
    - Integrated housing and shelter needs
    - Additional housing support services
- GSD 11 – Therapeutic Foster Care added

Prevention and Early Intervention:

- Homeless Prevention and Early Intervention Team added
- Youth Leadership and Resiliency Programs revised to Child and Youth Resiliency
- Community Faith-Based Mental Health Prevention Program added
- Afghan Path Towards Wellness Early Intervention Program added

Innovations:

- NAMI on High School Campus added

CalHFA Housing:

- Kansas House Project leveraging No Place Like Home (NPLH) funds added

FY 2019-2020 Programs Concluded

Prevention and Early Intervention:

- Friends are Good Medicine ended as a Prevention program and is now a part of Outreach for Increasing Recognition of Early Signs of Mental Illness Program.
- Homeless Prevention and Early Intervention Team
- Community Faith-Based Mental Health

Innovation:

- The Suicide Prevention Innovation Project ended in September 2019. Elements of this project served to launch suicide prevention resources and enhanced BHRS' ability to respond to the needs of the community during the COVID-19 pandemic.

CalHFA Housing:

- Kansas House Project leveraging No Place Like Home (NPLH) funds.

FY 2020-2021 Programs Added

Prevention and Early Intervention:

- Family Urgent Response System - The Family Urgent Response System (FURS) was established by Senate Bill (SB) 80 (Chapter 27, Statutes of 2019) and amended by Assembly Bill (AB) 79 (Chapter 11, Statutes of 2020) which requires counties to develop and implement a mobile response system to respond to current and former foster youth experiencing tension, conflict, emotional distress, behavioral issues and/or other difficulties that may threaten their family relationships. The FURS is defined as a coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response, during situations of instability for purposes of preserving the relationship of the caregiver and the child or youth. Response includes providing developmentally appropriate conflict management and resolution skills, stabilizing the living situation, mitigating the distress of the caregiver, child or youth, connecting the caregiver and child or youth to existing local services, and promoting a healthy and healing environment for families. Services to start March 1, 2021.
    - Community Based Cultural and Ethnic Engagement – This was previously included with Prevention but has been moved to Outreach for Increasing Recognition of Early Signs of Mental Illness.
    - Resiliency and Prevention – This was previously included with Brief Intervention Counseling under Early Intervention but has been moved to Prevention,

- NAMI – This was previously included with Outreach for Increasing Recognition of Early Signs of Mental Illness but has been moved to Prevention.

Fiscal Year 2020-2021 Programs Concluded

Community Services and Supports:

- FSP – 01 Westside Stanislaus Homeless Outreach
- FSP – 02 Juvenile Justice
- FSP – 05 Integrated Forensic Team
- FSP – 06 High Risk Health & Senior Access
- FSP – 07 Turning Point-ISA
- FSP – 08 FSP for Children/Youth with SED
- FSP – 09 Assisted Outpatient Treatment
- FSP – 10 Co-Occurring Disorders FSP
- O&E – 02 Housing Program – Garden Gate Respite
- O&E – 02 Employment - Garden Gate Respite
- O&E – 03 Outreach and Engagement
- GSD – 01 Transition Age Young Adult Drop in Center
- GSD – 02 CERT/Warm Line
- GSD – 04 Families Together
- GSD – 05 Consumer Empowerment Center
- GSD – 06 Crisis Stabilization Unit
- GSD – 07 Crisis Intervention Program for Children and Youth
- GSD – 08 Youth Peer Navigators
- GSD – 09 Short Term Residential Therapeutic Program
- GSD – 10 Crisis Residential Unit
- GSD – 11 Therapeutic Foster Care
- GSD Portion of Westside Stanislaus Homeless Outreach GSD
- Portion of Integrated Forensic Team
- GSD Portion of High Risk Health & Senior Access

Prevention and Early Intervention:

- RAIZ Promotores Program (being renamed to Promotores/Community Health Outreach Workers in FY 2021-2022)
- Afghan Path Towards Wellness
- Child and Youth Resiliency (being renamed to Child and Youth Resiliency Prevention in FY 2021-2022)
- Resiliency and Prevention
- Community Faith Based Mental Health
- Prevention
- NAMI (being renamed to Training and Education in FY 2021-2022)

- Brief Intervention Counseling
- Child Sexual Abuse Treatment Services
- LIFE Path, Early Psychosis (being renamed to Early Psychosis Intervention in FY 2021-2022)
- Aging and Veteran Services (being renamed to Older Adult and Veteran Access and Linkage in FY 2021-2022)

Workforce Education and Training:

- Workforce Staffing – Services will continue to be provided as an administrative function for the entire Department. Costs have been pulled out of MHSA and transferred to the Behavioral Health and Recovery Services fund.

FY 2021-2022 Programs Added

Community Services and Supports (CSS) Full Service Partnership (FSP) programs:

- **Adult Behavioral Health Services Team (BHST)** - The Department is recommending establishing a standard Core Treatment Model (CTM) for mental health services. The new BHST team structure aims to broaden access to services for clients across programs by eliminating the current structure in which teams specialize with certain populations or treatment needs. All treatment teams would serve the range of populations that meet criteria such as criminal justice involved, homelessness, co-occurring SUDs, and high-risk health issues. BHSTs have levels of care to allow clients to progress through the recovery process with support from a trusted mental health treatment team. By integrating levels of care in a team, the client can access higher or lower levels of services, while maintaining the valuable therapeutic relationship within a team that uniquely understands the client's mental health needs and has developed a trusted relationship.
- **Adult Medication Clinic (AMC)** – The AMC will support BHSTs by providing psychiatric consultation, evaluation, and treatment of BHRS clients. Interventions provided include prescribing, administering, dispensing, and monitoring of psychotropic medications. Prescribers (psychiatrists and/or nurse practitioners) and nurses are part of the patient's interdisciplinary treatment team and help guide the course of a patient's treatment. AMCs will be centralized in Modesto and Turlock and medication services will be embedded in the BHSTs.
- **Children and Transition Age Youth Behavioral Health Services Team (CTYA-BHST)**- **CTYA-BHST** provides core treatment services for children and youth who are at risk for out of home placement in publicly funded care, such as resource families, STRTPs, correctional institutions or psychiatric facilities due to emotional, social and/or behavioral problems. The goal of these services is to improve the child's overall functioning within their family, school, peer group and community; reduce risk and incidence of mental health disability; and improve family well-being and functioning. Children and youth who are at acute risk for disruption in home or school placement, or for incarceration or psychiatric hospitalization, will receive a team based, "Full Service Partnership" (FSP) approach, that includes a Child and Family Team (CFT) made up of the child or youth, family members, professional, peer,

and natural supports. Peer support is embedded in the team to support caregivers or youth. Services and supports are available 24 hours a day, 7 days a week. Within the FSP team structure is an ACT level and an Intensive Community Support level to ensure that the child or youth receives services based on the intensity and frequency determined through the CFT process.

Community Services and Supports (CSS) Outreach and Engagement (O&E) Services:

- **Behavioral Health Outreach and Engagement (BHOE)** – The BHOE team will provide outreach and engagement to unserved/underserved individuals who may need specialty mental health services and are identified as not currently receiving needed care or only receiving episodic or crisis mental health services. BHOE services include proactive outreach services in community settings with the aim of building trusting relationships, implementing coordinated individualized intervention plans, and connecting individuals directly to treatment and supportive services.
- **Assisted Outpatient Treatment (AOT)**- Civil court-ordered treatment for individuals with severe and persistent mental illness who meet strict legal criteria. Often, these individuals experience severe mental health symptoms which impact their ability to recognize the need for treatment. AOT allows for a Qualified Referring Party (QRP) to refer an individual for mental health treatment without the consent of the individual. The AOT Team connects with the QRP and the individual to assess for Severe Mental Illness (SMI), their level of engagement, and their risk. Individuals are referred to an appropriate BHRS team while the AOT team continues to assist with engagement and assess for appropriateness for the court-ordered treatment. The AOT program began in 2018 as a pilot program and was to be evaluated for its effectiveness. After the start of the pilot, the State of California passed Assembly Bill (AB) 1976 (Chapter 140, Statutes of 2020) that requires counties to offer an AOT program, unless the County opts out by a resolution passed by the Board of Supervisors. Based on the learning through the pilot program, BHRS is recommending that the County does not "opt out" and continues with the AOT services and program development
- **Housing Support Services –** HSS provides intensive supports to assist individuals in maintaining current living situations. Supports include but are not limited to MH/SUD recovery principles, money management, connecting to a community, socialization skills, grocery shopping/cooking skills, and daily problem-solving skills.
- **Garden Gate Respite (GGR)–** GGR will be BHRS's primary short-term crisis housing option for individuals with known or suspected mental illness, who are at risk for homelessness, incarceration, victimization, or psychiatric hospitalization. GGR is a 24/7 home-like setting and consists of two houses with an 11-bed total capacity.
- **Short-Term Shelter and Housing -** Partnership with community shelters to provide overnight sleeping accommodations with the primary purpose of providing temporary shelter for BHRS clients experiencing a crisis or as part of a treatment plan. **Homelessness**
- **Access Center Integration** – Agreement with other Stanislaus County departments for operational support of the Access Center. The Access Center is a "one-stop" shop where coordinated services can be provided along with critical housing

supported by a community-wide increase in transitional and affordable housing as a key factor to reduce homelessness.

Community Services and Supports (CSS) General System Development (GSD) Supports:

- **Adult Residential Facilities (ARFs) -** An ARF is licensed by the state to provide enhanced mental health services with a higher staffing ratio than a regular board and care. This is an unlocked setting that provides care and supervision of clients on conservatorship, and those who agree to stay at the facility and do not present a risk of leaving the facility. The ARF level of care can be used to avoid placement in an Institution for Mental Disease, and as a step down from the locked setting prior to progressing to the community. The Department contracts with the following ARFs:
    - Davis Guest Home
    - Ever Well Health Systems
    - Mar-Ric
    - Turner Residential
    - Woods Board and Care Home
- **Residential Substance Use Disorder Board and Care -** Residential services are provided for clients who require 24/7 care in a sober, substance-free environment and have not succeeded with outpatient treatment services. Clients live at the residential facility full-time while receiving intensive SUD treatment services such as assessment, treatment planning, individual and group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination. Treatment services are covered under the Drug Medi-Cal Organized Delivery System (DMC-ODS), however, the cost of room and board is not an allowable reimbursement. MHSA funds will be accessed for clients with co-occurring mental health and substance use disorders since the availability of other funding for room and board is limited.
- **Housing Placement Assistance -** BHRS has partnerships with affordable housing developers/property managers to obtain and utilize properties to house BHRS clients. These housing properties are spread across Stanislaus County and include:
    - Transitional Housing (TH): TH refers to a supportive, yet temporary, type of accommodation that is meant to bridge the gap from homelessness to permanent housing by offering structure, supervision, behavioral health treatment support, life skills, and in some cases, education and training.
    - Permanent Supportive Housing (PSH): PSH is an intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically homeless people. The services are designed to build independent living and tenancy skills and connect people with community-based health care, treatment, and employment services.
- **Employment Support Services (ESS) –** Provides supportive employment to individuals with psychiatric disabilities who are working towards employment and housing independence. The program provides an opportunity for individuals with severe mental health disabilities to work in the community. These individuals may require ongoing support on or off the job to obtain and retain competitive employment within the community. The

goal of ESS is to provide individuals with limited job skills and/or those who have been out of the job market for an extended period with extensive support to maintain competitive employment.

- **Behavioral Health Wellness Center (BHWC) –** Provides a safe and welcoming community location for BHRS clients to access peer support and to support other clients in their recovery. The BHWC Peer Support Specialist Staff and Peers support each other in strengthening peer and community networks, while participating in wellness and rehabilitative activities and groups. The BHWC is also a place where clients will be able to gather to relax and hang out with other peers, creating a supportive environment for any client who walks through the door looking for support, someone to talk to, or just to hang out with a few friends. Each Treatment Team has an embedded Peer Support Specialist that ensures the BHWC services compliment and align with treatment services provided by a BHRS treatment team.
- **Behavioral Health Advocacy Services –** Supports clients and family members in both adult and children's system of care with accessing, understanding, and utilizing behavioral health services. In addition, support and information are provided to family members to help cope with the behavioral health crisis and illness of loved ones. Family advocates works independently of all service providers and assist families in their interactions with the service providers to help improve and facilitate these important relationships.
- **Mobile Community Emergency Response Team (MCERT)** – MCERT is a partnership between the Modesto Police Department and BHRS that will pairs a trained clinician with police officers in the field to respond to sub-acute mental health situations. Ride-along services have been limited over the last few years due to various staffing challenges. The program is currently under review with Law Enforcement partners and will be redesigned and relaunched in Fiscal Year 2021-2022
- **Behavioral Health Crisis and Support Line (BHCSL) -** Connects community members experiencing a behavioral health crisis with staff from the Community Emergency Response Team (CERT), who will assess the caller's behavioral health needs. In the event of a psychiatric emergency, CERT staff will facilitate access to immediate emergency psychiatric care. For non-emergent situations, the BHCSL staff can assist new clients in scheduling an assessment, and for current BHRS clients, assist them following-up with outpatient treatment services. BHCSL staff can also provide immediate supportive services over the phone. Specially trained BHCSL staff may also provide a supportive conversation over the phone, providing real-time and essential support to deal with a crisis. The BHCSL will facilitate a connection to peer support and to the Behavioral Health Wellness Center. The BHCSL may also answer after hours calls to the Medi-Cal Access Line, which is available to community members seeking general information about an assessment or needing to obtain a referral to an outpatient program.
- **Short Term Residential Therapeutic Programs (STRTPs) -** Assembly Bill (AB) 403 (Chapter 773, Statutes of 2015), otherwise known as Continuum of Care Reform (CCR), established a new category of community care licensed residential facility called Short-Term Residential Therapeutic Program (STRTP). An STRTP is a residential facility that provides an integrated program of specialized and intensive care and supervision, services and supports, treatment,

and 24-hour care and supervision to children and non-minor dependents. An STRTP may also provide a specialized program for a commercially sexually exploited child, juvenile sex offender, youth affiliated with or impacted by a gang, and youth whose parent is seeking a voluntary private placement. The program is designed to be short-term, individualized, and intensive, to stabilize youth who have complex needs to support a successful transition to a permanent and supportive family placement

- **Crisis Residential Unit (CRU) –** A multi-county collaboration for a 16-bed CRU facility located in Merced County. The residential program provides a supportive, welcoming environment for each resident and assists residents to resolve immediate crises and improve functioning and coping skills. Four beds are designated for use by Stanislaus County clients. BHRS only pays for the beds that are occupied by Stanislaus County residents, and there is no obligation to use the beds or pay for them when not in use. Having a facility available when necessary without having the expense of operating it at less than capacity is a substantial benefit, allowing additional flexibility in finding intensive treatment alternatives for clients.
- **Therapeutic Foster Care Services (TFC) -** The TFC service model is a short-term, intensive, highly coordinated, rehabilitative service that is provided to a child/youth up to age 21 with complex emotional and behavioral needs who is placed with trained and intensely supervised and supported TFC parents. The TFC parents serve as a key participant in the therapeutic treatment process of the child/youth. TFC services assist the child/youth in achieving client plan goals and objectives, improve functioning and well-being and help the child/youth to remain in community settings, thereby avoiding residential, inpatient, or institutional care.
- **GSD Portion of Adult Medication Clinic –** Medication support for non-Full Service Partnership BHSTs.

Prevention:

- **Promotores/Community Health Outreach Workers** – Services will not change; however, the program is being renamed to provide clarity. In prior plans, this program was referred to as the RAIZ Promotores Program
- **Child and Youth Resiliency Prevention –** Services will not change; however, the program is being renamed to provide clarity. In prior plans, this program was referred to as Child and Youth Resiliency.

Early Intervention:

- **Early Psychosis Intervention -** Services will not change; however, the program is being renamed to provide clarity. In prior plans, this program was referred to as LIFE Path, Early Psychosis.
- **Community Assessment, Response, and Engagement (CARE) -** CARE is a multidisciplinary team of mental health, criminal justice, and other service providers who facilitate, provide, and share responsibilities of assessment coordination and treatment services to appropriately meet the complex mental, physical, and social needs of the targeted population. The target population includes individuals who may have severe and persistent

mental illness, exhibit high-risk health and safety behaviors, engage in vagrancy-related criminal behavior, and experience severe SUDs; and for a variety of reasons, they are not accessing or accepting services. BHRS mental health services providers are embedded on the team to support clients with SMI and facilitate direct access to treatment services. The overarching goal is to see an increase in the target population transition from saying "no" to help to saying "yes" to help.

- **Children's Early Intervention -** The program will focus on children new to the behavioral health system with a first-time serious emotional disturbance (SED) diagnosis. Referrals may come from a variety of sources, including other programs, schools, parents, and other community partners. The services are intended to be short-term, up to 18 months, and include mental health treatment and other interventions that address and promote recovery and related functional outcomes. The goal is to prevent mental illness from becoming severe and debilitating and decrease negative outcomes that could result from untreated mental illness. If there is a need for additional treatment time or a higher level of care, children/youth can be transitioned to a BHST. As children/youth meet their treatment goals, they will move to a lower level of community care or complete treatment.
- **School Based Behavioral Health Services (SBBHS) –** Provides mental health consultation services and training for school site staff to support them in addressing individual and school-wide mental health concerns and issues. SBBHS will provide a spectrum of behavioral health services from wellbeing activities, training, consultation, de-escalation, brief counseling, and short-term treatment services. SBBHS will be provided at schools within unserved/underserved priority population communities, and at Modesto City Schools through a contract for services with the school district. County funded services will be provided through Empire Union School District, Orville Wright Elementary, Newman-Crows Landing Unified School District, and Cunningham Elementary School.
- **Kinship Supportive Services –** Provides individual and group supportive services to grandparents and/or other relative caregivers who are raising a relative's child or children. Services will include a guardian workshop and access to legal support for obtaining guardianship of the child/children, family oriented recreational activities, educational workshops, assistance accessing mental health services and other community resources.
- **Child Abuse Interview, Referrals and Evaluation –** Provides domestic violence/sexual abuse services at the CAIRE Center, which is co-located with the Stanislaus County Family Justice Center. CAIRE interviews are scheduled by law enforcement or Child Protective Services when an allegation of child abuse must be investigated. The CAIRE Center includes a multi-disciplinary team that is on-site to support the child/youth and family through this investigative process. Behavioral health services will be available to the child and family and can include emotional support, trauma-informed assessment, referrals and linkage, or ongoing trauma-informed treatment. This program will increase appropriate access and linkage to mental health services for these children and families experiencing the effects of trauma.

PEI Outreach for Increasing Recognition of Early Signs of Mental Illness:

- **Training and Education -** Activities and services designed to inform, train, and/or educate the community about mental health and mental health services and support. Outreach is an early stage in the process of engaging individuals with early signs of mental illness and/or potential responders (i.e., those in a position to identify, support, or refer individuals for assistance).

PEI Access and Linkage:

- **Older Adult and Veteran Access and Linkage -** Services will not change; however, the program is being renamed to provide clarity. In prior plans, this program was referred to as Aging and Veteran Services.

Innovation (INN)

- **Early Psychosis Learning Healthcare Network Statewide Collaborative**
  The proposed Innovation Project is a 5-year program that will make a change to an existing practice in the field of mental health by introducing a collaborative Learning Health Care Network (LHCN) to support quality improvements, consumer engagement and provider use of measurement-based care in early psychosis (EP) programs. This LHCN will collect and visualize real-time data at the individual, clinic, county and state levels to inform consumer- and program-level decisions and develop learning opportunities for individuals, staff, programs and administrators, in order to improve consumer outcomes.

- **Full-Service Partnership (FSP) Multicounty Collaborative**
  The proposed Innovation Project is a Statewide evaluation of 6 counties currently, Stanislaus County upon approval would be the seventh county, that will enhance meaningful outcomes and improve client experiences across FSP Programs. The data-driven project goals will help with consistent implementation of FSP programs service eligibility, enrichment of client experiences and service delivery; moreover, providing structure to share newly created data-driven opportunities and learning to promote ongoing program improvements. The proposed project is county-driven and seeks to address two main barriers to meeting the "whatever it takes" model through FSP programs:
    - A lack of information about FSP programs and their components that are found to deliver the greatest impact; and
    - Inconsistent FSP implementation.

  The program implementation and components of this project are specific to each counties' identified needs.

Workforce Education and Training (WET)

- **Regional Partnership**

  The 2021-2025 Workforce Education and Training (WET) program will address the shortage of mental health practitioners in the public mental health system (PMHS) through a framework that engages Regional Partnerships and supports individuals through pipeline development, undergraduate scholarships, education stipends, and educational loan repayment.

  The WET program also supports systems through peer personnel preparation, psychiatric education capacity, the Train New Trainers Psychiatry Fellowship Scholarship, and research and evaluation.

  This opportunity will result in agreement(s) with WET Regional Partnerships (RP) administering programs that oversee training and support to the Public Mental Health System workforce in their region.

  - The RP program will have one or more of the following components:
  - Pipeline Development
  - Undergraduate College and University Scholarships
  - Clinical Master and Doctoral Graduate Education Stipends
  - Loan Repayment Program
  - Retention Activities

Mental Health Services Act (MHSA) Overview

California voters passed Proposition 63, the Mental Health Services Act (MHSA), in November 2004 to expand and improve mental health services in the state. Enacted into law on January 1, 2005, the measure places a 1% tax on personal income above 1 million dollars with funds distributed to counties for local allocation. The goal is to transform the mental health system and improve the quality of life for Californians living with a mental illness.

MHSA has five (5) components:

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

Stanislaus County Behavioral Health and Recovery Services (SCBHRS) is working continuously to expand and improve behavioral health services using a “help first” approach that enables community members to access services and supports before they are in crisis. MHSA funds are an investment in services, supports, prevention, and system infrastructure to support a full and robust continuum of behavioral health care in Stanislaus County.

In partnership with the community, our mission is to provide and manage effective prevention and behavioral health services that promote our community’s capacity to achieve wellness, resiliency, and recovery outcomes. MHSA services require six essential elements: community collaboration, cultural competence, consumer driven and family driven systems of care, a focus on wellness, recovery, and resiliency, and integrated services experiences for consumers and families.

Three Year Plan and Annual Update Overview

Three Year Plan Description:

According to Welfare and Institution Code (WIC) § 5847 and California Code of Regulations (CCR) § 3310 a Three Year Program and Expenditure Plan shall address each MHSA component: Community Services and Supports (CSS) for children and youth, transition age youth, adults, and older adults (WIC § 5800 and § 5850); Capital Facilities and Technology Needs (CFTN) (WIC § 5847); Workforce Education and Training (WET) (WIC § 5820); Prevention and Early Intervention (PEI) (WIC § 5840); and Innovative Programs (INN) (WIC § 5830). This shall be one plan, incorporating all these elements, and making expenditure projections for each component per year.

Annual Update Description:

CCR § 3310 states that a county shall update the Plan annually. An Annual Update includes an update to the Plan addressing the elements that have changed and that year's expenditure plan.

2020 -2023 Three Year Plan and Annual Update for FY 2019-2020 and FY 2020-2021:

This years' Plan and Update summarizes Stanislaus County's progress in implementing all services and activities. New or proposed changes to services or programs have been added to each reporting component section as related to the funding terms and regulations required by the ARER for each reporting fiscal year; please reference the data considerations in the Eexecutive summary when reviewing the data provided in this Plan and Update.

In addition, the report provides an overview of all MHSA funded programs and component funding and proposals for new or expanded programs, when they are developed, for each of the components.

The Plan and Annual Update is developed with feedback from the MHSA Representative Stakeholder Steering Committee (RSSC). The committee is comprised of one primary member and one alternate from the following groups and communities:

- Behavioral Health and Recovery Services
- Stanislaus County Chief Executive Office
- Community Consumer Partners
- Contract Providers of Public Mental Health Services
- Stanislaus County Courts
- Diverse Communities
- Education
- Family Member Partners
- Health Care Public and Private
- Law Enforcement
- Stanislaus County Probation Department
- Housing: Public and Private
- Public Mental Health Labor Organization
- Regional Areas: South and Westside

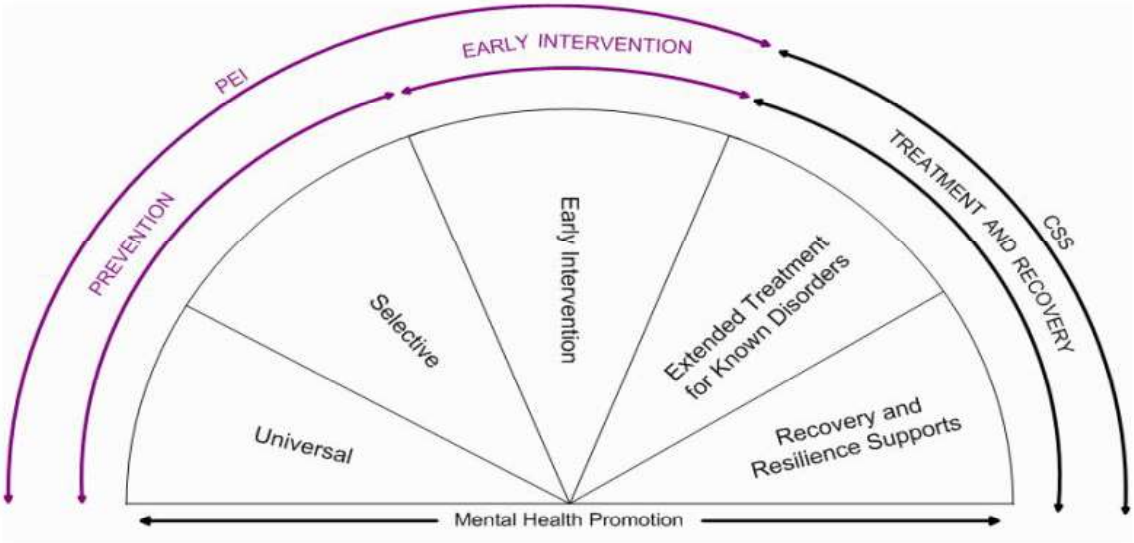
- Senior Services
- Social Services
- Veterans community
- Veteran Serving Organization
- Faith/Spiritually Based Organizations

The Plan and Annual Update development process must also include a 30-day public review/comment period and a public hearing conducted by the Stanislaus County Behavioral Health Board (WIC § 5848).

The completed documents must be submitted to the State Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after adoption by the Stanislaus County Board of Supervisors.

MHSA Funding Summary

By statute (WIC § 5847), each county shall prepare and submit a Three-Year Plan that is based on existing approved plans. BHRS has developed a local approach to show how MHSA programs are integrated into the county behavioral health system. We have incorporated the Mental Health Intervention Spectrum Diagram initially adapted from Mrazek and Haggerty (1994) and Commonwealth of Australia (2000). BHRS previously used the model to showcase the continuum of mental health intervention in Prevention and Early Intervention (PEI) planning. The diagram below now shows the spectrum of services and MHSA components that reach across the entire system. It illustrates levels of behavioral health care currently available from universal prevention, treatment, and recovery. The MHSA components CSS and PEI are shown in relationship to the levels of service. Cross-system components that support all services are shown across the entire spectrum; WE&T and CFTN support essential infrastructure; and INN supports learning and contribution to new and better practices.



Workforce Education & Training - Capital Facilities/Technological Needs - Innovation

Fiscal Sustainability

The distribution of Mental Health Services Act (MHSA) funds takes place on a monthly basis (W&I Code Section 5892(j)(5)) and counties are responsible for ensuring that funds are spent in compliance with W&I Code Section 5892(a) - 76% for Community Services and Supports (CSS), 19% for Prevention and Early Intervention (PEI) programs, and 5% for Innovations (INN) programs. Annually, based on an average of the past five years allocation, up to 20% of CSS funds may be used for any one or a combination of Workforce, Education and Training (WET); Capital Facilities/ Technological Needs (CFTN) or Prudent Reserve.

Counties receive monthly payments from the California State Controller's Office based on a basis of available cash. MHSA can be a volatile funding source and is driven by the state of the economy and the way in which state income taxes are assessed and paid. Due to potential volatility in funding, sufficient cash flow to support and sustain MHSA programs is needed to operate and to recommend programmatic changes in the event of an economic downturn. BHRS will continue to project MHSA funds based on the recommendations set forth by the County Behavioral Health Directors Association of California's (CBHDA) fiscal consultant.

An update to the FY 2019-2020 expenditure plan is shown below. These updates were approved by the Board of Supervisors in December of 2019 (Resolution 2019-0763), after the convening of three stakeholder meetings. However due to the COVID-19 pandemic and the quick response needed from SCBHRS to respond to the public health crisis, programs that were added in Fiscal Year 2019-2020 may have been temporarily delayed and/or continued into Fiscal Year 2020-2021.

Expenditure plans for FY 2020-2021, 2021-2022, and 2022-2023 are also shown below. The Fiscal Year 2021-2022 budget projection is subject to change up until the point that it is officially adopted as part of the Proposed Budget presentation to the Stanislaus County Board of Supervisors in June of 2021. Expenditure and revenue projections are updated during each budget cycle and material changes are discussed during the Representative Stakeholder Steering Committee (RSSC) review process.

Funding Summary Tables

FY 2018 - FY 2019 Funding Summary

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 B (02/19)
Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2018-19
Component Summary Worksheet

County:	Stanislaus	**Date:**	12/11/2019

		A	B	C	D	E	F
SECTION 1: Interest		**CSS**	**PEI**	**INN**	**WET**	**CFTN**	**TOTAL**
1	Component Interest Earned	$540,995.35	$182,427.87	$79,762.01	$7,084.36	$12,763.59	$823,033.18
2	Joint Powers Authority Interest Earned		$1,155.00				$1,155.00

		A	B	C
SECTION 2: Prudent Reserve		**CSS**	**PEI**	**TOTAL**
3	Local Prudent Reserve Beginning Balance			$500,000.00
4	Transfer from Local Prudent Reserve			$0.00
5	CSS Funds Transferred to Local Prudent Reserve	$0.00		$0.00
6	Local Prudent Reserve Adjustments			$0.00
7	Local Prudent Reserve Ending Balance			$500,000.00

		A	B	C	D	E	F
SECTION 3: CSS Transfers to PEI, WET, CFTN, or Prudent Reserve		**CSS**	**PEI**	**WET**	**CFTN**	**PR**	**TOTAL**
8	Transfers	-$300,000.00	$0.00	$300,000.00	$0.00	$0.00	$0.00

		A	B	C	D	E	F
SECTION 4: Program Expenditures and Sources of Funding		**CSS**	**PEI**	**INN**	**WET**	**CFTN**	**TOTAL**
9	MHSA Funds	$19,600,986.12	$4,134,394.87	$1,393,907.09	$566,941.23	$918,428.81	$26,614,658.12
10	Medi-Cal FFP	$6,676,084.06	$87,470.65	$522,373.97	$0.00	$0.00	$7,285,928.68
11	1991 Realignment	$111,065.00	$0.00	$0.00	$0.00	$0.00	$111,065.00
12	Behavioral Health Subaccount	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
13	Other	$664,974.87	$5,633.85	$16,920.38	$436.04	$0.00	$687,965.14
14	**TOTAL**	**$27,053,110.05**	**$4,227,499.37**	**$1,933,201.44**	**$567,377.27**	**$918,428.81**	**$34,699,616.94**

		A
SECTION 5: Miscellaneous MHSA Costs and Expenditures		**TOTAL**
15	**Total Annual Planning Costs**	$139,714.86
16	**Total Evaluation Costs**	$163,863.90
17	**Total Administration**	$2,655,287.54
18	**Total WET RP**	
19	**Total PEI SW**	$0.00
20	**Total MHSA HP**	$1,126,891.00
21	**Total Mental Health Services For Veterans**	$469,830.85

DHCS 1822 C (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2018-19
Community Services and Supports (CSS) Summary Worksheet

County:	Stanislaus	Date:	12/11/2019

SECTION ONE

		A Total MHSA Funds (Including Interest)	B Medi-Cal FFP	C 1991 Realignment	D Behavioral Health Subaccount	E Other	F Grand Total
1	**CSS Annual Planning Costs**						$0.00
2	**CSS Evaluation Costs**						$0.00
3	**CSS Administration Costs**	$1,772,479.43	$754,679.99			$107.80	$2,527,267.22
4	**CSS Funds Transferred to JPA**						$0.00
5	**CSS Expenditures Incurred by JPA**						$0.00
6	**CSS Funds Transferred to CalHFA**						$0.00
7	**CSS Funds Transferred to PEI**						$0.00
8	**CSS Funds Transferred to WET**	$300,000.00					$300,000.00
9	**CSS Funds Transferred to CFTN**						$0.00
10	**CSS Funds Transferred to PR**						$0.00
11	**CSS Program Expenditures**	$17,828,506.69	$5,921,404.07	$111,065.00	$0.00	$664,867.07	$24,525,842.83
12	**Total CSS Expenditures (Excluding Funds Transferred to JPA)**	**$19,900,986.12**	**$6,676,084.06**	**$111,065.00**	**$0.00**	**$664,974.87**	**$27,353,110.05**
13	**Total CSS Expenditures (Excluding Funds Transferred to JPA, PEI, WET, CFTN and PR)**	**$19,600,986.12**	**$6,676,084.06**	**$111,065.00**	**$0.00**	**$664,974.87**	**$27,053,110.05**

SECTION TWO

	A	B	C	D	E	F	G	H	I	J
#	County Code	Program Name	Prior Program Name	Program Type	Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
14	50	FSP - 01 Westside Stanislaus Homeless Outreach		FSP	$3,328,045.20	$1,699,516.47			$71,724.44	$5,099,286.11
15	50	FSP - 02 Juvenile Justice		FSP	$461,200.78	$197,543.41			$221.47	$658,965.66
16	50	FSP - 05 Integrated Forensic Team		FSP	$1,669,205.70	$608,548.91			$27,299.82	$2,305,054.43
17	50	FSP - 06 High Risk Health & Senior Access		FSP	$1,522,633.35	$837,030.15			$118,489.50	$2,478,153.00
18	50	FSP - 07 Turning Point-ISA		FSP	$491,949.58					$491,949.58
19	50	FSP - 08 FSP for Children/Youth with SED		FSP	$335,911.02	$458,476.74			$1,737.69	$796,125.45
20	50	FSP - 09 Assisted Outpatient Treatment		FSP	$335,025.73					$335,025.73
21	50	GSD - 01 Transition Age Young Adult Drop-In Center		Non-FSP	$605,984.85	$638,643.51			$26,550.99	$1,271,179.35
22	50	GSD - 02 CERT/Warmline		Non-FSP	$914,094.82					$914,094.82
23	50	GSD - 04 Families Together		Non-FSP	$522,802.11				$245.99	$523,048.10
24	50	GSD - 05 Consumer Empowerment Center		Non-FSP	$484,978.94					$484,978.94
25	50	O&E - 02 Housing Program - Garden Gate Respite		Non-FSP	$2,346,060.45		$45,847.00		$266,459.91	$2,658,367.36
26	50	O&E - 02 Employment - Garden Gate Respite		Non-FSP	$442,291.36		$65,218.00		$76,874.16	$584,383.52
27	50	O&E - 03 Outreach and Engagement		Non-FSP	$457,772.28	$20,065.29			$1,052.42	$478,889.99
28	50	GSD - 06 Crisis Stabilization Unit		Non-FSP	$462,389.59	$1,155,085.45			$54,132.69	$1,671,607.73
29	50	GSD - 07 Crisis Intervention Program for Children and Youth		Non-FSP	$439,197.57	$27,345.50			$20,077.99	$486,621.06
30	50	GSD - 08 Youth Peer Navigators		Non-FSP	$11,396.36					$11,396.36
31	50	GSD - 09 Short Term Residential Therapeutic Program		Non-FSP	$461,190.08	$279,148.64				$740,338.72
32	50	GSD - 10 Crisis Residential Unit		Non-FSP	$85,702.00					$85,702.00
33	50	GSD Portion of Westside Stanislaus Homeless Outreach		Non-FSP	$1,699,762.04					$1,699,762.04
34	50	GSD Portion of Integrated Forensic Team		Non-FSP	$427,326.60					$427,326.60
35	50	GSD Portion of High Risk Health & Senior Access		Non-FSP	$323,586.28					$323,586.28

DHCS 1822 D (02/19)
Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2018-19
Prevention and Early Intervention (PEI) Summary Worksheet

County:	Stanislaus	Stanislaus	Date:	12/11/2019

SECTION ONE

		A Total MHSA Funds (Including Interest)	B Medi-Cal FFP	C 1991 Realignment	D Behavioral Health Subaccount	E Other	F Grand Total
1	**PEI Annual Planning Costs**						$0.00
2	**PEI Evaluation Costs**	$163,863.90					$163,863.90
3	**PEI Administration Costs**	$578,526.09				$158.80	$578,684.89
4	**PEI Funds Expended by CalMHSA for PEI Statewide**						$0.00
5	**PEI Funds Transferred to JPA**	$109,947.00					$109,947.00
6	**PEI Expenditures Incurred by JPA**	$43,700.73					$43,700.73
7	**PEI Program Expenditures**	$3,348,304.15	$87,470.65	$0.00	$0.00	$5,475.05	$3,441,249.85
8	**Total PEI Expenditures (Excluding Transfers and PEI Statewide)**	**$4,134,394.87**	**$87,470.65**	**$0.00**	**$0.00**	**$5,633.85**	**$4,227,499.37**

SECTION TWO

		A Percent Expended for Clients Age 25 and Under, All PEI	B Percent Expended for Clients Age 25 and Under, JPA
9	**MHSA PEI Fund Expenditures in Program to Clients Age 25 and Under (calculated from weighted program values) divided by Total MHSA PEI Expenditures**	**48.40%**	**53.00%**

SECTION THREE

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
#	County Code	Program Name	Prior Program Name	Combined/Standalone Program	Program Type	Program Activity Name (in Combined Program)	Subtotal Percentage for Combined Program	Percent of PEI Expended on Clients Age 25 & Under (Standalone and Program Activities in Combined Program)	Percent of PEI Expended on Clients Age 25 & Under (Combined Summary and Standalone)	Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
10	50	RAIZ Promotiosis Program		Standalone	Prevention		100%	55%	55.0%	$682,158.32					$682,158.32
11	50	Friends Are Good Medicine		Standalone	Prevention		100%	85%	85.0%	$86,518.72					$86,518.72
12	50	Prevention		Standalone	Prevention		100%	50%	50.0%	$320,814.73					$320,814.73
13	50	Brief Intervention Counseling		Standalone	Early Intervention		100%	34%	34.0%	$695,723.96					$695,723.96
14	50	...ns United- Child Sexual Abuse Treatment Services		Standalone	Early Intervention		100%	36%	36.0%	$120,000.00					$120,000.00
15	50	Sierra Vista- LIFE Path, Early Psychosis		Standalone	Early Intervention		100%	100%	100.0%	$302,842.13	$87,470.65			$5,442.91	$395,755.69
16	50	School Behavioral Health Integration		Standalone	Early Intervention		100%	100%	100.0%	$569,881.06				$32.14	$569,913.20
17	50	...for Increasing Recognition of Early Signs of Mental Illness		Standalone	Outreach		100%	85%	85.0%	$126,723.19					$126,723.19
18	50	Stigma Discrimination Reduction		Standalone	Stigma & Discrimination Reduction		100%	85%	85.0%	$61,164.50					$61,164.50
19	50	Suicide Prevention		Standalone	Suicide Prevention		100%	80%	80.0%	$70,477.54					$70,477.54
20	50	Aging and Veteran Services		Standalone	Access and Linkage		100%	0%	0.0%	$312,000.00					$312,000.00

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 E (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2018-19
Innovation (INN) Summary Worksheet

County:	Stanislaus	Date:	12/11/2019

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Fund (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
1	**INN Annual Planning Costs**	$139,714.86					$139,714.86
2	**INN Indirect Administration**	$202,209.86					$202,209.86
3	**INN Funds Transferred to JPA**						$0.00
4	**INN Expenditures Incurred by JPA**						$0.00
5	**INN Project Administration**	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
6	**INN Project Evaluation**	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
7	**INN Project Direct**	$1,051,982.37	$522,373.97	$0.00	$0.00	$16,920.38	$1,591,276.72
8	**INN Project Subtotal**	$1,051,982.37	$522,373.97	$0.00	$0.00	$16,920.38	$1,591,276.72
9	**Total Innovation Expenditures (Excluding Transfers to JPA)**	**$1,393,907.09**	**$522,373.97**	**$0.00**	**$0.00**	**$16,920.38**	**$1,933,201.44**

SECTION TWO

		A	B	C	D	E	F	G	H	I	J	K	L	M	N
#		County Code	Project Name	Prior Project Name	Project MHSOAC Approval Date	Project Start Date	MHSOAC-Authorized MHSA INN Project Budget	Amended MHSOAC-Authorized MHSA INN Project Budget	Project Expenditure Type	Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
10	A	50	INN-16 - Co-Occurring Disorders Project		8/27/2015	9/1/2015	$2,377,554.00		Project Administration						$0.00
10	B	50	INN-16 - Co-Occurring Disorders Project		8/27/2015	9/1/2015	$2,377,554.00		Project Evaluation						$0.00
10	C	50	INN-16 - Co-Occurring Disorders Project		8/27/2015	9/1/2015	$2,377,554.00		Project Direct	$824,787.39	$522,373.97			$16,530.02	$1,363,691.38
10	**D**	**50**	**INN-16 - Co-Occurring Disorders Project**		**8/27/2015**	**9/1/2015**	**$2,377,554.00**		**Project Subtotal**	**$824,787.39**	**$522,373.97**	**$0.00**	**$0.00**	**$16,530.02**	**$1,363,691.38**
11	A	50	INN-17 - Suicide Prevention Initiative		4/28/2016	9/1/2016	$627,957.00		Project Administration						$0.00
11	B	50	INN-17 - Suicide Prevention Initiative		4/28/2016	9/1/2016	$627,957.00		Project Evaluation						$0.00
11	C	50	INN-17 - Suicide Prevention Initiative		4/28/2016	9/1/2016	$627,957.00		Project Direct	$227,194.98				$390.36	$227,585.34
11	**D**	**50**	**INN-17 - Suicide Prevention Initiative**		**4/28/2016**	**9/1/2016**	**$627,957.00**		**Project Subtotal**	**$227,194.98**	**$0.00**	**$0.00**	**$0.00**	**$390.36**	**$227,585.34**

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 F (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2018-19
Workforce Education and Training (WET) Summary Worksheet

County:	Stanislaus	Date:	12/11/2019

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
1	**WET Annual Planning Costs**						$0.00
2	**WET Evaluation Costs**						$0.00
3	**WET Administration Costs**	$102,072.16				$436.04	$102,508.20
4	**WET Funds Transferred to JPA**						$0.00
5	**WET Expenditures Incurred by JPA**						$0.00
6	**WET Program Expenditures**	$464,869.07	$0.00	$0.00	$0.00	$0.00	$464,869.07
7	**Total WET Expenditures (Excluding Transfers to JPA)**	**$566,941.23**	**$0.00**	**$0.00**	**$0.00**	**$436.04**	**$567,377.27**

SECTION TWO

	A	B	C	D	E	F	G	H
#	County Code	Funding Category	Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
8	50	Workforce Staffing	$181,983.03					$181,983.03
9	50	Training/Technical Assistance	$206,881.20					$206,881.20
10	50	Mental Health Career Pathways	$86,457.17					$86,457.17
11		Residency/Internship						$0.00
12	50	Financial Incentive	-$10,452.33					-$10,452.33

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 G (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2018-19
Capital Facility Technological Needs (CFTN) Summary Worksheet

County:	Stanislaus	Date:	12/11/2019

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
1	**CFTN Annual Planning Costs**						$0.00
2	**CFTN Evaluation Costs**						$0.00
3	**CFTN Administration Costs**						$0.00
4	**CFTN Funds Transferred to JPA**						$0.00
5	**CFTN Expenditures Incurred by JPA**						$0.00
6	**CFTN Project Expenditures**	$918,428.81	$0.00	$0.00	$0.00	$0.00	$918,428.81
7	**Total CFTN Expenditures (Excluding Transfers to JPA)**	**$918,428.81**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$918,428.81**

SECTION TWO

	A	B	C	D	E	F	G	H	I	J
#	County Code	Project Name	Prior Project Name	Project Type	Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
8	50	SU-01 Electronic Health Record (EHR) System		Technological Need	$542,037.56					$542,037.56
9	50	SU-02 Consumer Family Access		Technological Need	$243,195.15					$243,195.15
10	50	SU-03 Electronic Health Data Warehousing		Technological Need	$82,277.25					$82,277.25
11	50	SU-04 Document Imaging		Technological Need	$50,918.85					$50,918.85

FY 2019 – FY 2020 Funding Summary

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 B (02/19)
Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Component Summary Worksheet

County:	Stanislaus	Date:	12/22/2020

		A	B	C	D	E	F
SECTION 1: Interest		**CSS**	**PEI**	**INN**	**WET**	**CFTN**	**TOTAL**
1	Component Interest Earned	$440,549.63	$177,650.74	$91,410.00	$8,081.53	$11,455.67	$729,147.57
2	Joint Powers Authority Interest Earned		$1,625.22				$1,625.22

		A	B	C
SECTION 2: Prudent Reserve		**CSS**	**PEI**	**TOTAL**
3	Local Prudent Reserve Beginning Balance			$500,000.00
4	Transfer from Local Prudent Reserve			$0.00
5	CSS Funds Transferred to Local Prudent Reserve	$0.00		$0.00
6	Local Prudent Reserve Adjustments			$0.00
7	Local Prudent Reserve Ending Balance			$500,000.00

		A	B	C	D	E	F
SECTION 3: CSS Transfers to PEI, WET, CFTN, or Prudent Reserve		**CSS**	**PEI**	**WET**	**CFTN**	**PR**	**TOTAL**
8	Transfers	-$1,600,000.00	$0.00	$600,000.00	$1,000,000.00	$0.00	$0.00

		A	B	C	D	E	F
SECTION 4: Program Expenditures and Sources of Funding		**CSS**	**PEI**	**INN**	**WET**	**CFTN**	**TOTAL**
9	MHSA Funds	$22,868,909.30	$4,942,671.35	$268,087.72	$455,294.08	$886,039.25	$29,421,001.70
10	Medi-Cal FFP	$8,945,848.16	$95,728.78	$0.00	$0.00	$0.00	$9,041,576.94
11	1991 Realignment	$111,065.00	$0.00	$0.00	$0.00	$0.00	$111,065.00
12	Behavioral Health Subaccount	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
13	Other	$1,077,321.32	$10,587.42	$0.00	$0.00	$0.00	$1,087,908.74
14	**TOTAL**	**$33,003,143.78**	**$5,048,987.55**	**$268,087.72**	**$455,294.08**	**$886,039.25**	**$39,661,552.38**

		A
SECTION 5: Miscellaneous MHSA Costs and Expenditures		**TOTAL**
15	**Total Annual Planning Costs**	$121,144.74
16	**Total Evaluation Costs**	$220,452.99
17	**Total Administration**	$2,298,307.91
18	**Total WET RP**	
19	**Total PEI SW**	$0.00
20	**Total MHSA HP**	$1,100,000.00
21	**Total Mental Health Services For Veterans**	$556,496.18

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 C (02/19)
Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Community Services and Supports (CSS) Summary Worksheet

County:	Stanislaus	Date:	12/22/2020

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Funds (Including Interest)	**Medi-Cal FFP**	**1991 Realignment**	**Behavioral Health Subaccount**	**Other**	**Grand Total**
1	**CSS Annual Planning Costs**						$0.00
2	**CSS Evaluation Costs**						$0.00
3	**CSS Administration Costs**	$1,554,180.69	$872,346.38				$2,426,527.07
4	**CSS Funds Transferred to JPA**						$0.00
5	**CSS Expenditures Incurred by JPA**						$0.00
6	**CSS Funds Transferred to CalHFA**						$0.00
7	**CSS Funds Transferred to PEI**						$0.00
8	**CSS Funds Transferred to WET**	$600,000.00					$600,000.00
9	**CSS Funds Transferred to CFTN**	$1,000,000.00					$1,000,000.00
10	**CSS Funds Transferred to PR**						$0.00
11	**CSS Program Expenditures**	$21,314,728.61	$8,073,501.78	$111,065.00	$0.00	$1,077,321.32	$30,576,616.71
12	**Total CSS Expenditures (Excluding Funds Transferred to JPA)**	**$24,468,909.30**	**$8,945,848.16**	**$111,065.00**	**$0.00**	**$1,077,321.32**	**$34,603,143.78**
13	**Total CSS Expenditures (Excluding Funds Transferred to JPA, PEI, WET, CFTN and PR)**	**$22,868,909.30**	**$8,945,848.16**	**$111,065.00**	**$0.00**	**$1,077,321.32**	**$33,003,143.78**

SECTION TWO

	A	B	C	D	E	F	G	H	I	J
#	**County Code**	**Program Name**	**Prior Program Name**	**Program Type**	**Total MHSA Funds (Including Interest)**	**Medi-Cal FFP**	**1991 Realignment**	**Behavioral Health Subaccount**	**Other**	**Grand Total**
14	50	FSP - 01 Westside Stanislaus Homeless Outreach		FSP	$3,140,673.82	$1,775,310.02			$135,673.70	$5,051,657.54
15	50	FSP - 02 Juvenile Justice		FSP	$365,702.08	$227,208.10			$2,477.65	$595,387.83
16	50	FSP - 05 Integrated Forensic Team		FSP	$1,949,373.85	$645,599.64			$58,298.20	$2,653,271.69
17	50	FSP - 06 High Risk Health & Senior Access		FSP	$1,217,627.80	$1,029,946.54			$164,281.78	$2,411,856.12
18	50	FSP - 07 Turning Point-ISA		FSP	$531,328.31					$531,328.31
19	50	FSP - 08 FSP for Children/Youth with SED		FSP	$347,717.59	$422,990.35			$14,897.06	$785,605.00
20	50	FSP - 09 Assisted Outpatient Treatment		FSP	$379,330.35	$82,376.77				$461,707.12
21	50	FSP - 10 Co-Occurring Disorders FSP		FSP	$1,058,341.81	$443,964.05			$25,718.31	$1,528,024.17
22	50	GSD - 01 Transition Age Young Adult Drop in Center		Non-FSP	$464,113.74	$647,774.92			$23,677.97	$1,135,566.63
23	50	GSD - 02 CERT/Warmline		Non-FSP	$991,061.27					$991,061.27
24	50	GSD - 04 Families Together		Non-FSP	$513,289.03				$832.03	$514,121.06
25	50	GSD - 05 Consumer Empowerment Center		Non-FSP	$451,125.37				$36,401.21	$487,526.58
26	50	O&E - 02 Housing Program - Garden Gate Respite		Non-FSP	$4,328,611.49		$45,847.00		$286,785.90	$4,661,244.39
27	50	O&E - 02 Employment - Garden Gate Respite		Non-FSP	$390,970.10		$65,218.00		$85,423.00	$541,611.10
28	50	O&E - 03 Outreach and Engagement		Non-FSP	$394,904.08	$33,413.42			$1,809.81	$430,127.31
29	50	GSD - 06 Crisis Stabilization Unit		Non-FSP	$448,727.01	$1,116,383.06			$74,065.70	$1,639,175.77
30	50	GSD - 07 Crisis Intervention Program for Children and Youth		Non-FSP	$457,137.89	$23,401.91			$164,143.69	$644,683.49
31	50	GSD - 08 Youth Peer Navigators		Non-FSP	$41,964.13					$41,964.13
32	50	GSD - 09 Short Term Residential Therapeutic Program		Non-FSP	$1,289,414.92	$1,298,426.13			$2,835.31	$2,590,676.36
33	50	GSD - 10 Crisis Residential Unit + 4 Beds		Non-FSP	$133,108.13	$326,706.87				$459,815.00
34		GSD - 11 Therapeutic Foster Care		Non-FSP	$0.00					$0.00
35	50	GSD Portion of Westside Stanislaus Homeless Outreach		Non-FSP	$1,683,885.85					$1,683,885.85
36	50	GSD Portion of Integrated Forensic Team		Non-FSP	$418,940.54					$418,940.54
37	50	GSD Portion of High Risk Health & Senior Access		Non-FSP	$317,379.45					$317,379.45

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 D (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Prevention and Early Intervention (PEI) Summary Worksheet

County:	Stanislaus	Stanislaus	Date:	12/22/2020

SECTION ONE

		A Total MHSA Funds (Including Interest)	B Medi-Cal FFP	C 1991 Realignment	D Behavioral Health Subaccount	E Other	F Grand Total
1	PEI Annual Planning Costs						$0.00
2	PEI Evaluation Costs	$220,452.99					$220,452.99
3	PEI Administration Costs	$497,464.14					$497,464.14
4	PEI Funds Expended by CalMHSA for PEI Statewide						$0.00
5	PEI Funds Transferred to JPA	$90,990.13					$90,990.13
6	PEI Expenditures Incurred by JPA	$103,928.56					$103,928.56
7	PEI Program Expenditures	$4,120,825.66	$95,728.78	$0.00	$0.00	$10,587.42	$4,227,141.86
8	**Total PEI Expenditures (Excluding Transfers and PEI Statewide)**	**$4,942,671.35**	**$95,728.78**	**$0.00**	**$0.00**	**$10,587.42**	**$5,048,987.55**

SECTION TWO

		A Percent Expended for Clients Age 25 and Under, All PEI	B Percent Expended for Clients Age 25 and Under, JPA
9	MHSA PEI Fund Expenditures in Program to Clients Age 25 and Under (calculated from weighted program values) divided by Total MHSA PEI Expenditures	43.09%	59.00%

SECTION THREE

#	A County Code	B Program Name	C Prior Program Name	D Combined/Standalone Program	E Program Type	F Program Activity Name (in Combined Program)	G Subtotal Percentage for Combined Program	H Percent of PEI Expended on Clients Age 25 & Under (Standalone and Program Activities in Combined Program)	I Percent of PEI Expended on Clients Age 25 & Under (Combined Summary and Standalone)	J Total MHSA Funds (Including Interest)	K Medi-Cal FFP	L 1991 Realignment	M Behavioral Health Subaccount	N Other	O Grand Total
10	50	RAIZ Promotores Program	RAIZ Promotoras Program	Standalone	Prevention		100%	20%	20.0%	$701,217.08					$701,217.08
11	50	Afghan Path Towards Wellness		Standalone	Prevention		100%	7%	7.0%	$127,569.18					$127,569.18
12	50	Child and Youth Resiliency		Standalone	Prevention		100%	100%	100.0%	$85,424.96					$85,424.96
13	50	Community Faith Based Mental Health		Standalone	Prevention		100%	0%	0.0%	$0.00					$0.00
14	50	Friends Are Good Medicine		Standalone	Prevention		100%	51%	51.0%	$31,047.84					$31,047.84
15	50	Prevention		Standalone	Prevention		100%	51%	51.0%	$302,768.21					$302,768.21
16	50	Brief Intervention Counseling		Standalone	Early Intervention		100%	40%	40.0%	$995,460.55					$995,460.55
17	50	Parents United- Child Sexual Abuse Treatment Services		Standalone	Early Intervention		100%	23%	23.0%	$119,243.41					$119,243.41
18	50	Sierra Vista- LIFE Path, Early Psychosis		Standalone	Early Intervention		100%	100%	100.0%	$399,021.88	$95,728.78			$10,587.42	$505,338.08
19	50	School Behavioral Health Integration		Standalone	Early Intervention		100%	100%	100.0%	$748,191.23					$748,191.23
20	50	Homeless Prevention and Early Intervention Team		Standalone	Early Intervention		100%	0%	0.0%	$0.00					$0.00
21	50	Outreach for Increasing Recognition of Early Signs of Mental Illness		Standalone	Outreach		100%	28%	28.0%	$151,587.08					$151,587.08
22	50	Stigma & Discrimination Reduction	Stigma Discrimination Reduction	Standalone	Stigma & Discrimination Reduction		100%	22%	22.0%	$39,012.74					$39,012.74
23	50	Suicide Prevention		Standalone	Suicide Prevention		100%	59%	59.0%	$54,723.50					$54,723.50
24	50	Aging and Veteran Services		Standalone	Access and Linkage		100%	2%	2.0%	$365,558.00					$365,558.00

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 G (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Capital Facility Technological Needs (CFTN) Summary Worksheet

County:	Stanislaus	Date:	12/22/2020

SECTION ONE

		A Total MHSA Funds (Including Interest)	B Medi-Cal FFP	C 1991 Realignment	D Behavioral Health Subaccount	E Other	F Grand Total
1	CFTN Annual Planning Costs						$0.00
2	CFTN Evaluation Costs						$0.00
3	CFTN Administration Costs						$0.00
4	CFTN Funds Transferred to JPA						$0.00
5	CFTN Expenditures Incurred by JPA						$0.00
6	CFTN Project Expenditures	$886,039.25	$0.00	$0.00	$0.00	$0.00	$886,039.25
7	**Total CFTN Expenditures (Excluding Transfers to JPA)**	**$886,039.25**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$886,039.25**

SECTION TWO

#	A County Code	B Project Name	C Prior Project Name	D Project Type	E Total MHSA Funds (Including Interest)	F Medi-Cal FFP	G 1991 Realignment	H Behavioral Health Subaccount	I Other	J Grand Total
8	50	SU-01 Electronic Health Record (EHR) System		Technological Need	$495,652.27					$495,652.27
9	50	SU-02 Consumer Family Access		Technological Need	$216,086.85					$216,086.85
10	50	SU-03 Electronic Health Data Warehousing		Technological Need	$119,672.77					$119,672.77
11	50	SU-04 Document Imaging		Technological Need	$54,627.36					$54,627.36

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Department of Health Care Services

…02/19)
…tal Health Services Act (MHSA) Revenue and Expenditure Report
…2019-20
…INN) Summary Worksheet

	Stanislaus	Date:	12/22/2020

…NE

	A Total MHSA Fund (Including Interest)	B Medi-Cal FFP	C 1991 Realignment	D Behavioral Health Subaccount	E Other	F Grand Total
…ual Planning Costs	$121,144.74					$121,144.74
…ect Administration	$31,427.79					$31,427.79
…ds Transferred to JPA						$0.00
…enditures Incurred by JPA						$0.00
…ect Administration	$115,515.19	$0.00	$0.00	$0.00	$0.00	$115,515.19
…ect Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
…ect Direct	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
…ect Subtotal	$115,515.19	$0.00	$0.00	$0.00	$0.00	$115,515.19
…ovation Expenditures (Excluding Transfers to JPA)	**$268,087.72**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$268,087.72**

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A County Code	B Project Name	C Prior Project Name	D Project MHSOAC Approval Date	E Project Start Date	F MHSOAC-Authorized MHSA INN Project Budget	G Amended MHSOAC-Authorized MHSA INN Project Budget	H Project Expenditure Type	I Total MHSA Funds (Including Interest)	J Medi-Cal FFP	K 1991 Realignment	L Behavioral Health Subaccount	M Other	N Grand Total
50	INN-17 - Suicide Prevention Initiative		4/28/2016	9/1/2016	$627,957.00		Project Administratio	$98,685.31					$98,685.31
50	INN-17 - Suicide Prevention Initiative		4/28/2016	9/1/2016	$627,957.00		Project Evaluation						$0.00
50	INN-17 - Suicide Prevention Initiative		4/28/2016	9/1/2016	$627,957.00		Project Direct						$0.00
50	**INN-17 - Suicide Prevention Initiative**		**4/28/2016**	**9/1/2016**	**$627,957.00**		**Project Subtotal**	**$98,685.31**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$98,685.31**
50	INN-18 - NAMI on Campus High School Innovation Plan		4/2/2020	5/1/2020	$923,259.00		Project Administratio	$16,829.88					$16,829.88
50	INN-18 - NAMI on Campus High School Innovation Plan		4/2/2020	5/1/2020	$923,259.00		Project Evaluation						$0.00
50	INN-18 - NAMI on Campus High School Innovation Plan		4/2/2020	5/1/2020	$923,259.00		Project Direct						$0.00
50	**INN-18 - NAMI on Campus High School Innovation Plan**		**4/2/2020**	**5/1/2020**	**$923,259.00**		**Project Subtotal**	**$16,829.88**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$16,829.88**

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 F (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Workforce Education and Training (WET) Summary Worksheet

County:	Stanislaus	Date:	12/22/2020

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Funds (Including Interest)	**Medi-Cal FFP**	**1991 Realignment**	**Behavioral Health Subaccount**	**Other**	**Grand Total**
1	**WET Annual Planning Costs**						$0.00
2	**WET Evaluation Costs**						$0.00
3	**WET Administration Costs**	$99,720.10					$99,720.10
4	**WET Funds Transferred to JPA**						$0.00
5	**WET Expenditures Incurred by JPA**						$0.00
6	**WET Program Expenditures**	$355,573.98	$0.00	$0.00	$0.00	$0.00	$355,573.98
7	**Total WET Expenditures (Excluding Transfers to JPA)**	**$455,294.08**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$455,294.08**

SECTION TWO

	A	B	C	D	E	F	G	H
#	**County Code**	**Funding Category**	**Total MHSA Funds (Including Interest)**	**Medi-Cal FFP**	**1991 Realignment**	**Behavioral Health Subaccount**	**Other**	**Grand Total**
8	50	Workforce Staffing	$155,072.16					$155,072.16
9	50	Training/Technical Assistance	$111,970.86					$111,970.86
10	50	Mental Health Career Pathways	$88,530.96					$88,530.96
11		Residency/Internship						$0.00
12		Financial Incentive						$0.00

FY 2020-21 Through 2022-23 Mental Health Services Act Expenditure Plan
Funding Summary

County: Stanislaus

Date: 5/26/2021

	MHSA Funding							
	A	B	C	D	E		F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Housing (Returned from CalHFA)	Prudent Reserve	Total
A. Estimated FY2020/21 Funding								
1. Estimated Unspent Funds from Prior Fiscal Years	12,193,506	5,954,006	3,841,051	317,276	386,736	17,152	500,000	23,209,725
2. Estimated New FY2020/21 Funding + Interest	24,355,124	6,146,003	1,658,584	3,452	3,115	15,000		32,181,278
3. Transfer in FY2020/21[a/]	(900,000)			250,000	650,000			0
4. Access Local Prudent Reserve in FY2020/21							0	0
5. Estimated Available Funding for FY2020/21	35,648,630	12,100,009	5,499,635	570,728	1,039,851	32,152		54,891,003
B. Estimated FY2020/21 Expenditures	30,526,617	6,099,509	1,425,444	522,597	974,250	30,000		39,578,417
C. Estimated FY2021/22 Funding								
1. Estimated Unspent Funds from Prior Fiscal Years	5,122,013	6,000,500	4,074,191	48,131	65,601	2,152	500,000	15,812,586
2. Estimated New FY2021/22 Funding + Interest	25,376,233	6,438,058	1,729,226	1,000	1,400	10,000		33,555,917
3. Transfer in FY2021/22[a/]	(750,000)			425,000	325,000			0
4. Access Local Prudent Reserve in FY2021/22							0	0
5. Estimated Available Funding for FY2021/22	29,748,246	12,438,558	5,803,417	474,131	392,001	12,152		48,868,503
D. Estimated FY2021/22 Expenditures	26,734,128	10,328,635	2,570,382	400,755	334,557	10,000		40,378,457
E. Estimated FY2022/23 Funding						0		
1. Estimated Unspent Funds from Prior Fiscal Years	3,014,118	2,109,923	3,233,035	73,376	57,444	2,152	500,000	8,990,046
2. Estimated New FY2022/23 Funding + Interest	21,265,838	5,337,709	1,431,766	1,400	1,000	10,000		28,047,713
3. Transfer in FY2022/23[a/]	(500,000)			175,000	325,000			0
4. Access Local Prudent Reserve in FY2022/23							0	0
5. Estimated Available Funding for FY2022/23	23,779,956	7,447,632	4,664,801	249,776	383,444	12,152		36,537,759
F. Estimated FY2022/23 Expenditures	26,734,128	10,328,635	2,570,382	204,313	334,557	10,000		40,182,015
G. Estimated FY2022/23 Unspent Fund Balance	(2,954,172)	(2,881,003)	2,094,419	45,463	48,887	2,152	500,000	(3,144,256)

FY 2020-21 Through 2022-23 Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Stanislaus Date: 5/26/21

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
FSP - 01 Westside Stanislaus Homeless Outreach	5,867,642	4,247,886	1,519,885			99,871
FSP - 02 Juvenile Justice	552,098	339,663	212,262			173
FSP - 05 Integrated Forensic Team	2,532,683	1,959,345	533,547			39,791
FSP - 06 High Risk Health & Senior Access	2,440,255	1,620,405	686,275			133,575
FSP - 07 Turning Point-ISA	907,734	907,734				
FSP - 08 FSP for Children/Youth with SED	883,371	485,831	397,540			
FSP - 09 Assisted Outpatient Treatment	365,664	331,304	34,360			
FSP - 10 Co-Occurring Disorders FSP	1,664,773	1,193,823	449,157			21,793
Non-FSP Programs						
O&E - 02 Housing Program - Garden Gate Respite	6,579,516	6,387,323		45,847		146,346
O&E - 02 Employment - Garden Gate Respite	480,739	330,069		65,218		85,452
O&E - 03 Outreach and Engagement	535,800	513,957	20,277			1,566
GSD - 01 Transition Age Young Adult Drop-In Center	1,100,414	379,303	679,060			42,051
GSD - 02 CERT/Warmline	1,013,339	1,013,339				
GSD - 04 Families Together	305,605	305,590				15
GSD - 05 Consumer Empowerment Center	539,142	539,142				
GSD - 06 Crisis Stabilization Unit	1,870,061	1,124,330	603,308			142,423
GSD - 07 Crisis Intervention Program for Children and Y	782,133	563,965	13,829			204,339
GSD - 08 Youth Peer Navigators	29,840	29,840				
GSD - 09 Short Term Residential Therapeutic Program	3,464,000	1,880,345	1,583,655			
GSD - 10 Crisis Residential Unit	756,543	378,272	378,271			
GSD - 11 Therapeutic Foster Care	128,000	64,000	64,000			
GSD Portion of Westside Stanislaus Homeless Outreach	1,955,881	1,955,881				
GSD Portion of Integrated Forensic Team	610,126	610,126				
GSD Portion of High Risk Health & Senior Access	509,758	509,758				
CSS Administration	3,555,436	2,855,386	700,050			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	39,430,553	30,526,617	7,875,476	111,065	0	917,395
FSP Programs as Percent of Total	49.8%					

FY 2020-21 Through 2022-23 Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Stanislaus Date: 5/26/21

	Fiscal Year 2021/22					
	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						
Adult Behavioral Health Services Team	8,377,627	4,216,313	4,161,314			
Adult Medication Clinic	3,815,196	1,810,998	1,810,998			193,200
Children and Transition Age Youth Behavioral Health Services Team	3,670,000	1,835,000	1,835,000			
Non-FSP Programs						
O&E Programs						
Behavioral Health Outreach and Engagement	1,539,114	1,392,680				146,434
Assisted Outpatient Treatment	506,819	456,819	50,000			
Housing Support Services	971,988	971,988				
Garden Gate Respite	1,071,559	1,071,559				
Short-Term Shelter and Housing	67,666	67,666				
Homelessness Access Center Integration	200,000	200,000				
GSD Programs						
Adult Residential Facilities	4,062,894	4,062,894				
Residential Substance Use Disorder Board and Care	85,000	85,000				
Housing Placement Assistance	601,200	601,200				
Employment Support Services	185,141	99,718				85,423
Behavioral Health Wellness Center	1,285,471	1,285,471				
Behavioral Health Advocacy Services	451,322	451,322				
Mobile Community Emergency Response Team	413,182	413,182				
Behavioral Health Crisis and Support Line	1,054,238	1,054,238				
Short Term Residential Therapeutic Programs	3,264,000	1,632,000	1,632,000			
Crisis Residential Unit	756,543	378,272	378,271			
Therapeutic Foster Care Services	128,000	64,000	64,000			
GSD Portion of Adult Medication Clinic	924,178	438,689	438,689			46,800
CSS Administration	4,845,119	4,145,119	700,000			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	38,276,257	26,734,128	11,070,272	0	0	471,857
FSP Programs as Percent of Total	59.3%					

FY 2020-21 Through 2022-23 Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Stanislaus Date: 5/26/21

	Fiscal Year 2022/23					
	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						
Adult Behavioral Health Services Team	8,377,627	4,216,313	4,161,314			
Adult Medication Clinic	3,815,196	1,810,998	1,810,998			193,200
Children and Transition Age Youth Behavioral Health Services Team	3,670,000	1,835,000	1,835,000			
Non-FSP Programs						
O&E Programs						
Behavioral Health Outreach and Engagement	1,539,114	1,392,680				146,434
Assisted Outpatient Treatment	506,819	456,819	50,000			
Housing Support Services	971,988	971,988				
Garden Gate Respite	1,071,559	1,071,559				
Short-Term Shelter and Housing	67,666	67,666				
Homelessness Access Center Integration	200,000	200,000				
GSD Programs						
Adult Residential Facilities	4,062,894	4,062,894				
Residential Substance Use Disorder Board and Care	85,000	85,000				
Housing Placement Assistance	601,200	601,200				
Employment Support Services	185,141	99,718				85,423
Behavioral Health Wellness Center	1,285,471	1,285,471				
Behavioral Health Advocacy Services	451,322	451,322				
Mobile Community Emergency Response Team	413,182	413,182				
Behavioral Health Crisis and Support Line	1,054,238	1,054,238				
Short Term Residential Therapeutic Programs	3,264,000	1,632,000	1,632,000			
Crisis Residential Unit	756,543	378,272	378,271			
Therapeutic Foster Care Services	128,000	64,000	64,000			
GSD Portion of Adult Medication Clinic	924,178	438,689	438,689			46,800
CSS Administration	4,845,119	4,145,119	700,000			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	38,276,257	26,734,128	11,070,272	0	0	471,857
FSP Programs as Percent of Total	59.3%					

FY 2020-21 Through 2022-23 Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Stanislaus Date: 5/26/21

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
RAIZ Promotores Program	870,255	870,255				
Afghan Path Towards Wellness	97,796	97,796				
Child and Youth Resiliency	230,000	230,000				
Resiliency and Prevention	58,000	58,000				
Prevention	317,153	317,153				
NAMI	35,073	35,073				
PEI Programs - Early Intervention						
Brief Intervention Counseling	1,060,000	1,060,000				
Child Sexual Abuse Treatment Services	120,000	120,000				
LIFE Path, Early Psychosis	541,575	478,395	60,132			3,048
School Behavioral Health Integration	933,402	933,402				
Family Urgent Response System	301,253	50,000	50,000			201,253
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
Outreach for Increasing Recognition of Early Signs of Mental Illness	131,110	131,110				
Community Based Cultural and Ethnic Engagement	150,000	150,000				
PEI Programs -Stigma & Discrimination Reduction						
Stigma & Discrimination Reduction	57,998	57,998				
PEI Programs -Suicide Prevention						
Suicide Prevention	117,647	117,647				
PEI Programs -Access and Linkage						
Aging and Veteran Services	374,400	374,400				
PEI Administration and Evaluation	931,230	931,230				
PEI Assigned Funds	87,050	87,050				
Total PEI Program Estimated Expenditures	6,413,942	6,099,509	110,132	0	0	204,301

FY 2020-21 Through 2022-23 Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Stanislaus Date: 5/26/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
Promotores/Community Health Outreach Workers	904,622	904,622				
Child and Youth Resiliency Prevention	390,000	390,000				
PEI Programs - Early Intervention						
Early Psychosis Intervention	556,380	473,980	82,400			
School Behavioral Health Integration	2,294,809	2,294,809				
Family Urgent Response System	653,000	50,000	50,000			553,000
Community Assessment, Response, and Engagement	1,731,755	633,107				1,098,648
Children's Early Intervention	2,367,469	1,186,834	1,180,635			
School Based Behavioral Health Services	527,422	67,422	160,000			300,000
Kinship Supportive Services	576,138	81,682				494,456
Child Abuse Interview, Referrals and Evaluation	425,228	130,039	212,189			83,000
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
Outreach for Increasing Recognition of Early Signs of Mental Illness	336,454	336,454				
Community Based Cultural and Ethnic Engagement	250,000	250,000				
Training and Education	60,833	60,833				
PEI Programs -Stigma & Discrimination Reduction						
Stigma & Discrimination Reduction	336,880	336,880				
PEI Programs -Suicide Prevention						
Suicide Prevention	133,000	133,000				
PEI Programs -Access and Linkage						
Older Adult and Veteran Access and Linkage	374,400	374,400				
PEI Administration and Evaluation	2,521,132	2,521,132				
PEI Assigned Funds	103,441	103,441				
Total PEI Program Estimated Expenditures	14,542,963	10,328,635	1,685,224	0	0	2,529,104

FY 2020-21 Through 2022-23 Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Stanislaus Date: 5/26/21

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
Promotores/Community Health Outreach Workers	904,622	904,622				
Child and Youth Resiliency Prevention	390,000	390,000				
PEI Programs - Early Intervention						
Early Psychosis Intervention	556,380	473,980	82,400			
School Behavioral Health Integration	2,294,809	2,294,809				
Family Urgent Response System	653,000	50,000	50,000			553,000
Community Assessment, Response, and Engagement	1,731,755	633,107				1,098,648
Children's Early Intervention	2,367,469	1,186,834	1,180,635			
School Based Behavioral Health Services	527,422	67,422	160,000			300,000
Kinship Supportive Services	576,138	81,682				494,456
Child Abuse Interview, Referrals and Evaluation	425,228	130,039	212,189			83,000
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
Outreach for Increasing Recognition of Early Signs of Mental Illness	336,454	336,454				
Community Based Cultural and Ethnic Engagement	250,000	250,000				
Training and Education	60,833	60,833				
PEI Programs -Stigma & Discrimination Reduction						
Stigma & Discrimination Reduction	336,880	336,880				
PEI Programs -Suicide Prevention						
Suicide Prevention	133,000	133,000				
PEI Programs -Access and Linkage						
Older Adult and Veteran Access and Linkage	374,400	374,400				
PEI Administration and Evaluation	2,521,132	2,521,132				
PEI Assigned Funds	103,441	103,441				
Total PEI Program Estimated Expenditures	14,542,963	10,328,635	1,685,224	0	0	2,529,104

FY 2020-21 Through 2022-23 Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Stanislaus Date: 5/26/21

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
Innovations Planning	0					
INN-18 NAMI on Campus High School Innovation Plan	200,000	200,000				
New Requests for Proposals	1,000,000	1,000,000				
INN Administration	225,444	225,444				
Total INN Program Estimated Expenditures	1,425,444	1,425,444	0	0	0	0

	Fiscal Year 2021/22					
	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. NAMI on Campus High School Innovation Plan	200,000	200,000				
2. New Requests for Proposals	1,800,000	1,800,000				
INN Administration	570,382	570,382				
Total INN Program Estimated Expenditures	2,570,382	2,570,382	0	0	0	0

	Fiscal Year 2022/23					
	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						
NAMI on Campus High School Innovation Plan	200,000	200,000				
New Requests for Proposals	1,800,000	1,800,000				
INN Administration	570,382	570,382				
Total INN Program Estimated Expenditures	2,570,382	2,570,382	0	0	0	0

FY 2020-21 Through 2022-23 Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Stanislaus Date: 5/26/21

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing	251,140	251,140				
2. Training/Technical Assistance	70,000	70,000				
3. Mental Health Career Pathways	92,578	92,578				
WET Administration	108,879	108,879				
Total WET Program Estimated Expenditures	522,597	522,597	0	0	0	0

	Fiscal Year 2021/22					
	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						
Workforce Staffing	0					
Training/Technical Assistance	178,400	178,400				
Mental Health Career Pathways	5,000	5,000				
WET Central Region Partnership	196,442	196,442				
WET Administration	20,913	20,913				
Total WET Program Estimated Expenditures	400,755	400,755	0	0	0	0

	Fiscal Year 2022/23					
	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						
Workforce Staffing	0					
Training/Technical Assistance	178,400	178,400				
Mental Health Career Pathways	5,000	5,000				
WET Administration	20,913	20,913				
Total WET Program Estimated Expenditures	204,313	204,313	0	0	0	0

FY 2020-21 Through 2022-23 Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Stanislaus Date: 5/26/21

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects	0					
CFTN Programs - Technological Needs Projects						
SU-01 Electronic Health Record (EHR Systen	516,353	516,353				
SU-02 Consumer Family Access	233,820	233,820				
SU-03 Electronic Health Data Warehouse	165,623	165,623				
SU-04 Document Imaging	58,455	58,455				
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	974,250	974,250	0	0	0	0

	Fiscal Year 2021/22					
	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	0					
CFTN Programs - Technological Needs Projects						
Electronic Health Record (EHR System)	303,186	303,186				
Consumer Family Access	20,298	20,298				
Electronic Health Data Warehouse	9,869	9,869				
Document Imaging	1,204	1,204				
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	334,557	334,557	0	0	0	0

	Fiscal Year 2022/23					
	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	0					
CFTN Programs - Technological Needs Projects						
Electronic Health Record (EHR System)	303,186	303,186				
Consumer Family Access	20,298	20,298				
Electronic Health Data Warehouse	9,869	9,869				
Document Imaging	1,204	1,204				
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	334,557	334,557	0	0	0	0

FY 2020-21 Through 2022-23 Mental Health Services Act Expenditure Plan
Housing Component Worksheet (Returned from CalHFA)

County: Stanislaus Date: 5/26/21

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated Housing Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Housing Programs						
Housing Project	30,000	30,000				
Housing Administration	0					
Total Housing Program Estimated Expenditures	30,000	30,000	0	0	0	0

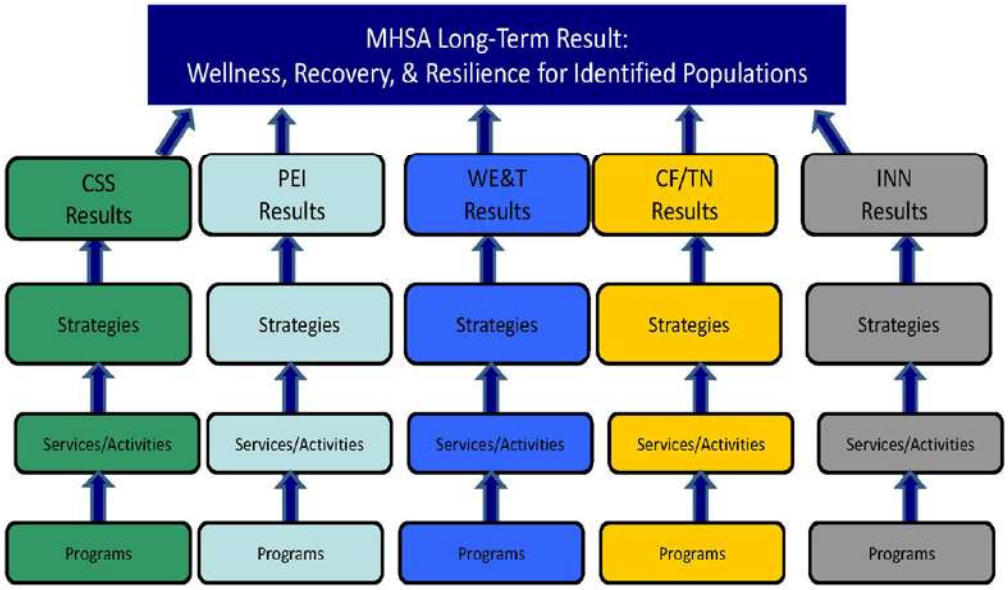
	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated Housing Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Housing Programs						
Housing Project	10,000	10,000				
Housing Administration	0					
Total Housing Program Estimated Expenditures	10,000	10,000	0	0	0	0

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated Housing Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Housing Programs						
Housing Project	10,000	10,000				
Housing Administration	0					
Total Housing Program Estimated Expenditures	10,000	10,000	0	0	0	0

MHSA Theory of Change
Results Based Accountability Framework

Transformation of the public mental health system is the goal of BHRS as we embrace the values of the Mental Health Services Act (MHSA) to improve behavioral health outcomes for those struggling with mental illness in our community. Our long-term result is to create an environment of Wellness, Recovery, and Resilience. To guide that effort, BHRS has implemented the Theory of Change and Results Based Accountability (RBA) frameworks.

The Theory of Change (shown below) is a type of methodology, a road map for planning and evaluation to promote change. It defines long-term goals and desired outcomes. RBA is a method to develop, interpret, and present program results. BHRS is utilizing RBA framework to evaluate service programs and progress to show how MHSA programs are impacting lives.



Community Program Planning
Stakeholder Planning Activities

MHSA Community Program Planning (CPP) Overview

The Community Planning Process as Defined in MHSA Regulations
Section 5898, Welfare and Institutions Code. Reference: Sections 5813.5(d) and 5892(c), Welfare and Institutions Code.

Community Program Planning means the process to be used by the County to develop the Three Year Program and Expenditure Plans, and updates in partnership with stakeholders to:

- Identify community issues related to mental illness resulting from a lack of community services and supports, including any issues identified during the implementation of the MHSA.
- Analyze the mental health needs in the community.
- Identify and re-evaluate priorities and strategies to meet those mental health needs.

Stakeholders: Each Plan and Update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests.

Meaningful Stakeholder Involvement: Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations.

Public Review and Comment: A draft Plan and Update shall be prepared and circulated for review and comment for at least 30 days to representatives.

MHSA Population Definitions

Underserved: Title 9 CCR 3200.300: "Underserved" means clients of any age who have been diagnosed with a serious mental illness (SMI) and/or serious emotional disturbance (SED) 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 (Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5814(a)(1), 5814(d), 5814.5, 5830, 5840 and 5848, Welfare and Institutions Code):

Unserved: Title 9 CCR 3200.310: "Unserved" means those individuals who may have serious mental illness (SMI) and/or serious emotional disturbance (SED) 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 (Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5814(a)(1), 5814.5, 5830, and 5840 Welfare and Institutions Code).

Transition Age Youth: Title 9 CCR 3200.280: "Transition Age Youth" means youth 16 years to 25 years of age (Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5847(c), Welfare and Institutions Code).

CPP Activities Based on Fiscal Year

FY 2019-2020 CPP Activities:

- April 19, 2019 RSSC Meeting, 34 attendees: RSSC members received an overview of the MHSA components and budget process. Highlights from MHSA funded programs for FY 2017-2018 were shared the recommendations as well for the MHSA Annual Update for FY 2019-2020.

- May 29, 2021 Guiding Principles Workgroup, 9 attendees: The guiding principles workgroup was convened to provide an opportunity to engage stakeholders in dialogue about how the department can work towards the goals of increasin
engagement and re-establishing shared understanding of roles and responsibilities among the diverse stakeholder group members. Key items were covered such as approaches outreach and capacity building. An MHSA timeline was provided of implementation activities in the past to present day as well as past attendance records so that attendees could see the gradual decline. Potential strategies were also shared.

- July 23, 2019 RSSC Meeting, 47 attendees: RSSC members were provided a status update of the MHSA Annual Update for FY 2019-2020. Innovation process planning was reviewed and Innovation proposals were shared for discussion only.

- October 18, 2019 RSSC Meeting, 62 attendees: RSSC members received an overview of SCBHRS Strategic Planning. Additional information regarding reducing homelessness for SCBHRS clients with SMI, prudent reserve assessment, therapeutic foster care, prevention and early intervention, and suicide prevention innovation. The following link will provide further information regarding the board agenda item which was a result of this meeting. This item was approved in December 17, 2019; Mental Health Services Act Plan Update (stanislausmhsa.com).

FY 2020-2021 CPP Activities:

In March of 2020, Governor Newsom implemented a mandatory Stay At Home Order due to the Coronavirus Disease 2019 (COVID-19). Although SCBHRS was amongst many public agencies to be considered "essential" and staff continued to provide treatment services, large gatherings and in-person public meetings were restricted which hindered the department's ability to convene the required community planning and local review process to develop the Plan and Update. Due to the increase in cases and increased risk to convene in face to face forums, SCBHRS began to convene web-based video streaming meetings.

- June 12, 2020 RSSC Meeting, 75 attendees: RSSC attendees received information regarding the COVID-19 crisis and the effects of the crisis on MHSA reporting requirements and MHSA flexibility opportunities. Members were also provided with an MHSA overview, funding overview for MHSA and discussion of the overall strategic plan for the department.

- June 26, 2020 RSSC Meeting, 82 attendees: RSSC attendees were provided with additional information on MHSA Flexibility Opportunities and the overarching planning framework for the department. The CPP process was also discussed and how the process would be leveraged to assist in the overall planning process for the Department.

- September 18, 2020 RSSC Meeting, 62 attendees: An MHSA update was provided regarding MHSA funding gaps and projections for future funding. As a result, the attendees were also invited to participate in the Human Center Design (HCD) process which included one-on-one interviews from October through December of 2020. The purpose of the meetings was to analyze the mental health needs in the community and to identify and re-evaluate priorities and strategies to meet those needs.

- December 11, 2020 RSSC Meeting, 98 attendees: Attendees were provided a budget update that also included updates from the State Department of Health Care Services (DHCS) regarding reversion on MHSA Innovation Projects. RSSC attendees were also given an update on the HCD process and invited to participate in an Innovations Projects Information session.

- December 29, 2020 MHSA Innovation Projects Informational session, 44 attendees: RSSC members were provided with information regarding three proposed innovations projects and had opportunities to ask questions. The informational session was recorded. The recording passcode can be requested by contacting the MHSA Planning Office at (209) 525-6247

Local Review Process

The Plan and Annual Update were posted for a 30-day public review and comment on April 1, 2021. Notification of the public review dates and access to copies of the Plan and Annual Update were made available through the following methods:

- An electronic copy was posted on the County's MHSA website: www.stanislausmhsa.com.
- Paper copies of the Plan and Update were delivered to Stanislaus County Public Libraries.
- Electronic notification was sent to all SCBHRS service sites with a link to www.stanislausmhsa.com, announcing the posting of this report
- Representative Stakeholder Steering Committee RSSC, Stanislaus County Behavioral Health Board members (SCBHB), as well as other community stakeholders were sent the Public Notice informing them of the start of the 30-day review, and how to obtain a copy of the Plan and Update.
- Public Notices were posted in newspapers throughout Stanislaus County. The Public Notice included access to the Plan and Update on-line at www.stanislausmhsa.com and a contact number to request a copy of the document.
- SCBHRS Cultural Competency Newsletter.

Comments are solicited through a comment form attached to the back of this document and may be faxed to (209) 558-4326 or U.S. mail to Martha Cisneros Campos, MHSA Planning Manager 800 Scenic Drive, Modesto, CA 95354. Contact may be made through the website www.stanislausmhsa.com and e-mail (mcisneros@stanbhrs.org).

The public comment period will conclude with a public hearing conducted by the Stanislaus County Behavioral Health Board meeting at 800 Scenic on April 29, 2019 at 5PM. All community stakeholders are invited to participate.

All public comments will be considered, and substantial comments included with a response in the final and submitted version of the Annual Update.

There was one substantive public comment received at the public hearing. The comment was related to improving the method of gathering stakeholder input and a desire to have increased peer representation at the RSSC meetings.

Community Services and Supports

Community Services & Supports (CSS) programs provide direct services to individuals of all ages with mental illness in Stanislaus County. There are three levels of service under Adult/Older Adult, Forensic and Children's Systems of Care:

1. Full Service Partnership
2. General System Development
3. Outreach and Engagement.

CSS is the largest component and makes up 80% of county MHSA funding. It funds direct services to individuals with severe mental illness and children with serious emotional problems. The culturally competent services are focused on wellness, recovery, and resiliency while integrating the service experience for clients and families. Long term supported housing is also part of CSS funding.

All CSS programs are committed to providing services that embrace the MHSA general standards:

- Community Collaboration
- Cultural Competence
- Client Driven
- Family Driven
- Wellness, Recovery, and Resilience Focused
- Integrated Service Experiences for clients and their families

Full Service Partnership (FSP) funded programs provide integrated services to the most unserved or underserved and those at high risk for homelessness, incarceration, hospitalization, and out-of-home placement. MHSA mandates that the majority of CSS funding must be used for services to this population. Strategies are considered a "wraparound" approach to engaging service recipients as partners in their own self-care, treatment, and recovery. In doing so, they can achieve and sustain stability in medical and psychiatric well-being and help end their homelessness and involvement in the criminal justice system. Program results include reductions in incarceration, homelessness, psychiatric hospitalizations, and emergency medical services/hospitalization.

FY 18-19 Programs:

- FSP-01 – Westside Stanislaus Homeless Outreach
- FSP-02 – Juvenile Justice (JJ)
- FSP-05 – Integrated Forensic Team (IFT)
- FSP-06 – High Risk Health & Senior Access (HRHSA)
- FSP-07 – Turning Point Integrated Services Agency (ISA)
- FSP-08 – FSP for Children/Youth with SED
- FSP-09 – Assisted Outpatient Treatment

FY 19-20 Programs

- FSP-01 – Westside Stanislaus Homeless Outreach
- FSP-02 – Juvenile Justice (JJ)
- FSP-05 – Integrated Forensic Team (IFT)
- FSP-06 – High Risk Health & Senior Access (HRHSA)
- FSP-07 – Turning Point Integrated Services Agency (ISA)
- FSP-08 – FSP for Children/Youth with SED
- FSP-09 – Assisted Outpatient Treatment
- FSP-10 – Co-Occurring Disorders FSP

General System Development (GSD) funded programs were established to increase capacity to provide crisis services, peer/family support, and drop-in centers for individuals with mental illness and serious emotional disturbance. These programs are focused on reducing stigma, encouraging and increasing self-care, recovery and wellness, and accessing community resources. The goal is to increase overall well-being and decrease the need for more intensive and expensive services.

FY 18-19 Programs:

- GSD-01 – Transitional Age Young Adult Drop-in Center
- GSD-02 – CERT/Warm Line
- GSD-04 – Families Together
- GSD-05 – Consumer Empowerment Center
- GSD-06 – Crisis Stabilization Unit
- GSD-07 – Crisis Intervention Program for Children and Youth
- GSD-08 – Youth Peer Navigators*
- GSD-09 – Short Term Residential Therapeutic Program
- GSD-10 – Crisis Residential Unit

**Youth Peer Navigators is reported within FSP-02 Juvenile Justice (JJ) as a strategy. The budget has been reported separately in this section as well.*

FY 19-20 Programs:

- GSD-01 – Transitional Age Young Adult Drop-in Center
- GSD-02 – CERT/Warm Line
- GSD-04 – Families Together
- GSD-05 – Consumer Empowerment Center
- GSD-06 – Crisis Stabilization Unit
- GSD-07 – Crisis Intervention Program for Children and Youth
- GSD-08 – Youth Peer Navigators
- GSD-09 – Short Term Residential Therapeutic Program
- GSD-10 – Crisis Residential Unit
- GSD-11 – Therapeutic Foster Care

Outreach & Engagement (O&E) funded programs focus on special activities needed to reach diverse underserved communities. Strategies include community outreach to diverse community-based organizations. Crisis-oriented respite housing was also established to avoid unnecessary incarceration and psychiatric hospitalization and to provide short-term housing, and linkage to services.

FY 18-19 Programs:

- O&E-02 – Housing Program - Garden Gate Respite*
- O&E-02 – Employment - Garden Gate Respite*
- O&E-03 – Outreach and Engagement

**O&E-02 Housing Program – Garden Gate Respite and O&E-02 Employment – Garden Gate Respite are combined in one summary in this Plan and Update.*

FY 19-20 Programs:

- O&E-02 – Housing Program - Garden Gate Respite*
- O&E-02 – Employment - Garden Gate Respite*
- O&E-03 – Outreach and Engagement

**O&E-02 Housing Program – Garden Gate Respite and O&E-02 Employment – Garden Gate Respite are combined in one summary in this Plan and Update.*

Westside Stanislaus Homeless Outreach (SHOP)– FSP 01

Operated by Telecare Corporation
in the Behavioral Health and Recovery Services Adult System of Care

PROGRAM DESCRIPTION

The Westside Stanislaus Homeless Outreach Program (SHOP) provides culturally competent mental health services to individuals with serious mental illness and a history of homelessness that have mental health or co-occurring issues of mental health and substance abuse. These individuals may also be uninsured or underinsured and involved with other agencies. The program goals are to reduce the risk for emergency room use, contact with law enforcement, homelessness, and psychiatric hospitalization.

TARGET POPULATION

- Transitional Age Youth (TAY) – age range for TAY is 18-25.
- Adults – age range is 26-59.
- Older Adults – age range is 60+

SERVICES AND ACTIVITIES

SHOP employs a team approach to provide a continuity of care and a menu of treatment options utilizing the Assertive Community Treatment (ACT) model. Clients receive support including individualized housing plans to successfully achieve their own personal recovery goals.

Under the name "FSP-01 SHOP" there are five (5) FSP teams serving different populations:

1. Westside SHOP
2. Partnership Telecare Recovery Access Center (Partnership TRAC)
3. Josie's Telecare Recovery Access Center (Josie's TRAC)
4. Modesto Recovery Services TRAC (MRS TRAC) - FSP Access and Supports.
5. Turlock Recovery Services TRAC

All FSP teams utilize ACT strategies including, but not limited to, integrated intensive community-based services and supports with 24/7 availability with a known service provider, a "housing first" approach, alongside a wellness and recovery focus with client/family centered services that inspires hope.

SHOP offers 3 levels of care within the Full Service Partnerships.

1. Full Service Partnership (FSP) – ACT Model
2. Intensive Support Services – Less frequent contact and more peer support
3. Wellness/Recovery – Primarily peer support with service contact as needed

This level of care approach within an FSP allows an individual to enter the program at the level they need and then move to a lesser or greater level of care as their needs change.

SHOP also includes services funded by General System Development (GSD) dollars that expand capacity to support individuals to receive group and peer support in achieving and maintaining recovery and wellness goals.

GSD Funded Levels;

1. Intensive Support Services (ISS) TRAC/Fast TRAC
2. Wellness/Recovery
3. Transition TRAC

Led by clinical service staff, SHOP group support is offered to individuals, along with peer-led wellness/recovery support groups. All levels of care include a multi-disciplinary approach.

Transition TRAC is an effort to assist individuals who are being discharged from the acute psychiatric inpatient hospital in Stanislaus County. The Transition TRAC team also contacts individuals who are not receiving behavioral health services prior to hospitalization and attempts to engage them following hospitalization. The goal is to prevent re-admissions to inpatient psychiatric services.

In FY 2019-2020, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 2019-2020 is 615; 456 in the Full Service Partnership and 159 in Intensive Support Services and Wellness/Recovery.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$5,027,807	2,467	$2,038

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Participant FY 2019/2020
$4,823,187	2,526	$1,909

PROGRAM DEMOGRAPHICS SERVED:

UNIQUE COUNTS FOR FSP-01 / FSP

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	21	8%	18	7%
Asian	15	6%	16	6%
Hispanic	84	34%	82	33%
Native American	*	*	*	*
Pacific Islander	*	*	*	<1%
White	111	45%	116	47%
Other	*	*	*	*
Unknown	*	<1%	*	<1%
Total:	**249**	**100%**	**248**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	0	0%	0	0%
TAYA (16-25)	59	24%	66	27%
Adult (26-59)	176	71%	166	66%
Older Adult (60+)	14	5%	16	7%
Unknown	0	0%	0	0%
Total:	**249**	**100%**	**248**	**100%**

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	227	91%	225	91%
Spanish	13	5%	13	5%
Other	*	*	10	4%
Unknown	0	0%	0	0%
Total:	**249**	**100%**	**248**	**100%**

UNIQUE COUNTS FOR FSP-01 / GSD

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	108	8%	110	8%
Asian	48	3%	55	4%
Hispanic	452	32%	496	37%
Native American	20	1%	17	1%
Pacific Islander	*	<1%	*	<1%
White	713	51%	633	47%
Other	24	2%	25	2%
Unknown	22	2%	19	1%
Total:	**1,393**	**100%**	**1,360**	**100%**

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	0	0%	0	0%
TAYA (16-25)	265	19%	218	16%
Adult (26-59)	1,053	76%	1,087	80%
Older Adult (60+)	75	5%	55	4%
Unknown	0	0%	0	0%
Total:	**1,393**	**100%**	**1,360**	**100%**

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	1293	93%	1,254	92%
Spanish	79	6%	85	6%
Other	21	1%	21	2%
Unknown	0	0%	0	0%
Total:	**1393**	**100%**	**1,360**	**100%**

PROGRAM UPDATE:

FY 18/19:

- Policy changes allowed Telecare Clinicians to complete SUD assessments with their existing consumer base, which allowed for greater linkage to SUD Treatment where needed.
- An increased emphasis to support the dismantling of the City of Modesto sanctioned homeless encampment located in Modesto, while relocating this population to a new site. Increased efforts as a multi-community organizational effort, to connect these consumers in need to supportive services in this transition.

FY 19/20:

- Additional policy changes were made disallowing Telecare Clinicians to complete SUD assessments with their existing consumer base, requiring a certification.
- A new Program Director was added that saw an opportunity to build additional capacity within the clinician staff to be trained in Sand Therapy as a method to successfully work with and engage clients who are dealing with trauma.
- New supportive groups were added and rotated. Staff survey the clients to see their level of interest in certain groups as well as consider their diagnosis and design groups that are most in alignment with their interest and/or needs.
- Post COVID-19, the Program redesigned its services and activities to be in compliance with regulations and safety guidance pertaining to how to provide essential services safely. Client facing services remained, without interruption, but were modified slightly, such as in person meetings offered on the porch. However, face to face engagement during this time was still challenging due to the fear of COVID-19. Group therapy was provided via telehealth.

OUTCOMES:

MHSA OUTCOMES FOR FSP-01 / FSP – TELECARE WESTSIDE SHOP

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	249	248
Average number of clinical services per individual*	40 (9,958/249)	41 (10, 109/248)
Average number of support services per individual*	10 (2,580/249)	14 (3,506/248)
How Well?		
% of annual target of individuals served*	125% (249/200)	124% (248/200)
Average length of FSP services – days*	731 (181,943/249)	788 (195,517/248)
% of discharged individuals met goals or transitioned to a lower level of care**	30% (20/67)	42% (22/53)
% of surveyed individuals were satisfied with services**	93% (125/135)	93% (113/121)
% of surveyed individuals said that "staff believed I could change"**	92% (122/133)	93% (110/118)
Better Off?		
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	87% (113/130)	84% (96/114)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	71% (89/125)	74% (86/117)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services. **	87% (694/795)	88% (611/692)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY19/20 (calculation) Access database
- **State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020
- State DCR Application with Enhanced Partnership Level Data program ran 3/11/2020 for FY 18/19 and 12/4/2020 for FY 19/20

FY 18/19 Outcomes for Partners After One Year in FSP 01 n=203		
	Partners	*Days*
Homelessness	↓ 40% (from 45 to 27)	↓ 81.8% (from 8,366 to 1,524)
Incarcerations	↓ 37% (from 46 to 29)	↓ 47% (from 2,391 to 1,267)
Acute Medical Hospitalizations	↑ 11.8% (from 17 to 19)	↓ 1.3% (from 301 to 297)
Acute Psych Hospitalizations	↓ 20.5% (from 151 to 120)	↑ 21.5% (from 4,070 to 4,946)
State Psychiatric	↓ 33.3% (from 3 to 2)	↓ 85.8% (from 590 to 84)

FY 19/20 Outcomes for Partners After One Year in FSP 01 n= 194		
	Partners	*Days*
Homelessness	↓ 40.4% (from 47 to 28)	↓ 75.9% (from 8,623 to 2,077)
Incarcerations	↓ 39% (from 41 to 25)	↓ 34% (from 1,818 to 1,201)
Acute Medical Hospitalizations	↑ 30.8% (from 13 to 17)	↑ 57% (from 149 to 234)
Acute Psych Hospitalizations	↓ 23.2% (from 151 to 116)	↑ 28.8% (from 4,228 to 5,445)
State Psychiatric	= 0% (from 2 to 2)	↓ 85% (from 560 to 84)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY19/20 (calculation) Access database
- **State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020
- State DCR Application with Enhanced Partnership Level Data program ran 3/11/2020 for FY 18/19 and 12/4/2020 for FY 19/20

CHALLENGES/STRATEGIES TO MITIGATE & OPPORUNTIES:

FY 18/19

- The Mental Health/SUD connection is a continuous challenge for some clients. For clients where there is co-occurring mental health and SUD challenges their mental health outcomes are affected especially when clients refuse to receive SUD services.
- For those who are willing to participate in SUD treatment, there is a shortage of SUD placement opportunities and a need for ongoing placement services after they complete their 30, 60, or 90 day Program. Often without additional supportive housing/treatment services, these clients can have more barriers to maintaining their sobriety and program success.

FY19/20

- Due to COVID-19 and the fear of contracting the virus, there were challenges from some around receiving face to face levels of care. For those who were willing to receive supportive services, they didn't have a phone. Teams continued to do their best to stay engaged with clients despite the challenges.
- Once linked to mental health treatment, clients referred to mild to moderate services by the Outreach Team expressed that childcare and transportation were barriers to them remaining in treatment.
- An increased number of clients in Temporary Conservatorship (T-Con) and clients who are on permanent conservatorship entered the SHOP program. Due to the high demand, it made it difficult to find placement for these individuals.

PROPOSED CHANGES:

FY 18/19

- No program changes proposed.

FY 19/20

- No program changes proposed.

JUVENILE JUSTICE FSP-02

Operated by Stanislaus Behavioral Health and Recovery Services Children's System of Care/Transitional Aged Youth

PROGRAM DESCRIPTION

The Juvenile Justice FSP Program is a full-service partnership that provides intensive mental health treatment to youth and their families. The target population are youth that have been involved with the Juvenile Justice system or are at risk of becoming involved due to their behaviors. Many of the youth are victims of trauma and have not successfully been engaged by traditional methods of treatment. As a result, they tend to become more seriously ill, have more aggressive behavior, and subsequently higher rates of incarceration and institutionalization.

Juvenile Justice (JJ) also includes services and support funded by GSD, which encompasses a Drop-in Center called "The Spot" and a Youth Peer Navigator program. Staff continues to offer Youth Leadership and Youth In Mind programs to give young people access to supports that encourage the development of leadership skills. Staff facilitate youth leadership meetings and support, mentor, and educate youth group members.

TARGET POPULATION

- Children and Youth – age range 0 to 16
- Transitional Age Youth (TAY) – age range for TAY is 16-25

SERVICES AND ACTIVITIES

Juvenile Justice FSP Program

The Juvenile Justice program has a 'whatever it takes' approach to treatment. This approach includes transportation to appointments, home based/field-based services, and after-hours crisis on call. There is also funding that allows for purchase of essential items intended to improve functioning and promote overall success. The program also offers Aggression Replacement Training groups that have been instrumental in decreasing behavioral symptoms and providing coping skills that make recidivism in the Justice System less likely.

Each participant has a team of two, which includes a Behavioral Health Specialist and a Mental Health Clinician. Additionally, the program has a Parent Partner and access to the Youth Peer Navigator Program and the Drop in Center. The additional services are informed by each participant's individualized treatment plan.

The clients will be provided mental health services which includes the following: individual therapy, group therapy, intensive targeted case management, collateral, individual rehabilitation, group rehabilitation, intensive care coordination (ICC) (ages 0-20), intensive

home-based services (IHBS) (ages 0-20), and medication support services to help decrease mental health symptoms.

Youth Peer Navigator Project

Integrated youth-centered approach to help young people in need of mental health services navigate through Stanislaus County's mental health services system and to help youth improve their mental health and well-being.

- Navigators provide mental health education, peer support, and mentoring to youth in the Behavioral Health and Recovery Service's (BHRS) Children's Systems of Care/Transitional Aged Youth (CSOC/TAY) and to those youth that need help connecting to mental health services.
- Project goals include increasing youth's developmental assets, reducing psychiatric hospitalization and reduce the juvenile criminal recidivism rate.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 through FSP intensive services is 25 at any given time; 13 Children/Youth and 12 Transitional Aged Youth. The estimated number of individuals served in FY 19-20 through the GSD services is 75; 25 Children/Youth and 50 Transitional Aged Youth.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$461,201	292	$1,579

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Participant FY 2019/2020
$365,702	317	$1,154

PROGRAM DEMOGRAPHICS SERVED:

UNIQUE COUNTS FOR FSP-02 / FSP

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	*	*	*	*
Asian	0	0%	*	*
Hispanic	19	54%	19	59%
Native American	0	0%	0	0%
Other	*	*	0	0%
Pacific Islander	0	0%	0	0%
Unknown	0	0%	0	0%
White	13	37%	10	32%
Total:	**35**	**100%**	**32**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	8	23%	4	12%
TAYA (16-25)	27	77%	28	88%
Adult (26-59)	0	0%	0	0%
Older Adult (60+)	0	0%	0	0%
Unknown	0	0%	0	0%
Total:	**35**	**100%**	**32**	**100%**

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	32	91%	28	88%
Spanish	*	*	*	12%
Other	0	0%	0	0%
Unknown	0	0%	0	0%
Total:	**35**	**100%**	**32**	**100%**

**Due to privacy any value <10 has been removed*

UNIQUE COUNTS FOR FSP-02 / GSD

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	17	6%	22	7%
Asian	*	*	*	*
Hispanic	100	37%	115	38%
Native American	*	*	*	*
Other	10	4%	10	3%
Pacific Islander	*	<1%	*	<1 %
Unknown	46	17%	53	18%
White	92	34%	89	30%
Total:	**274**	**100%**	**301**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	85	32%	69	23%
TAYA (16-25)	187	68%	226	75%
Adult (26-59)	*	<1%	*	*
Older Adult (60+)	0	0%	0	0%
Unknown	0	0%	0	0%
Total:	**274**	**100%**	**301**	**100%**

**Due to privacy any value <10 has been removed*

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	218	80%	245	81%
Spanish	18	7%	16	5%
Other	0	0%	0	0%
Unknown	38	13%	40	13%
Total:	**274**	**100%**	**301**	**100%**

Data Source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY19/20 (calculation) Access database

PROGRAM UPDATE:

FY18/19

Juvenile Justice FSP Program:

- A Parent Partner was assigned to the JJ FSP program and is co-located with the JJ FSP Team. The use of Parent Partners, The Spot staff and Youth Peer Navigators has demonstrated an increase in family involvement and overall success of our high risk youth.
- The JJ FSP program obtained training for the program's clinician that allowed the JJ FSP Program to re-implement Aggression Replacement Training (ART). This highly effective training was stopped in the previous fiscal cycle due to lack of clinician resources necessary to conduct the trainings. JJ FSP program currently has the number of facilitators required to provide this training on an ongoing basis.

"The Spot":

- No program updates.

FY 19/20

Juvenile Justice FSP Program:

- The severity of mental health issues with the JJ FSP program population required a consistent and steady response from staff to ensure that client's needs were met during the pandemic. The staff were creative in meeting with clients face to face. This included meeting in back yards, on front porches, or wherever a safe distance could be maintained while ensuring confidentiality. However, not all clients had a living situation that allowed for meeting in person. In these instances, the office was utilized in a safe manner to provide treatment.
- Staff also learned how to use telehealth platforms effectively. Telehealth was utilized so treatment could continue at the frequency needed to assist client's in meeting their mental health goals.

"The Spot":

- During FY 19-20, The Youth in Mind Leadership Program was discontinued at The Spot due to low participation.
- An out of county trip to Monterey was offered to youth that had attended The Spot for at least six months, had a good rapport with the staff, and followed The Spot rules. Many of the youth selected had not seen the ocean before which made this trip memorable, expanding their view of the world.
- In February 2020, a new eight week life skills group was initiated for youth on probation.

OUTCOMES:

MHSA OUTCOMES FOR FSP-02 / JUVENILE JUSTICE

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	142	138
Average number of clinical services per individual*	18.44 (2,618/142)	21.16 (2,920/138)
Average number of support services per individual*	20.47 (2,907/142)	25.88 (2,201/138)
How Well?		
% of annual target of individuals served*	154.3% (142/92)	150% (138/92)
Average length of FSP services – days*	356.35 (50,601/142)	431.67 (59,570/138)
% of surveyed individuals were satisfied with services**	100% (23/23)	82.8% (24/29)
% of surveyed individuals said that "staff believed I could change"**	100% (23/23)	86.2% (25/29)
Better Off?		
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	81.8% (18/22)	88.5% (23/26)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community**	90.9% (20/22)	76.9% (20/26)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services**	97.8% (134/137)	83.0% (142/171)

FY 18/19 Outcomes for Partners After One Year in FSP 02 n=20

	Partners	Days
Homelessness	0% (from 0 to 0)	0% (from 0 to 0)
Incarcerations	↓ 53.8% (from 13 to 6)	↓ 55.9% (from 397 to 175)
Acute Medical Hospitalizations	0% (from 0 to 0)	0% (from 0 to 0)
Acute Psych Hospitalizations	↓ 50% (from 8 to 4)	↓ 13% (from 100 to 87)
State Psychiatric	↓ 0% (from 0 to 0)	↓ 0% (from 0 to 0)

FY 19/20 Outcomes for Partners After One Year in FSP 02 n= 19

	Partners	Days
Homelessness	= 0% (from 0 to 0)	= 0% (from 0 to 0)
Incarcerations	↓ 75% (from 12 to 3)	↓ 93.7% (from 414 to 26)
Acute Medical Hospitalizations	= 0% (from 0 to 0)	= 0% (from 0 to 0)
Acute Psych Hospitalizations	↓ 66.7% (from 6 to 2)	↓ 34.9% (from 43 to 28)
State Psychiatric	= % (from 0 to 0)	= 0% (from 0 to 0)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY19/20 (calculation) Access database
- **State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020

MHSA OUTCOMES FOR FSP-02 / GSD

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	274	301
Average number of clinical services per individual*	0 (0/274)	0.02 (7/301)
Average number of support services per individual*	4 (1,166/274)	2 (489/301)
How Well?		
% of annual target of individuals served*	365% (274/75)	401% (301/75)
Average length of GSD services – days*	478 (130,965/274)	702 (211,270/301)
% of surveyed individuals were satisfied with services**	100% (13/13)	100% (3/3)
% of surveyed individuals said that "staff believed I could change"**	100% (12/12)	100% (2/2)
Better Off?		
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	91% (10/11)	100% (3/3)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community**	92% (12/13)	100% (3/3)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services**	100% (26/26)	67% (4/6)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY19/20 (calculation) Access database
- **State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES:

FY 18/19

Juvenile Justice FSP Program:

- Youth and families that participate in the program have a misperception that the JJ FSP program is associated with probation or law enforcement, partially due to the co-location of the program with Juvenile Hall and the Commitment Facility. The staff collaborate with probation and engage with families to ensure that clients understand the JJ FSP program is not a part of the JJ system.

"The Spot":

- No program challenges to report.

FY19/20

Juvenile Justice FSP Program:

- The challenges for FY 19/20 have been related to the pandemic. The JJ FSP program population has been best served intensely and in person. Staff have continued to meet with clients in person whenever possible throughout the pandemic. However, staff have not been going into homes. Additionally, prior to COVID-19, clients were available to meet staff during their school day. It has been much more difficult to contact clients for appointments during remote-based school. Strategies have included
- additional communication with clients and families, reminder calls, check in calls between appointments and a continuance of doing whatever it takes to help clients meet their goals.

"The Spot":

- Due to COVID-19 onsite services at "The Spot" had to be placed on hold. Staff continued to reach out to members via telephone and Zoom.

PROPOSED CHANGES:

FY 18/19

Juvenile Justice FSP Program:

- No program changes proposed.

"The Spot":

- No program changes proposed.

FY 19/20

Juvenile Justice FSP Program:

- No program changes proposed.

"The Spot":

- No program changes proposed.

INTEGRATED FORENSICS TEAM FSP 05

Operated by Stanislaus Behavioral Health and Recovery Services
in the Forensic System of Care

PROGRAM DESCRIPTION

The Integrated Forensic Team (IFT) works in partnership with the Stanislaus County Criminal Justice System to serve individuals with serious mental illness or co-occurring substance abuse issues who are also at risk for more serious consequences in the criminal justice system. The goals of this program are to reduce the risk for emergency room use, contact with law enforcement, homelessness, and psychiatric hospitalization.

TARGET POPULATION

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

SERVICES AND ACTIVITIES

A multidisciplinary team approach that includes 24/7 access to a known service provider, access to supportive service funds, individualized service planning, crisis stabilization alternatives to jail, re- entry support from a state hospital, and linkages to existing community support groups. Both service recipients and family members are offered education regarding the management of mental health issues, benefits advocacy, and housing support. Culturally and linguistically appropriate services are provided to diverse consumers.

Partner collaboration is central to reducing disparities and achieving an integrated service experience for consumers and family members. In addition to law enforcement agencies and probation, collaboration occurs with agencies including Turning Point Community Programs, Salvation Army, United Samaritans Homeless Services, and Golden Valley Health Center (a Federally Qualified Health Clinic).

General System Development (GSD) activities expand capacity to provide crisis services to known clients, peer and family support, and access to community resources for achieving and maintaining recovery and wellness goals.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 is 92; 52 Full Service Partnership level and 40 in Intensive Support Services or Wellness/Recovery Levels.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$2,096,532	142	$14,764

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Participant FY 2019/2020
$2,367,187	138	$17,154

PROGRAM DEMOGRAPHICS SERVED:

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	19	13%	12	9%
Asian	*	*	*	*
Hispanic	48	34%	45	33%
Native American	*	*	*	*
Pacific Islander	*	<1%	*	<1%
White	62	44%	68	49%
Other	*	*	*	*
Unknown	*	<1%	0	0%
Total:	**142**	**100%**	**138**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	0	0%	0	0%
TAYA (16-25)	15	11%	*	*
Adult (26-59)	124	87%	125	90%
Older Adult (60+)	*	2%	*	*
Unknown	0	0%	0	0%
Total:	**142**	**100%**	**138**	**100%**

**Due to privacy any value <10 has been removed*

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	136	96%	134	97%
Spanish	*	*	*	*
Other	*	<1 %	0	0%
Unknown	0	0%	0	0%
Total:	**142**	**100%**	**138**	**100%**

**Due to privacy any value <10 has been removed*

Data Source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) Access database

PROGRAM UPDATE:

FY 18/19

- As relationship and rapport building is of utmost importance to successfully engage participants into meaningful recovery, the length of time a client remains opens to a treatment program is often closely correlated with improved outcomes. The average length of stay for program participants in FY 18-19 was 356 days, up from 325 days in FY 17-18. Though no major programmatic changes took place in FY 18-19, it should be noted that IFT was able to retain much of its clinical team, experiencing very little staff turnover. This allowed for the development of long lasting, meaningful relationships between clients and their treatment providers.

FY 19/20

- The Assisted Outpatient Treatment (AOT) program became co-located within the IFT program in early March, 2020. This move allowed both teams to leverage existing staffing resources to help manage capacity issues during the Department's strategic hiring pause. Again, throughout FY 19-20 IFT was able to retain much of its clinical team, including several typically difficult to recruit positions. IFT was able to serve 138 clients during FY 19-20, 150% of it's annual target for individuals served.
- The impact of the COVID-19 crisis was significant. Prior to the pandemic, only medication services had been offered via telehealth. In 2020, the team began offering all interventions (case management, individual rehab, individual therapy, and group therapy) through telehealth platforms. Many clients were unable to participate via telehealth, however, still requiring in person, face-to-face services both at the office and within the community.
- Additionally, due to significant staffing concerns during the pandemic, several Forensic System of Care programs were consolidated into one office as staff began rotating between on site and remote work. In addition to ensuring program coverage, this consolidation allowed for an increase in collaboration between the IFT program and several substance use disorder programs. This allowed for daily informal cross training, further increasing the team's exposure to SUD interventions and strategies.

OUTCOMES:

MHSA OUTCOMES FOR FSP-05 / IFT

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	142	138
Average number of clinical services per individual*	18.44 (2,618/142)	21.16 (2,920/138)
Average number of support services per individual*	20.47 (2,907/142)	25.88 (2,201/138)
How Well?		
% of annual target of individuals served*	154.3% (142/92)	150% (138/92)
Average length of FSP services – days*	356.35 (50,601/142)	431.67 (59,570/138)
% of surveyed individuals were satisfied with services**	100% (23/23)	82.8% (24/29)
% of surveyed individuals said that "staff believed I could change"**	100% (23/23)	86.2% (25/29)
Better Off?		
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	81.8% (18/22)	88.5% (23/26)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	90.9% (20/22)	76.9% (20/26)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	97.8% (134/137)	83.6% (122/146)

FY 18/19 Outcomes for Partners After One Year in FSP 05 n=76		
	Partners	***Days***
Homelessness	↓ 30.8% (from 26 to 18)	↓ 48.3% (from 4,194 to 2,169)
Incarcerations	↓ 47.4% (from 57 to 30)	↓ 67% (from 4,921 to 1,624)
Acute Medical Hospitalizations	↑ 300% (from 1 to 4)	↑ 10% (from 100 to 110)
Acute Psych Hospitalizations	↑ 6.1% (from 33 to 35)	↑ 6.8% (from 843 to 900)
State Psychiatric	↓ 95.2% (from 21 to 1)	↓ 97.4% (from 4,639 to 120)

FY 19/20 Outcomes for Partners After One Year in FSP 05 n= 78		
	Partners	***Days***
Homelessness	↓ 25.9% (from 27 to 20)	↓ 58.9% (from 4,833 to 1,985)
Incarcerations	↓ 44.6% (from 56 to 31)	↓ 72.4% (from 5699 to 1573)
Acute Medical Hospitalizations	↑ 200% (from 1 to 3)	↑ 1% (from 100 to 101)
Acute Psych Hospitalizations	↑ 6.5% (from 31 to 33)	↑ 10% (from 897 to 987)
State Psychiatric	↓ 96.6% (from 29 to 1)	↓ 98.2% (from 6,497 to 120)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database
- **State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020
- State DCR Application with Enhanced Partnership Level Data program ran 3/11/2020 for FY 18/19 and 12/4/2020 for FY 19/20

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES:

FY 18/19

- Successfully engaging individuals with co-occurring mental health and severe substance use disorders remains a challenge. This co-occurring population presents with a unique set of needs that may not be successfully addressed via traditional mental health treatment interventions.

FY 19/20

- Medi-Cal documentation requirements can be at odds with the provision of MHSA services. This misalignment created a significant strain on treatment staff's time and morale as they worked to hold true to the tenets of the MHSA while still adequately documenting to "medical necessity" standards.
- The COVID-19 pandemic created countless challenges for the team. Program staff had to quickly transition into remote work, which for most was completely new territory. All treatment services were offered via telehealth for the first time which required that staff become familiar with new strategies for engaging and treating their clients. However,

many IFT clients were unable to utilize telehealth services, meaning staff continued to provide services face-to-face while managing their own anxieties about the virus. Additionally, already limited housing and placement options became even more scarce, frequently leading to longer stays in the hospital while clients awaited a bed within a transitional board and care or locked IMD setting. Acute hospitalization days were up 10% during 19-20.

PROPOSED CHANGES

FY 18/19

- IFT plans to implement further cross-training opportunities for our mental health treatment staff. The importance of ensuring all staff have a comprehensive understanding of substance use disorders as well effective SUD treatment strategies cannot be overstated.

FY 19/20

- The learning that occurred through the Co-Occurring Disorders Full-Service Partnership Innovations project has highlighted several strategies that proved promising when working with the co-occurring population in our community. One of these strategies, utilizing both the Mental Health Recovery Treatment Stages (MHRTS) and the Substance Abuse Treatment Scale (SATS) as tools to improve client engagement and potentially introduce alternate intervention strategies will be explored for possible implementation by IFT. Unfortunately, this plan was placed on hold due to Covid-19 pandemic impacts. However, it will be carried forward into future planning efforts.

HIGH RISK HEALTH AND SENIOR ACCESS FSP 06

Operated by Stanislaus County Behavioral Health and Recovery Services
in the Adult/Older Adult System of Care

PROGRAM DESCRIPTION

This program is a Full-Service Partnership (FSP) that provides mental health services to adults with co-occurring health and mental health disorders. The program offers two levels of care: FSP and Intensive Support Services. This allows individuals to enter the program at an appropriate level of service for their need and then move to lesser or greater intensities of service if necessary. A graduated level of care allows more individuals to access the FSP level of service when needed.

TARGET POPULATION

- Adults – age range is 18+

SERVICES AND ACTIVITIES

Strategies include 24/7 access to a known service provider, individualized service plans, a multidisciplinary treatment approach, access to wellness and recovery focused groups and peer support, and linkage to existing community support groups. Both service recipients and family members receive education regarding the management of both health and mental health issues as well as benefits advocacy support and housing support. Outreach and engagement services are focused on engaging diverse ethnic/cultural populations and individuals who have or are at risk for mental illness and homelessness.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 is a maximum of 155 at the Full-Service Partnership level and Intensive Support Services or Wellness/Recovery levels.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$491,950	159	$3,094

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$531,328	159	$3,342

PROGRAM DEMOGRAPHICS SERVED:

UNIQUE COUNTS FOR FSP-06

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	12	8%	10	6%
Asian	*	*	*	*
Hispanic	41	27%	36	22%
Native American	*	*	*	*
Pacific Islander	*	<1%	*	*
White	86	56%	101	62%
Other	*	<1 %	*	*
Unknown	*	*	*	<1%
Total:	**153**	**100**%	**163**	**100**%

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	0	0%	0	0%
TAYA (16-25)	*	<1%	0	0%
Adult (26-59)	75	49%	89	55%
Older Adult (60+)	77	50%	74	45%
Unknown	0	0%	0	0%
Total:	**153**	**100**%	**163**	**100**%

**Due to privacy any value <10 has been removed*

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	145	95%	159	98%
Spanish	*	*	*	*
Other	*	*	*	*
Unknown	0	0%	0	0%
Total:	**153**	**100%**	**163**	**100%**

**Due to privacy any value <10 has been removed*

Data Source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) Access database

PROGRAM UPDATE:

FY 18/19:

- Coordinator was hired to help program manager. This was a new position to help manage program needs, client care, staff supervision, clinical needs and collaboration.

FY 19/20:

- An influx of clients experiencing homelessness came into the program, beyond the program's targeted population of individuals with health issues, such as hypertension and diabetes.
- Working during the pandemic changed the way of serving the community by working remotely, telehealth and phone calls. The HRHSA office closed to public access with rotating working remotely, field-based services, and supporting the emergency medication clinics in Modesto and Turlock. Staff needed to balance learning to work remotely on rotations, along with supporting emergency medication clinics, serving their clients in the field, including crisis evaluations. Some crisis contacts are currently handled in person, phone and/or iPad. Incoming clients are contacted via phone, telehealth, with in-person services as needed.

OUTCOMES:

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	153	163
Average number of clinical services per individual*	16 (2,380/153)	18 (3,006/163)
Average number of support services per individual*	20 (3,044/153)	23 (3,691/163)
How Well?		
% of annual target of individuals served*	122% (153/125)	130% (163/125)
Average length of FSP services – days*	485 (74,211/153)	521 (84,983/163)
% of surveyed individuals were satisfied with services**	92% (23/25)	93% (26.28)
% of surveyed individuals said that "staff believed I could change"**	91% (21/23)	79% (23/29)
Better Off?		
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	91% (19/21)	64% (18/28)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community**	81% (17/21)	60% (22/37)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services**	86% (122/142)	73% (127/175)

FY 18/19 Outcomes for Partners After One Year in FSP 06 n=117		
	Partners	***Days***
Homelessness	↓ 25.9% (from 27 to 20)	↓ 78.8% (from 6,102 to 1,293)
Incarcerations	↓ 60% (from 15 to 6)	↓ 65.6% (from 765 to 263)
Acute Medical Hospitalizations	↑ 18.8% (from 16 to 19)	↑ 41.5% (from 352 to 498)
Acute Psych Hospitalizations	↓ 20.9% (from 67 to 53)	↑ 65.4% (from 2,187 to 3,618)
State Psychiatric	↓ 100% (from 2 to 0)	↓ 100% (from 314 to 0)

FY 19/20 Outcomes for Partners After One Year in FSP 06 n= 120		
	Partners	***Days***
Homelessness	↓ 10.3% (from 29 to 26)	↓ 72.3% (from 7,420 to 2,053)
Incarcerations	↓ 40% (from 10 to 6)	↓ 34.6% (from 402 to 263)
Acute Medical Hospitalizations	= 0% (from 19 to 19)	↑ 29.5% (from 430 to 557)
Acute Psych Hospitalizations	↓ 16.4% (from 67 to 56)	↑ 101.3% (from 2,224 to 4,478)
State Psychiatric	↓ 100% (from 1 to 0)	↓ 100% (from 294 to 0)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) Access database
- **State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020
- State DCR Application with Enhanced Partnership Level Data program ran 3/11/2020 for FY 18/19 and 12/4/2020 for FY 19/20

CHALLENGES/STRATEGIES TO MITIGATE & OPPORUNITIES:

FY 18/19

- A growing challenge was the increase of those who were physically fragile with increased medical severity, coming to HRHSA, and because of their medical issues, not wanting to address their mental health symptoms and/or substance abuse.

FY 19/20

- Placement for clients with a medical condition has remained a challenge year over year, and while facing staff shortages the number of clients increased, but not the staff to support the additional caseloads. HRHSA continues to have two positions, one Behavioral Health Specialist, and one Mental Health Clinician that have not been filled.
- COVID-19 has affected how clients are served; from an organizational perspective, technology, monitoring, clients not knowing how to use phones, iPad and computers. Clients are seeing their doctor through telehealth. There was a shutdown of groups due to distancing requirements, and staff began working remotely and not available in the office, but available to provide field-based services and adhering to Covid-19 safety measures.

PROPOSED CHANGES:

FY 18/19

- No program changes proposed.

FY 19/20

- Trainings for staff included topics such as working with difficult people, mindfulness training, and understanding homelessness in our community, working with a diverse population, cultural trainings and preventing burn out training and/or self-care training.
- Consultation with Dr. Wenstrup provided expertise and educated staff on different medical conditions as well as co-occurring conditions. This helps staff understand the medical problems clients face and how to best serve this population.

TURNING POINT INTEGRATED SERVICES AGENCY FSP 07

Operated by Turning Point Community Programs
in the BHRS Adult/Older Adults Systems of Care

PROGRAM DESCRIPTION

This program is a Full-Service Partnership (FSP) that provides mental health services to adults with co-occurring health and mental health disorders. The program offers two levels of care: FSP and Intensive Support Services. This allows individuals to enter the program at an appropriate level of service for their need and then move to lesser or greater intensities of service if necessary. A graduated level of care allows more individuals to access the FSP level of service when needed. Turning Point – Integrated Services Agency (ISA) is a Full-Service Partnership (FSP) that serves people on the most severe end of the mental health spectrum within Stanislaus County. Turning Point ISA uses the Recovery Model approach to walk alongside our clients on the path to mental wellness. Turning Point ISA works towards progress by combining relational service with macro system advocacy. ISA coordinates with the entire continuum of care including family members, board and care staff, community members, medical personnel, psychiatric hospitals, the court system and social security. The frequency of contact of ISA staff (a minimum of 1x weekly for most clients) develops relationships which are the primary basis for healthy change. ISA walks through the minutiae of family dynamics while also available for crisis assessments.

Individuals at ISA are at high risk of psychiatric hospitalization, homelessness, jail time or law enforcement interaction. Reflecting the severity of ISA client's mental illness, nearly half of ISA's clients are conservatees. Many of these conservatees live in locked facilities throughout California. Clients can move from conservatorship and in a locked facility to the community, then off conservatorship while working with the same case management team. ISA staff have been a consistent support as client's mental stability fluctuates and as it improves.

While the ISA is an outpatient mental health program, for those individuals that are on a conservatorship, the program also provides conservatorship support in the form of staff also being in the role of deputy conservator and mental health provider for the same client.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 is a maximum of 155 at the Full-Service Partnership level and Intensive Support Services or Wellness/Recovery levels.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

TARGET POPULATION

- Adults – age range is 18+

SERVICES AND ACTIVITIES

As an FSP the services provided to open clients to the program include:

24/7 crisis services, including working closely with emergency settings in the county to provide crisis response. This includes Doctors Behavioral Health Center (DBHC), the Psychiatric Health Facility (PHF), and Emergency Room settings in the county.

Wrap around funds to make sure all client's needs are met and they do not go without necessities like food, clothing, or shelter.

The Program also works closely with other county services to meet client needs such as the Public Guardians office, Community Emergency Response Team CERT, and Warm Line, a peer support crisis line.

BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$491,950	159	$3,094

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$531,328	159	$3,342

PROGRAM DEMOGRAPHICS SERVED:

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	11	7%	12	8%
Asian	*	*	*	*
Hispanic	26	16%	28	17%
Native American	*	*	*	*
Pacific Islander	0	0%	0	0%
White	109	69%	105	66%
Other	*	*	*	*
Unknown	*	<1%	*	*
Total:	**159**	**100%**	**159**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	0	0%	0	0%
TAYA (16-25)	*	*	*	*
Adult (26-59)	116	73%	112	70%
Older Adult (60+)	40	25%	44	28%
Unknown	0	0%	0	0%
Total:	**159**	**100%**	**159**	**100%**

**Due to privacy any value <10 has been removed*

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	151	95%	151	95%
Spanish	*	*	*	*
Other	*	*	*	*
Unknown	0	0%	0	0%
Total:	**159**	**100%**	**159**	**100%**

**Due to privacy any value <10 has been removed*

PROGRAM UPDATE:

FY 18/19:

- Many clients are showing progress in their recovery and making steps to prepare to step down to a lower level of care. One thing we believe has contributed to this is our Modified DBT group we began offering in 18-19. This group incorporated art along with DBT principles to help clients who regularly experience psychosis learn the DBT principles using more tactile skills with art vs relying on reading and writing skills.
- There was a shift in program management to address challenges with staff retention and meet with increasing demands of clients' needs by hiring and retaining more clinical staff in this year than has been previously possible. Part of this shift includes making opportunities open to staff to do workplace internships while going through graduate programs and offering supervision for licensing hours for those post graduate school.
- There was also the addition and implementation of working with another program called the housing outreach management and engagement team (HOME team) to engage housing providers to client with SMI around behaviors plans to try and save client placements and lessen the amount of client evictions that were occurring.

FY 19/20:

- In the 19-20 year there was a huge shift in needing to provide more telehealth and distance services. The program had already started to see the opportunity pre-COVID with more Psychiatrist telehealth services being provided. Once COVID hit all our services switched to telehealth. While this was an adjustment for staff and clients, we were able to maintain all services, minus in person groups, but had referrals to zoom groups to give to clients from our drop-in center and county wellness center. The program was also able to support BHRS with capacity issues at the regional level by serving additional clients.
- The program also made some structural changes to help address county wide capacity issues. These changes allowed the program served max to increase from 155 to over

170+ and accept many clients from Regional Teams that were over capacity and struggling to provide services to those individuals.

OUTCOMES:

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	159	159
Average number of clinical services per individual*	36 (5,724/159)	43 (6,787/159)
Average number of support services per individual*	15 (2,427/159)	21 (3,389/159)
How Well?		
% of annual target of individuals served*	103% (159/155)	103% (159/155)
Average length of FSP services – days*	2,953 (469,581/159)	3,153 (501,359/159
% of surveyed individuals were satisfied with services**	90% (52/58)	82% (40/49)
% of surveyed individuals said that "staff believed I could change"**	80% (44/55)	82% (36/44)
Better Off?		
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	79% (37/47)	79% (34/43)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	71% (34/48)	71% (37/52)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	80% (264/331)	74% (202/273)

FY 18/19 Outcomes for Partners After One Year in FSP 07 n=159

	Partners	Days
Homelessness	↓ 36.4% (from 22 to 14)	↓ 75.9% (from 2,070 to 499)
Incarcerations	↓ 29.4% (from 17 to 12)	↓ 74.2% (from 1,836 to 474)
Acute Medical Hospitalizations	↑ 35.3% (from 17 to 23)	↑ 42.7% (from 344 to 491)
Acute Psych Hospitalizations	↑ 2.9% (from 68 to 70)	↑ 41.7% (from 3,038 to 4,304)
State Psychiatric	↓ 50% (from 10 to 5)	↓ 79.8% (from 3,029 to 613)

FY 19/20 Outcomes for Partners After One Year in FSP 07 n= 155

	Partners	Days
Homelessness	↓ 33.3% (from 21 to 14)	↓ 72.8% (from 1,835 to 499)
Incarcerations	↓ 33.3% (from 18 to 12)	↓ 74.6% (from 1,866 to 474)
Acute Medical Hospitalizations	↑ 46.2% (from 13 to 19)	↑ 82.% (from 161to 293)
Acute Psych Hospitalizations	↑ 1.5% (from 68 to 69)	↑ 43.2% (from 2.956 to 4,232)
State Psychiatric	↓ 45.5% (from 11 to 6)	↓ 81.3% (from 3,364 to 630)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database
- **State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020
- State DCR Application with Enhanced Partnership Level Data program ran 3/11/2020 for FY 18/19 and 12/4/2020 for FY 19/20

CHALLENGES/BARRIERS & STRATEGIES TO MITIGATE:

FY 18/19

- The Program continued experiencing the recurring supportive housing shortage. Housing options for people with SMI are very limited and back logged at all placement levels. Wait list are long and the criteria for clients to get accepted becomes more and more narrow. For that reason, individuals can sit in psych and medical hospital settings longer than necessary, which then contributes to the increase in medical and psych hospital days.
- In addition to housing criteria becoming narrower, housing providers were also evicting clients with SMI at higher rates and more clients were having difficulty getting accepted at alternate placements. The program started engaging housing providers in different ways to establish behavior plans for clients to give them another chance at not losing their placement. The addition of the HOME team helped in this collaboration and supported in saving client placements.

FY 19/20

- The Program experienced significant impacts related to COVID-19 in all areas of service. Client services transitioned from face to face to telehealth. While telehealth was being used in small instances, the program was not prepared for a 100% change and as a result worked rapidly to get enough equipment to staff and clients to make telehealth possible.
- Despite the concern for COVID-19 exposure, staff proved to be dedicated to continuing to show up to work daily. The Program made the adjustments necessary to not only serve all the program clients, but also take referrals from the regional team to help with capacity issues.

PROPOSED CHANGES

FY 18/19

- Continue growth in collaboration with the HOME team to help address the challenge of the housing shortage. This includes using internal resources like the increase clinical skill and experience of staff, creating more supportive and useful groups for clients to learn skills and address behaviors before they become a placement challenge, utilizing other program support and county resources such as the HOME team to put behavior plans with incentives in place to hopefully avoid 30-day evictions.

FY 19/20

- Continued focus on delivering services in as safe and effective ways as possible while the COVID-19 pandemic continues, including teaching clients and client identified support, how to access and use telehealth services.

CENTRAL STAR YOUTH WITH SED FSP 08

Operated by Stanislaus County Behavioral Health and Recovery Services
Children's System of Care Transitional Aged Youth Contractor

PROGRAM DESCRIPTION
Central Star's Full Service Partnership (FSP) for children provides behavioral health services, including outreach and engagement, to high risk children and youth with serious emotional disturbances (SED) and their families. The program opened March 2017 and has 24 client slots.

TARGET POPULATION

- Children and Youth – age range 0 to 16

SERVICES & ACTIVITES
This FSP provides 24 hour a day, seven (7) days a week crisis response, outreach and engagement, and on-site intensive mental health services. The FSP is designed to do "whatever it takes" to engage youth and their families; thus, they anchor their work to wraparound principles and service processes, including the use of Child & Family Teams (CFTs), and they focus service delivery primarily in homes, schools, and other community locations.

The program goals are to reduce recidivism within the justice system, out of home placements, homelessness, involuntary hospitalization, and institutionalization. At the inception of the program in January 2017, the program's target was to provide services for up to 48 individuals per year with a targeted 6-month length of stay. Due to the level of treatment needed to serve this population well, the program target of individuals served has eased to assure each individual client receives the appropriate amount of services as deemed clinically appropriate by the treatment team. This is not a short-term program and therefore there is no longer a target regarding the expected number served and length of stay. In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 is 48. Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET:

FY 18-19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$335,911	38	$8,840

FY 19-20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$347,718	43	$8,086

CLIENT DEMOGRAPHICS:

UNIQUE COUNTS FOR FSP-08

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	*	*	*	12%
Asian	*	*	*	*
Hispanic	22	58%	24	56%
Native American	*	*	*	*
Pacific Islander	0	0%	0	0%
White	12	31%	11	26%
Other	0	0%	*	*
Unknown	0	0%	0	0%
Total:	**38**	**100%**	**43**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	18	47%	28	65%
TAYA (16-25)	20	53%	15	35%
Adult (26-59)	0	0%	0	0%
Older Adult (60+)	0	0%	0	0%
Unknown	0	0%	0	0%
Total:	**38**	**100%**	**43**	**100%**

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	36	95%	39	91%
Spanish	*	*	*	*
Other	0	0%	0	0%
Unknown	0	0%	0	0%
Total:	**38**	**100%**	**43**	**100%**

**Due to privacy any value <10 has been removed*

Data Source:

- Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database

PROGRAM UPDATES:

FY 18-19

- In April 2019, all CS programs participated in SBHG's Joint Commission (JC) re-accreditation review and renewal process. In preparation for the external site visit, the central region's QA and program managers received refresher training in JC tracer methodology, an integrative QA practice that explores milestones along the expected trajectory of a client's care to assure that clinical staff understand and abide program operations and treatment best practices. While their final report was pending as of the close of the year, the JC review team flagged no corrective action items specific to Child FSP.
- Child FSP staff participated in an SBHG hosted training on CFT Facilitation – this curriculum involves an initial 8 hr. training day which occurred in early spring, followed by at least 3 follow-up team coaching sessions focused on reviewing the sticky types of dynamics that can arise during CFT collaborative problem-solving.
- Central Star as an agency launched a cultural attunement committee as a prior elective project, which serves to guide community integration activities. For their part, the Child FSP team embraced this elective and they sponsored a special event over the summer and provided tangible supports (food boxes) to clients/family for Thanksgiving.

FY 19-20

- Starting March 2020, the COVID-19 pandemic necessitated the transition of most services and supports to a telehealth service context, during which staff provided on-line sessions to children and caregivers, including hosting on-line CFT meetings. Some services continued in person, when all involved were: a) symptom-free or tested negative; b) comfortable about participating in person; and, c) willing and able to abide safety practices (i.e., facial masking, physical distancing, sanitizing space). Being in person was necessary for initial intakes, crisis interventions, and sometimes for complex and/or

difficult discussions. The team made every effort to see a discharging youth/family in person near/about the time of discharge.

- Mobilized telehealth services quickly and simultaneously launched a set of telehealth evaluation protocols to continuously assess the transition to, provision of, and impact of such services. Evaluative information tracked includes: a) central tendencies of service utilization per client; b) staff, client and caregiver perspectives about telehealth sessions; and, c) newly needed program/clinical supports.
- In response to COVID-19, created new website resources for both staff and clients/families. Staff resources promote telehealth engagement strategies and session scripts and staff understanding of mental health issues related to illness, loss and trauma. Client/family resources include useful tips and links for being at home with children, supporting their schooling, and improving health and wellness during such tough times.

OUTCOMES:

MHSA OUTCOMES FOR FSP-08 / CENTRAL STAR

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	38	43
Average number of clinical services per individual*	57 (2,184/38)	52 (2,239/43)
Average number of support services per individual*	8 (313/38)	27 (1,152/43)
How Well?		
% of annual target of individuals served*	79% (38/48)	90% (43/48)
Average length of FSP services – days*	256 (9,727/38)	258 (11,090/43)
% of surveyed individuals were satisfied with services**	89% (48/54)	100% (32/32)
% Of surveyed individuals said that "staff believed I could change"**	93% (52/56)	100% (31/31)
Better Off?		
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	55% (30/55)	87% (26/30)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	86% (47/55)	93% (28/30)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	86% (104/121)	96% (63/66)

FY 18/19 Outcomes for Partners After One Year in FSP 08 n=13

	Partners	Days
Homelessness	= 0% (from 0 to 0)	= 0% (from 0 to 0)
Incarceration	= 0% (from 0 to 0)	= 0% (from 0 to 0)
Acute Medical Hospitalizations	↓ 100% (from 1 to 0)	↓ 100% (from 25 to 0)
Acute Psych Hospitalizations	↓ 12.5% (from 8 to 7)	↓ 26.7% (from 150 to 110)
State Psychiatric	= 0% (from 0 to 0)	= 0% (from 0 to 0)

FY 19/20 Outcomes for Partners After One Year in FSP 08 n= 18

	Partners	Days
Homelessness	= 0% (from 0 to 0)	= 0% (from 0 to 0)
Incarceration	= 0% (from 0 to 0)	= 0% (from 0 to 0)
Acute Medical Hospitalizations	↓ 100% (from 2 to 0)	↓ 100% (from 27 to 0)
Acute Psych Hospitalizations	= 0% (from 11 to 11)	↑ 226.2% (from 141 to 460)
State Psychiatric	= 0% (from 0 to 0)	= 0% (from 0 to 0)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database
- **State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020
- State DCR Application with Enhanced Partnership Level Data program ran 3/11/2020 for FY 18/19 and 12/4/2020 for FY 19/20

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES:

FY 18-19

- Recruitment and Retention of qualified staff and a need for ongoing training.
- To improve children's outcomes, there is an ongoing need to early identify and link caregivers to their own mental health and substance abuse treatment services, along with community resources. However, many caregivers find it taxing to keep pace with FSP service intensity, let alone take on further treatment for themselves, so this continues to be a challenging "sell".

FY 19-20

- There were a high proportion of children/youth with emergent and/or ongoing issues related to anger control and impulsivity/hyperactivity. Assessment and outcome data shows that these may be clinical themes throughout our central valley service populations. To address this, Central Star started Aggression Replacement Training™ with their teams in the region they are bringing this training to the Child FSP Spring
- 2021.
  There continue to be high proportions of families with actionable issues by discharge regarding family functioning and living situation. No formalized additional QI plan was created to address this beyond the stepped up training focus on trauma and family functioning we commenced the prior year and are sustaining; and, because the team was intently focused on client/caregiver support needs during the necessary transition to telehealth services during these COVID-19 times.

PROPOSED CHANGES:

FY18-19

- No program changes proposed.

FY19-20

- No program changes proposed.

ASSISTED OUTPATIENT TREATMENT FSP 09

Operated by Stanislaus County Behavioral Health and Recovery Services
Forensic System of Care

PROGRAM DESCRIPTION

In August 2018, Stanislaus County BHRS implemented the Assisted Outpatient Treatment (AOT) Full Service Partnership Program. AOT is a civil court-order for the involuntary outpatient treatment of individuals with severe and persistent mental illness who have historically refused treatment and/or medication because their illness impairs their ability to make rational decisions. The program utilizes a multi-disciplinary approach with 24/7 access and support.

As AOT is defined as involuntary outpatient treatment, the primary goal of the AOT program is to connect clients to voluntary services within other BHRS programs via intensive outreach and engagement strategies. Those individuals who are not successfully connected to voluntary services are then court ordered into services through the AOT FSP team. As such, under the name "FSP-09 Assisted Outpatient Treatment" there are two distinct components:

- Assisted Outpatient Treatment, Outreach and Engagement
- Assisted Outpatient Treatment, Full Service Partnership

This program was approved for a three-year pilot.

TARGET POPULATION

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

SERVICES AND ACTIVITIES

The AOT Outreach and Engagement program provides intensive outreach services that seek to engage, assess, and refer individuals with serious mental illness to BHRS services and community supports. Outreach services include: family advocacy services, behavioral health screening/assessment, psychoeducation, behavioral health services navigation and referrals, and transportation to help with access to services and/or community supports.

The AOT Full Service Partnership program utilizes the Assertive Community Treatment (ACT) approach including, but not limited to, 24 hour, 7 days per week access to a known service provider, intensive community-based services, low client to staff caseload ratio, access to supportive service funds to assist with housing and basic needs, and a 'housing first' approach.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY19-20 is 25.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$335,026	93	$3,602

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$379,194	43	$8,818

PROGRAM DEMOGRAPHICS SERVED:

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	2	2%	0	0%
Asian	5	5%	3	7%
Hispanic	35	38%	16	37%
Native American	0	0%	0	0%
Pacific Islander	0	0%	0	0%
White	33	35%	19	44%
Other	3	3%	0	0%
Unknown	15	16%	5	12%
Total:	**93**	**100%**	**43**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	0	0%	0	0%
TAYA (16-25)	16	17%	4	9%
Adult (26-59)	67	73%	34	79%
Older Adult (60+)	10	10%	5	12%
Unknown	0	0%	0	0%
Total:	**93**	**100%**	**43**	**100%**

**Due to privacy any value <10 has been removed*

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	87	94%	41	95%
Spanish	3	3%	2	5%
Other	3	3%	0	0%
Unknown	0	0%	0	0%
Total:	**93**	**100%**	**43**	**100%**

**Due to privacy any value <10 has been removed*

Data Source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/16/2020 for FY 19/20 (calculation) access database

PROGRAM UPDATE

FY 18/19:

- The AOT program introduced a new way for the community to refer into what had previously been perceived as a closed behavioral health care system. For the first time, AOT provided family members, law enforcement and others the opportunity to make referrals regarding individuals who were unwilling or unable to seek out services themselves.
- This new referral source allowed the team to identify individuals who may have been silently suffering without the adequate level of support needed.

FY 19/20:

- AOT successfully recruited and hired a Behavioral Health Specialist (BHS) in late 2019. The team had previously been comprised of one mental health clinician, a family advocate, and the program coordinator. This BHS assisted the team with enhanced outreach and linkage efforts for those who were referred to AOT.

- The AOT program moved from the Substance Use Disorder System of Care to the Forensic System of Care in early March, 2020. The Forensic System of Care is home to several of the county's existing Collaborative Court programs, including Mental Health Treatment Court and Adult Drug Court as well as several Full Service Partnership programs. The intention of this move was to leverage existing resources and relationships to help increase the efficacy of the AOT program.

OUTCOMES:

MHSA OUTCOMES FOR FSP-09 / AOT

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Unique Individuals Referred to AOT*	93	43
How Well?		
% of annual target of individuals served*	372% (93/25)	172% (43/25)
Referral by	Family Member 62% Therapist 13% Other 12% Peace Officer 9% Agency/Hospital Director 4%	Family Member 67% Therapist 14% Peace Officer 11% Agency Director 2% Roommate 2% Other 4%
% of referrals linked to other BHRS programs OR % linked to treatment services	49% (46/93)	70% (30/43)
% engaged in voluntary services at time of referral	35% (16/46)	20% (6/30)

Average # services per individual	54 2461/46	25 756/30
Better Off?		
Since October 2018, 16 individuals have remained connected to Full Service Partnerships for one year or more post AOT referral.		

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database
- State DCR Application with Enhanced Partnership Level Data program ran 3/11/2020 for FY 18/19 and 12/4/2020 for FY 19/20

CHALLENGES/BARRIERS & STRATEGIES TO MITIGATE:

FY 18/19

- Educating the behavioral health care system and our community at large regarding how AOT fits within the system of care was a challenge during the first year of this pilot. The AOT team, in collaboration with community partners at NAMI, conducted numerous presentations to various organizations, groups and partnering agencies to further increase collaboration across the community.
- Capacity issues within existing BHRS FSP programs meant fewer resources were available to individuals referred into treatment by AOT. This was particularly true in terms of FSP's capacity to provide intensive outreach and engagement efforts.

FY 19/20

- The COVID-19 pandemic has created innumerable barriers for the AOT pilot project. Court proceedings were backlogged, creating difficulty in scheduling hearings for potential court petitioned cases. Additionally, the staffing shortage for BHRS as a whole created a strain on the AOT program.
- Finding where AOT "fits" into the larger behavioral health care system remained a challenge in FY 19-20. Several additional trainings and presentations were conducted; however, the training plan was greatly impacted by the pandemic. The team was unable to provide the number of presentations previously planned. The total number of AOT referrals for 19-20 was down from the previous year. At this point we cannot say whether this is related to a natural decline after the initial roll out of the program, if this was directly related to decreased awareness, or a combination there of.

PROPOSED CHANGES:

FY 18/19

- As the success of this program relies heavily on the cooperation of the county's full continuum of care, including community partners, community education presentations will continue throughout the life of the pilot.

FY 19/20

- An emphasis will be placed on identifying and implementing additional opportunities for the AOT team to support other BHRS FSP teams. The goal will be to help increase the consistency of outreach and engagement services across all FSPs within the BHRS system of care.

CO-OCCURRING DISORDERS FSP 10

Operated by Stanislaus County Behavioral Health and Recovery Services
in the Forensic System of Care

PROGRAM DESCRIPTION

Co-Occurring Disorders, Full-Service Partnership (COD) is an outpatient mental health program in Stanislaus County Behavioral Health & Recover Services. COD utilizes 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 a severe mental illness.

COD began as a learning project with the primary 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 developing the "Co-Occurring Lens." COD found that to successfully engage and treat individuals with co-occurring severe mental illness and substance use disorders, the emphasis needed was on the Stage-Based Treatment framework for both mental health and SUD concurrently and deliberately, addressing the sometimes contradictory strategies indicated for each stage separately. While all FSPs serving adults work with this issue and should have the capability to diagnose and treat SUDs (e.g. IDDT), there are some individuals for whom the extreme extent of their SUD behavior created challenges and reduced the effectiveness of the FSP. As a result, this population was significantly un/underserved and in need of a non-traditional approach, thus creating the "co-occurring lens."

To meet criteria for this program, the mental illness and substance use disorder must cause significant functional impairment in areas of life functioning (self-harm, social, employment, education, etc.). To support individuals, COD provides mental health therapy, education and support; case management to link and increase access to community services (substance use treatment, social security, housing, natural resources, etc.) and medication services. Further, COD is designed to divert crises by providing 24/7 access and services to our county's most vulnerable population.

TARGET POPULATION

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

SERVICES AND ACTIVITIES

Initially, COD provides outreach services to build relationships with this "hard to reach" population who have refused services in the past and have been found difficult to engage. The program utilizes a "whatever it takes" approach with individuals and "think outside of the box" of traditional mental health treatment. The program utilizes 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 and case management services. Engagement in the program is incentivized. Individuals engaged in COD receive 24/7 access and support by program providers who have built relationships with clients, understand their needs, thus having the ability to divert crises.

In the FY 19-20, the estimated number of individuals to be served is 60.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
N/A (See INN)	N/A (See INN)	N/A (See INN)

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$1,057,932	60	$17,632

PROGRAM DEMOGRAPHICS SERVED:

UNIQUE COUNTS FOR FSP-10 (NO DATA FOR FY 18/19)

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American			*	10%
Asian			0	0%
Hispanic			11	18%
Native American			*	*
Pacific Islander			0	0%
White			40	66%
Other			*	*
Unknown			*	*
Total:			**60**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)			0	0%
TAYA (16-25)			*	*
Adult (26-59)			54	90%
Older Adult (60+)			*	*
Unknown			0	0%
Total:			**60**	**100**%

**Due to privacy any value <10 has been removed*

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English			59	98%
Spanish			*	*
Other			0	0%
Unknown			0	0%
Total:			**60**	**100**%

**Due to privacy any value <10 has been removed*

Data Source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database

OUTCOMES:

MHSA OUTCOMES FOR FSP-10 / COD

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	N/A	60
Average number of clinical services per individual*		19 (1,120/60)
Average number of support services per individual*		22 (1,317/60)
How Well?		
% of annual target of individuals served*		100% (60/60)
Average length of FSP services – days*		455 (27,303/60)
% of surveyed individuals were satisfied with services**		100% (8/8)
% Of surveyed individuals said that "staff believed I could change"**		100% (8/8)
Better Off?		
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**		100% (8/8)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**		100% (8/8)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**		98% (47/48)

Outcomes for Partners After One Year in FSP 10 n= 27		
	Partners	*Days*
Homelessness	↓ 25% (from 8 to 6)	↓ 50.2% (from 2,448 to 1,219)
Incarcerations	= 0% (from 2 to 2)	↑ 218.4% (from 38 to 121)
Acute Medical Hospitalizations	= 0% (from 2 to 2)	↓ 55.2% (from 29 to 13)
Acute Psych Hospitalizations	↓ 6.3% (from 16 to 15)	↑ 38% (from 437 to 603)
State Psychiatric	= 0% (from 0 to 0)	= 0% (from 0 to 0)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) Access database
- **State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020
- State DCR Application with Enhanced Partnership Level Data program ran 3/11/2020 for FY 18/19 and 12/4/2020 for FY 19/20

PROGRAM UPDATE:

FY 18/19

COD spent time finalizing the "co-occurring lens" and preparing to transition from a learning environment where the focus is on "learning to treat" and consolidating data to an operational environment where the focus is implementing program findings. COD completed a 3-year project report and advocated for the transition from a learning project to a community support services project. Lastly, COD advocated for program expansion.

FY 19/20

Due to the success of the program, Behavioral Health & Recovery Services and Stanislaus County Board of Supervisors supported the transition to a community support service program and COD was implemented. In addition, an Intensive Level of Care was implemented and additional staff to support the new level of care.

CHALLENGES/STRATEGIES TO MITIGATE & OPPORUNITIES (RELATED TO OUTCOME DATA)

FY 18/19

- Co-Occurring Lens. In the learning environment, COD providers continued to develop the co-occurring lens. Time was spent analyzing and reflecting on data gathered to truly understand biases within the team, within the Behavioral Health system and the community at large regarding concurrent treatment of individuals who struggle with both mental health and substance use disorders. Time was also spent analyzing data collected over the 3-year project to identify strategies that worked well when working with this population.
- Level of Care. COD identified a challenge in the learning project regarding the significant gap between full-service partnership models, the "whatever it takes" approach and regional programs which continue to operate similar to traditional outpatient mental health treatment. Transitioning clients to lower levels of care proved to be difficult for most clients. Clients who had spent any time in COD became fearful of transitions to new

programs and remained concerned regarding the break in relationships with current program staff. Quite often, clients appeared to "self-sabotage" and an increase in crises would occur during this phase of treatment, halting the transition to the new program.

- Another challenge continues to be maintaining staff and managing staff burnout.

FY 19/20

- Co-occurring lens opportunities. The program was able to identify common misconceptions of treatment and advocate for clients in need of simultaneous treatment versus siloed treatment options. The program aimed to educate providers regarding successes found in treating disorders simultaneously. COD identified the need for education support and approaches for placements who struggle to maintain housing options for this population. COD continues to maintain building relationships with those who have adverse reactions to treatment, the behavioral health system and the community is the first and most important step that needs to be nurtured throughout the treatment process. This approach to treatment continues to be an area that is discussed in staff meetings to strengthen understanding, cross-train new staff regarding learned approaches and apply stage-based approaches to treatment.
- Level of Care opportunities. During implementation it was imperative to address operationally the concerns identified while in the Learning Environment. To reduce the gap between levels of services, COD implemented an Intensive Level to continue to provide services to individuals engaged, though reduce the frequency in preparation to transition to lower levels of care and open additional space for clients in need of ACT level services. To implement this level of care, COD advocated for an additional Behavioral Health Specialist and Community Clerical Aid. This was approved and implemented. Introducing this level of care increased the number of clients the program was able to serve by 20; created a reduction in services while maintaining the philosophy of the program and, created the structure necessary to continue working towards transitioning clients to lower levels of care.
- Once the intensive level of care and additional resources were implemented, program staff were no longer stretched among multiple roles and could develop specialized roles. On small teams, each provider needs to be skilled in several areas (i.e. outreach, group facilitation, crisis, mental health treatment, substance use treatment, housing, employment, vocational training, etc.). As the team grew with additional staff and volunteers, roles were able to be more focused and specialized which also reduced provider burn out. In addition, as the number of clients grew from "hard to engage" to engaged clients, there were enough individuals to implement psychoeducational and therapy groups for interested participants. It is imperative to not only teach clients how to meet their needs while in crisis, but also to prevent the occurrence of crisis by meeting needs consistently. Psychoeducational groups provided the foundation for continued engagement and learning to be proactive in treatment and maintain stability.
- In March of 2020, the COVID-19 pandemic disrupted service deliveries in unprecedented ways. Services for our most vulnerable population in the county were suddenly halted

with new procedures quickly identified to support clients. COD program lobby was closed, psychoeducational and support groups were stopped and ways of engaging with client were suddenly changed to increase safety to staff, clients and public at large. A month later, COD program was hit with additional challenges as 2 of the 6 clinical staff moved on to other opportunities. One of those clinical staff being the only clinician in the program. At that time, budget concerns and BHRS's hiring freeze impacted the ability to replace those staff members. Each staff member quickly adjusted to those program changes and began covering responsibilities and caseloads for those staff. Ultimately, the Intensive Level of Service became a responsibility of all staff versus and COD became closed to referrals due to the dramatic increase in case load size.

- While the pandemic and staff change certainly changed service delivery, opportunities for better treatment options quickly arose. COD program staff are well equipped with a valuable skill sets in creativity, thinking "outside of the box" and adapting to change rather quickly. Psychiatric appointments were quickly set up to telehealth appointments. COD psychiatric nurse was dedicated to providing medication injections in the field with additional safety procedures. COD case managers began moving sessions to telehealth and provided case management services to clients in crisis (with additional safety precautions) and clients who were unable to be reached by telephone.
- Crisis evaluations in hospitals transitioned to telehealth options to increase safety of staff and clients. COD set up teams of staff to work from the office two days per week and three days working from home to ensure staff were paired and split should an outbreak occur, not all staff would need to be quarantined simultaneously. Allowing staff to work from home increased morale and provided opportunities for staff to dedicate time to paperwork completion versus the fast-paced nature and crises that occur in the office. The lobby being closed decreased the amount of traffic in the office, greatly decreased case managers need to transport clients to and from groups, psychiatric and nurse appointments, which saves a great deal of time. In September, COD embraced the opportunity for an extra help Clinician for 2 days per week which provided much needed relief to program staff. In December 2020 an extra help case manager for 40 hours per week brought additional support and by February 2020 COD was able to begin receiving new referrals again.

PROPOSED CHANGES:

FY 18/19

- Adopt COD as a Full-Service Partnership (FSP) Program as part of the CSS Programs in FY 19-20.

FY 19/20

- Implement psychoeducational & support groups, implement intensive level of care, increase access and support to family advocates.

Transitional Aged Youth Drop-In Center (Josie's Place) GSD 01

Operated by Stanislaus County Behavioral Health and Recovery Services
Children's System of Care/Transitional Aged Youth

PROGRAM DESCRIPTION

Josie's Place is a membership-driven "clubhouse" type center for diverse transitional aged youth with mental illness. Programming consists of: 1) Drop in Center, and 2) Regional Level Outpatient Mental Health (Josie's Service Team). Clients (Members for Drop-In Center) have opportunities to utilize computers, develop social skills, engage in support groups, and one-on-one support.

TARGET POPULATION

- Transitional Age Youth – age range is 16-25

SERVICES AND ACTIVITIES

Drop in Center:

- Provides social skills and activities including independent living skills.
- Provides groups including anger management, LGBTQ and Transgendered support groups, SUD peer support, gender specific peer support groups.
- Linkage and advocacy for independent living skills including housing, eligibility, California IDs, SSI, vocational and education support.
- Outreach and engagement with TAY population in all settings to provide resource and referral.

Service Team provides:

- Mental Health Services includes: individual therapy, group therapy, intensive targeted case management, collateral, individual rehabilitation, group rehabilitation, intensive care coordination (ICC) (ages 0-20), intensive home-based services (IHBS) (ages 0-20), and medication support services.
- Works collaboratively with client, professional/natural supports to reduce mental health symptoms.
- Works to help stabilize housing, reduce hospitalizations, reduce incarcerations, and reduce substance use.
- Works to increase healthy coping skills, socialization and community supports.
- Works towards independence and Recovery on TAY terms.

Josie's Place is also home to the Young Adult Advisory Council (YAAC), a consumer-based group that provides leadership opportunities for youth to get involved in daily activities and have the voice of programming at Josie's Place. Services can be provided in English, Spanish, and Cambodian currently but all cultures and ethnicities are accommodated for all members/clients.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 is 250+ in the Drop in Center; approximately 175 with service team and 60+ at the TRAC level.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET (TABLE FORMAT):

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$608,985	464	$1,306

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$447,418	321	$1,394

PROGRAM DEMOGRAPHICS SERVED:

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	51	11%	37	12%
Asian	17	4%	11	3%
Hispanic	189	41%	136	42%
Native American	10	2%	5	2%
Pacific Islander	8	<1%	*	*
White	171	37%	115	36%
Other	*	*	*	*
Unknown	13	3%	*	*
Total:	**464**	**100%**	**321**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	*	<1%	0	0%
TAYA (16-25)	438	94%	307	96%
Adult (26-59)	22	5%	13	4%
Older Adult (60+)	0	0%	0	0%
Unknown	*	<1%	*	<1%
Total:	**464**	**100%**	**321**	**100%**

**Due to privacy any value <10 has been removed*

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	437	94%	312	97%
Spanish	13	3%	*	*
Other	*	<1%	*	<1%
Unknown	11	2%	*	<1%
Total:	**464**	**100%**	**321**	**100%**

**Due to privacy any value <10 has been removed*

Data Source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database

PROGRAM UPDATE

FY 18/19:

- The program focused new efforts around outreach and collaboration to increase awareness of the center and its services through presentations at other programs. This activity contributed to the substantial increase in program referrals.

FY 19/20:

- In FY 19/20, two Clinical Service Technician (CST) positions were filled, the Drop-In Center was able to add support groups back to its service offerings and the number of members began to increase.
- Zoom support groups initiated by Drop-In Center staff to help engage members.

- In March 2020, due to COVID-19, the service team offered telehealth services via zoom and telephone service to its members.
- The Service Team continues field based services pre COVID-19 and during. The initial response when COVID hit in March 2020 was to prioritize field-based services for more crisis situations only. Field based services opened back up and expanded with COVID-19 protocols in place. Telehealth has also been expanded where in person face to face wasn't possible.

OUTCOMES:

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	464	321
Average number of clinical services per individual*	5 (2,354/464)	7 (2,384/321)
Average number of support services per individual*	1 (530/464)	3 (833/321)
How Well?		
% of annual target of individuals served*	186% (464/250)	128% (321/250)
Average length of GSD services – days*	170 (78,795/464)	239 (76,676/321)
% of surveyed individuals were satisfied with services**	96% (42/44)	97% (36/37)
% Of surveyed individuals said that "staff believed I could change"**	93% (38/41)	92% (34/37)
Better Off?		
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	81% (33/41)	74% (25/34)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	67% (26/39)	57% (20/35)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community	75% (192/257)	88% (190/215)

resources or decreased need for extensive and expensive services.**		

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) Access database
- **State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES

FY 18/19

- The Drop-In Center Team experienced a loss of staff in FY18-19, Clinical Service Technician (CST) and Community Clerical Aid (CCA) which made them unable to facilitate groups and participate in outside activities at previous levels.

FY 19/20

- The Service Team lost one Clinician in FY 19-20 which limited the amount of therapy the Service Team was able to provide.
- During COVID-19, there have been barriers to engagement through telehealth by Drop In Center members and Service Team clients. Sessions and groups have been offered via Zoom and at times poorly attended by this population.
- Due to COVID-19, Drop-In Center support staff have been reassigned to other areas of the department and the Service Team were stationed where medical and other supportive services were provided.

PROPOSED CHANGES

FY 18/19

- No program changes proposed.

FY 19/20

- No program changes proposed.

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) & WARM LINE GSD 02

Operated by Stanislaus County Behavioral Health and Recovery Services and Turning Point Community Programs

PROGRAM DESCRIPTION

MCERT: (Modesto-CERT)

MCERT allows the Modesto Police Department (MPD) access to trained crisis mental health staff with Stanislaus County Behavioral Health and Recovery Services' (BHRS) Community Emergency Response Team (CERT) 24 hours a day and seven days a week. The CERT program is responsible for crisis assessments at the CERT office for psychiatric inpatient care or less restrictive care at the Crisis Stabilization Unit, assessments at area hospitals (emergency rooms and medical floors), and Doctors Behavioral Health Center (DBHC). CERT staff is available for consultation with MPD, ride along support, and completion of crisis assessments within the community.

WARM LINE (Warm Line) operates as a telephone support program, providing non-crisis peer-support to community members that could benefit from the support of a caring listener. The Warm Line is accessible 24 hours a day, 7 days a week. Warm Line also provides support to the local Community Emergency Response Team by answering calls from hospitals or other providers in the community that are awaiting clinician assessments for hospital placement. Warm Line is the default contact number for any after-hours needs or closures for Stanislaus County's Behavioral Health programs. This is the main contact for linkages to mental health services and support as well as for after-hours contact to ensure an individuals' information is still obtained and connected to.

TARGET POPULATION

- Children 0-16,
- Transition Age Youth 16-25
- Adults 26-59
- Older Adults 60 +

SERVICES AND ACTIVITIES

CERT staff is available for consultations regarding individuals contacted by MPD in the community who may need crisis mental health services. CERT is able to provide information and resources to MPD to assist in officer determinations whether a client needs to be taken to a safe assessment site for a crisis assessment or instead is more appropriate for referrals to other support services. CERT staff is also available, at MPD request, during the evening shift (4PM to 10PM) for ride along with an officer to respond directly within the community for mental health emergencies/issues. CERT has the ability to perform a crisis assessment in the field when accompanying an officer as

a ride along, initiate a psychiatric hold if necessary, and collaborate with MPD regarding disposition of the individual (i.e. transfer to an ED for medical clearance; transfer to CERT office for potential Crisis Stabilization Unit (CSU) or Psychiatric Health Facility (PHF); release to self or family with linkage to support services (i.e. Peer Navigators; Triage Support Team; AspiraNet).

Warm Line is staffed with individuals with a variety of lived experience. Our staff is committed to providing Peer Support to the residents to Stanislaus County, share relevant county and community resources for Mental Health and Substance Abuse Recovery, and linkages to housing, education and other resources. Warm Line offers a Face-to-Face component for our callers who may need extra support finding or connecting to services or resources. Warm Line can pair our community members with peer support specialist, Peer Navigators, who then can help *Navigate* our mental health system. All of Warm Line services are free of charge.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 is 3000.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$914,095	2,524	$362

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Participant FY 2019/2020
$991,061	2,297	$431

PROGRAM DEMOGRAPHICS SERVED:

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	190	8%	188	8%
Asian	70	3%	69	3%
Hispanic	961	38%	918	40%
Native American	38	1%	30	1%
Pacific Islander	12	<1%	*	<1%
White	1152	46%	995	43%
Other	51	2%	54	2%
Unknown	49	2%	36	2%
Total:	**2523**	**100%**	**2297**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	398	16%	382	17%
TAYA (16-25)	692	27%	616	27%
Adult (26-59)	1331	53%	1229	53%
Older Adult (60+)	93	4%	66	3%
Unknown	*	<1%	*	<1%
Total:	**2523**	**100%**	**2297**	**100%**

**Due to privacy any value <10 has been removed*

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	2333	93%	2123	92%
Spanish	160	6%	146	6%
Other	28	1%	26	1%
Unknown	*	<1%	*	<1%
Total:	**2523**	**100%**	**2297**	**100%**

**Due to privacy any value <10 has been removed*

Data Source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database

PROGRAM UPDATE

FY 18/19:

MCERT (Modesto-CERT)

- No program updates.

Warm Line

- No program updates.

FY 19/20:

MCERT (Modesto-CERT)

- No program updates.

Warm Line

- Bilingual/Spanish support – Stanislaus County and Warm Line created a new campaign to increase the bilingual mental health support in the County.

OUTCOMES:

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	2,523	2,297
Average number of clinical services per individual*	1 (3,477/2,523)	1 (3,012/2,297)
Average number of support services per individual*	0 (6/2,523)	0 (2/2,297)
How Well?		
% of annual target of individuals served*	84% (2,523/3,000)	77% (2,297/3,000)
Average length of GSD services – days*	1 (3,451/2,523)	1 (2,992/2,297)

Data source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database

CHALLENGES/BARRIERS & STRATEGIES TO MITIGATE:

FY 18/19

MCERT

- No program updates.

Warm Line

- There is a growing need identified to provide more culturally competent services and peer support in languages other than English.

FY19/20

MCERT

- Crisis services are unpredictable in regard to the frequency and intensity of referrals received requiring response by CERT staff. The CERT site is a 24-crisis assessment site and as such there is always a CERT staff member on site, however this may be the only staff member available as other staff members may be needed for responses to community safe assessments sites. As noted above CERT staff is responsible to respond to multiple medical

sites within the community for crisis evaluation for most children and adolescents within the community regardless of insurance or residency and for adults deemed uninsured county residents, adults with Stanislaus County Medi-Cal, and adults with Medi-Cal/Medicare who are open to BHRS services. CERT is also responsible for the process of locating psychiatric hospital placements, collaborating with persons to care/placements, and management of crisis issues calls/issues, which at times may fall to one staff member. Although CERT staff is available 24 hours for crisis consultations, the demands of crisis services within the community can exceed the availability of CERT staff for in person ride-along with MPD.

- Staffing at CERT has been more stable with increased retention. However, as is common within 24-hour programs, the possibility of higher turnover in staffing within crisis services remains, and likely will remain, a significant factor. In order for ride alongs with MPD to occur staff are required to complete a training program. At this time there are limited CERT staff that have received this training. It is imperative that CERT receive such training to ensure that they are knowledge and able to support MPD and not impede their ability to first and foremost provide law enforcement services to the community. Staff that did received the initial training likely would benefit from updated and ongoing training regarding the safety issues and challenges faced by MPD staff. Such trainings may be difficult to coordinate, and schedule given the demands of MPD and CERT to provide primary services to the community.

Warm Line

- In response to the growing need for more culturally competent services to our Spanish speaking community, the program has hired and trained a bilingual Peer Support Specialist.
- This position is dedicated to serving the peer needs of our County. In the continued effort to offer bilingual support, the program will work to continue to hire and train qualified Spanish speaking staff.

PROPOSED CHANGES

FY 18/19

MCERT

- No program changes proposed.

Warm Line

- No program changes proposed.

FY 19/20

MCERT

- No program changes proposed.

Warm Line

- The program has added a full-time bilingual staff person to Warm Line and looking to expand this support to the evening and after-hour shifts.

Families Together (The Family Partnership Center) GSD 04

Operated by Stanislaus County Behavioral Health and Recovery Services
Children's System of Care

PROGRAM DESCRIPTION

The Family Partnership Center provides a one stop shop for families. This program promotes collaboration between parents and mental health providers. The Behavioral Health & Recovery Services Children System of Care medication clinic is also housed at this site. The Family Partnership Center provides a wide variety of services to meet the needs of diverse families in our community. Services can include peer group and individual support, family education, guardian workshops, Individual Education Plan (IEP) workshops. A large part of what we do is provide assistance with navigating large complex systems such as mental health, juvenile justice, education and child welfare systems.

TARGET POPULATION

- Families and caregivers who have children with Serious Emotional Disturbance (SED)

SERVICES AND ACTIVITIES

Parent Partners Provide support, navigation, mentoring, and advocacy to help empower parents of children who are challenged by their behavioral and/or emotional needs.

Kinship Support staff provide respite, recreational activities, navigation and guardianship workshops for relative caregivers, primarily grandparents raising grandchildren.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 is 700 individuals.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$522,802	914	$572

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Participant FY 2019/2020
$514,121	725	$709

PROGRAM DEMOGRAPHICS SERVED:

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	20	2%	19	3%
Asian	*	<1%	*	<1%
Hispanic	426	47%	293	40%
Native American	*	<1%	0	0%
Pacific Islander	*	<1%	*	<1%
White	355	39%	226	31%
Other	26	3%	73	10%
Unknown	82	9%	111	15%
Total:	**917**	**100%**	**725**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	187	20%	68	9%
TAYA (16-25)	46	5%	20	3%
Adult (26-59)	181	20%	119	17%
Older Adult (60+)	91	10%	96	13%
Unknown	412	45%	422	58%
Total:	**917**	**100%**	**725**	**100%**

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	21	2%	10	1%
Spanish	*	<1%	0	0%
Other	0	0%	0	0%
Unknown	893	97%	715	99%
Total:	**917**	**100**%	**725**	**100**%

**Due to privacy any value <10 has been removed*

Data Source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database

PROGRAM UPDATE:

FY 18/19:

- A full-time Coordinator was hired for the FPC program, providing consistent on-site supervision and to help with a larger culture shift in the program to integrate volunteers, also known as Parent Partners, to help clients better navigate the program and supportive resources provided through the Children's System of Care (CSOC).
- Hubs were established at CSOC treatment program sites to help build collaborations with the Teams and provide greater linkages to the clients for programs and services.
- Reprioritization of caseloads and assignments was created so that those that were not active cases (hadn't participated in three to six months) were "closed", and for those that are not active cases but are utilizing support groups, they are moved to another billing subunit. This creates more efficiencies and ensuring staff and program resource goes to those who are most in need. Prior to this, non-active cases were left open with no end
- issued. Implemented a computer kiosk for mandatory guardianship training videos for clients. A Spanish video was added to better serve the Spanish speaking clients. The implementation of the kiosk, clients can come in independently and do these trainings.
- Integrated Medication clinic into the Family Partnership Center to consolidate and co-locate medication services with other supportive services.

FY 19/20:

- New Coordinator transferred to another program leaving a vacancy that was not filled due to hiring freeze within the department because of COVID-19 groups and support services were mainly done via phone and zoom calls.

OUTCOMES:
To provide necessary groups and support services for families in the Children's system of care

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	917	725
Average number of clinical services per individual*	0	0
Average number of support services per individual*	0	0
How Well?		
% of annual target of individuals served*	131% (917/700)	104% (725/700)
Average length of GSD services – days*	0	0
% of surveyed individuals were satisfied with services**	86.7% (13/15)	96% (48/50)
% Of surveyed individuals said that "staff believed I could change"**	N/A	N/A
Better Off?		
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	78.6% (11/14)	90% (43/48)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community**	80% (12/15)	94% (47/50)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services**	75.7% (78/103)	90% (300/333)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database
- **State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES

FY 18/19

- The Culture shift for staff to be integrated into the CSOC treatment teams presented some challenges as some staff struggled with this and needed much support and supervision.
- Closing families to workshop/support group only subunit was a challenge for staff due to the previous program culture where caseloads remained open with no end issued. Prior to implementing policy to close inactive caseloads, caseloads remained open with no end issued.

FY19/20

- Shifting staff towards working remotely and providing groups and supports virtually due to Covid-19 was a challenge initially.

PROPOSED CHANGES

FY 18/19

- No program changes proposed.

FY 19/20

- No program changes proposed.

THE CONSUMER EMPOWERMENT CENTER GSD 05

Operated by Turning Point Community Programs in the
SBHRS Consumer /Family Affairs System of Care

PROGRAM DESCRIPTION

The Consumer Empowerment Center (CEC) is a culturally diverse place where behavioral health consumers and family members gain peer support and recovery-mind input from others to reduce isolation, increase the ability to develop independence, and create linkages to mental health and substance abuse treatment services. It's a safe and friendly environment where they can flourish emotionally while developing skills.

TARGET POPULATION

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

SERVICES AND ACTIVITIES

The Empowerment Center (EC) is a drop-in center focusing on mental health and substance abuse recovery. Services are provided to the adult population of Stanislaus County.

The EC is a peer led support system that empowers and advocates for members in the areas of personal health and wellness. Peer support, employment training, employment support, career exploration, a computer lab, and peer led self-help groups are offered. Unique support is also offered to individuals seeking MH/SUD recovery. The EC is also supported by several other programs and agencies.

The EC is in collaboration with Turning Point's Warm Line, peer navigation, Community Activities and Rehabilitation and Transportation (CART), H.O.M.E team, several local board and care operators, The Garden of Eaten and Garden Gate Respite.

The EC has created its own client-centered continuum of care within our own system. The EC can support an individual asking for MH/SUD recovery by offering the county's phone number for assessments and provide transportation if needed. Once the assessment is complete, SUD clients will are offered either residential or outpatient care. The EC can arrange transportation via CART to SRC residential when their bed becomes available or EC will make arrangements with CART to transport to outpatient services. MH clients are usually referred to a treatment team or to their insurance/PCP's/etc. Most individuals entering recovery via the EC may have the opportunity to work with a peer navigator to complete their plan for support. The EC, the H.O.M.E. team and CART have teamed up to offer transportation and peer led groups to many of our local board and care residents. The H.O.M.E. team have created relationships with many of the BC operators and have introduced CART and the EC as resources for their residents. Their residents have taken advantage of this new service 522 times since July 1, 2019.

The EC also supports career explorers, people who wish to either gain or improve tangible and transferable employment skills, by offering job coaching in areas such as clerical, janitorial, and culinary. Job related skills such as mock interviews and resume building are also offered.

The Garden of Eaten is a full-service commercial kitchen used in food service training. Clerical and janitorial skills are offered at the EC and Garden Gate Respite where people learn to clean, organize, sanitize, inventory control, in a commercial and residential setting. The EC also has limited means to acquire original birth certificates, California Identification cards, and other vital documents for members.

The EC offers 20 peer led support groups that range from men and women's support to SUD recovery, anti-stigma, MH recovery and more. Every month the EC hosts a gathering of members, several board and care facilities, and other supportive agencies to show appreciation to those the EC is privileged to serve. These events are modeled after common monthly events such as February's Valentine's Day where a friendship party is offered, in December a winter celebration dinner, in August a Hawaii themed luau is offered as well as partnerships with agencies such as The Wellness Recovery Center, Josie's Place, SRC residential and outpatient and more. Peer Navigation also utilizes the EC as a central point for all Peer navigator clients to meet, utilize resources, and return to services should we lose contact.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 is 400.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$484,979	641	$757

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$487,527	518	$941

PROGRAM DEMOGRAPHICS SERVED:

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	632	99%	509	98%
Spanish	*	<1%	*	1%
Other	*	<1%	*	<1%
Unknown	0	0%	0	0%
Total:	**641**	**100%**	**518**	**100%**

**Due to privacy any value <10 has been removed*

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	76	12%	59	11%
Asian	*	*	10	2%
Hispanic	158	25%	109	21%
Native American	21	3%	19	4%
Pacific Islander	*	<1%	*	<1%
White	360	56%	310	60%
Other	10	2%	*	*
Unknown	*	<1%	*	<1%
Total:	**641**	**100%**	**518**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	0	0%	0	0%
TAYA (16-25)	43	7%	19	4%
Adult (26-59)	519	81%	413	80%
Older Adult (60+)	78	12%	86	16%
Unknown	*	<1%	0	0%
Total:	**641**	**100%**	**518**	**100%**

**Due to privacy any value <10 has been removed*

PROGRAM UPDATE:

FY 18/19:

- A new peer led group was created to engage residents in board and care.
- Internal processes were created to make better linkages to SUD supports and services.
- The Garden of Eaten began to provide food services for trainings and full-service commercial kitchen that is currently providing all of the food and commodities shopping for Garden Gate Respite. Creating another avenue of food service made available directly to the public in the future is anticipated.
- In response to the challenge of individuals camping or sleeping at or near the building and upsetting several of neighbor, a private security was hired to patrol and remove any individuals on site after hours.

FY 19/20:

- Pre-COVID-19: A kickball tournament was created to collaborate between peer support programs in the area.
- Post-COVID-19: March 2020 incorporated ZOOM for telehealth and peer support groups, in June there was a curbside services launch, and in July the EC was mobilized to go to Board and Care Facilities.
- In 2020, post COVID-19, a re-design of the drop in center was done to be an outdoor drive-thru, curbside model to be COVID-19 responsive. A mobile CART system was developed to go into the community with the Empowerment Center services.
- 522 instances of Board and Care residents have left their home to join us at the EC for our peer-led groups.
- EC supported just over 20 individuals that specifically asked for SUD recovery.

OUTCOMES:

MHSA Outcomes for GSD-05 / The Consumer Empowerment Center

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	641	518
Average number of clinical services per individual*	0	0
Average number of support services per individual*	0	0
		How Well?
% of annual target of individuals served*	160% (641/400)	129% (518/400)
Average length of GSD services – days*	0	0
% of surveyed individuals were satisfied with services**	94.6% (105/111)	88.9% (40/45)
% Of surveyed individuals said that "staff believed I could change"**	88% (95/108)	87.8% (36/41)
		Better Off?
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	82.7% (91/110)	64.3% (27/42)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community.**	73.4% (80/109)	51.1% (24/47)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.**	84.4% (521/617)	79.9% (203/254)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database
- **State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020

CHALLENGES/BARRIERS & STRATEGIES TO MITIGATE:

FY 18/19

- Garden of Eaten is challenged by inadequate cold storage. There is simply no room to store more than a few days worth of food on site. Storage is limited to a few days' worth of food to be cooked and prepared a few days worth of cooked/ prepared food, both cannot be done.

FY 19/20

- Adequate number of staff needed to support a growing member base continues to be a challenge. Utilization of community agencies such as the Department of Rehab, BHRS employment services, and the EC career explorers to support this need.
- Meeting the rising cost of member supplies such as hygiene kits, bus passes, birth cert, etc., we have caused for the EC to create fundraisers to help financially support the center.

PROPOSED CHANGES:

FY 18/19

- Hiring additional peer staff would help us increase the number of individuals we can serve here at the EC and other Turning Point programs. We have added Career explorers to Garden Gate Respite for peer training to then return to the EC and support.

FY 19/20

- The EC continues to hire and train career explorers and are now placing the individuals at other programs for continued peer training. The CE is located at Garden Gate Respite and The Garden of Eaten kitchen.

CRISIS STABLIZATION UNIT GSD 06

Operated by Telecare Corporation

PROGRAM DESCRIPTION

The Crisis Stabilization Unit (CSU) provides crisis stabilization through meeting basic needs, brief forms of therapy, skill development, medical assessments, psychiatric assessments, medication evaluations, collateral support, safety planning, and resource connection. The CSU opened in February 2016 and is co-located with the county's Community Emergency Response Team known as CERT and Turning Point's Warm Line. The CSU's goal is to focus on recovery-centered, individualized care and create an opportunity for each consumer to be treated in a less restrictive setting with the focus of avoiding hospitalization whenever possible.

TARGET POPULATION

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

SERVICES AND ACTIVITIES

CSU is an unlocked crisis unit. It is a safe, welcoming, recovery-focused place for people who are experiencing a mental health crisis and need support to regain stability. The goal of the CSU is to help adults age 18+ experiencing mental health crisis receive the support they need to return to the community and reduce the risk of hospitalization. Individuals are referred through the Community Emergency Response Team (CERT). Our length of stay is 23 hours and we are able to serve 4 adults at any time. Mental health clinicians provide crisis assessment and evaluation, brief crisis therapy, coping skills development and education regarding symptoms and symptom management. Nurses provide nursing assessment and medication administration, Psychiatrists provide psychiatric assessment, medication assessment, and short-term medication orders based on assessment. Peer Support Specialists provide engage with clients to identify recovery goals and make a plan of action, develop good self-care practices, and provide referrals to appropriate services.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 is 110.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability and stakeholder input.

BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$462,390	307	$1,506

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$448,727	211	$2,127

PROGRAM DEMOGRAPHICS SERVED:

Unique Counts for GSD-06

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	26	9%	12	6%
Asian	*	*	*	*
Hispanic	119	39%	69	33%
Native American	*	*	*	*
Pacific Islander	*	<1%	0	0%
White	142	46%	111	53%
Other	*	*	*	*
Unknown	*	*	0	0%
Total:	**307**	**100%**	**211**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	0	0%	0	0%
TAYA (16-25)	76	25%	53	25%
Adult (26-59)	224	73%	155	74%
Older Adult (60+)	7	2%	3	1%
Unknown	0	0%	0	0%
Total:	**307**	**100%**	**211**	**100%**

**Due to privacy any value <10 has been removed*

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	294	96%	201	95%
Spanish	11	4%	*	*
Other	*	<1%	*	<1%
Unknown	0	0%	0	0%
Total:	**307**	**100%**	**211**	**100%**

**Due to privacy any value <10 has been removed*

Data Source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database

PROGRAM UPDATE:

FY 18/19:

- Improved community visibility; there was in FY 17/18 a real barrier to people understanding that the CSU was not the university (also called the CSU). CSU Director attended many community meetings to educate community partners about CSU services. CSU and CERT worked to develop a better understanding of everyone's roles.

FY 19/20:

- Use of Telepsychiatry: The CSU has contracted with a psychiatrist, Dr. David Lee, to complete telepsychiatry on an as needed basis which will allow for better, more flexible access to psychiatric and medication evaluations for CSU patients.
- Stays over 24 hours: CSU stays over 24 hours decreased significantly from 8 patients in FY 2018-2019 to two patients year-to-date. This is due to increased program

efficiency and improved connections with community providers. Developing closer relationships between the CSU and the community mental health case managers has allowed CSU to include existing service providers in the discharge and follow-up planning, creating better and more feasible aftercare plans for clients which increases client success.

OUTCOMES:

MHSA Outcomes for GSD-06 / CSU

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	307	211
Average number of clinical services per individual*	1 (450/307)	2 (374/211)
Average number of support services per individual*	8 (2,447/307)	8 (1,734/211)
How Well?		
% of annual target of individuals served*	279% (307/110)	192% (211/110)
Average length of GSD services – days*	1 (441/307)	2 (320/211)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES:

FY 18/19

- Extreme nurse staffing shortage.
- Access to psychiatric services is limited due to time constraints from sharing practitioners with the PHF.
- Increasing the CSU census: Increasing the CSU census continues to be challenge. While the census has generally been operating below capacity, this past year in August 2019, the CSU census dropped significantly to 23 patients per month. FY 18-19, the average CSU census was 32 patients per month.

- Lack of collaboration regarding transportation from DBHC to the CSU. This year, an additional barrier has developed in that physicians at DBHC will not discharge patients to voluntarily go to the CSU in a taxi and ambulances are only available to transport patients on a legal hold. This unwritten policy at DBHC went into effect after a DBHC client was released and assaulted a taxi driver. That discharge assessment was not completed by a Telecare or county clinician. This has resulted in clients who could have utilized CSU services to stabilize their crisis in the least restrictive environment instead being put on a 5150 hold. CSU leadership have been working on strategies to reduce or eliminate the barrier of insufficient transportation to the CSU and advocating with other outpatient providers and the police department for the use of CSU services.

FY 19/20

- The CSU census has been a re-occurring challenge every year. The unique set up of an unlocked program that accepts both voluntary and involuntary patients has limited the ability for the CSU to accept patients that could leave the program against medical advice or to accept patients that may need some level of physical management.

PROPOSED CHANGES:

FY 18/19

- Proposed wage increase for nursing staff to generate more interest in open positions. Proposal for addition of psychiatric practitioner for CSU.

FY 19/20

- No program changes proposed.

CRISIS INTERVENTION PROGRAM FOR CHILDREN AND YOUTH GSD-07

Operated by Stanislaus County Behavioral Health and
Recovery Services Contractor

PROGRAM DESCRIPTION

The Aspiranet Children's Crisis Intervention Program (CIP) provides immediate, intensive, support for clients and their parents/legal guardians for clients when a child has been evaluated for a 5150/5585 hold. The CIP provides a variety of services in lieu of hospitalization in these circumstances. One aspect of services provided by CIP staff is to assist in connecting the client and family to community supports, thereby avoiding subsequent hospitalizations or crisis evaluations. For those that have Medi-Cal, private insurance (except Kaiser), or are uninsured CIP staff develop a Safety Plan with Client/family, provide support working toward long term outpatient counseling services and crisis de-escalation services. Those that have Medi-Cal or are uninsured are linked to Aspiranet Stabilization Program (ASP) and County mental health services with the goal of preventing a gap in services and reducing the risk of hospitalization. Clients with private insurance are referred to their insurance carrier for long-term outpatient services.

CIP services are available 24 hours a day, 7 days a week to meet the needs of clients and families in crisis when they occur. Our staff provides in-person, intensive intervention and skill development for crisis de-escalation. The goal is to discharge client's home with their families or to respite services once they are stable and confident, they can return home safely.

TARGET POPULATION

- Children and Youth, 0 - 16
- Transitional Aged Youth, 16 – 25

SERVICES AND ACTIVITES

- Provides 24 hours a day, seven days a week availability; response to calls from Crisis Emergency Response Team (CERT).
- Provides primary crisis intervention services in the CIP office, for all children and adolescents who are referred by CERT seeking crisis services in Stanislaus County.
- Immediate crisis intervention counseling to Children/Adolescents and their family to stabilize the crisis.
- Mobilize community resources and support as necessary for children and their family. Foster preventive, intervention, and education measures to reduce subsequent hospitalizations or crisis evaluations.
- Provide interactive support and intervention to children while in the CIP office.
- Provide referrals to long-term outpatient therapy and crisis de-escalation services. Support families by coordinating transition to ASP when appropriate.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 is 100; 60 Children/Youth and 40 Transitional Age Youth.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET (TABLE FORMAT)

FY 18/19

Actual FY 2018/2029	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$439,198	80	$5,490

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$456,306	98	$4,656

PROGRAM DEMOGRAPHICS SERVED:

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	*	*	*	*
Asian	*	*	*	*
Hispanic	38	47%	54	55%
Native American	*	*	0	0%
Pacific Islander	0	0%	0	0%
White	30	37%	37	38%
Other	*	*	*	*
Unknown	0	0%	0	0%
Total:	**80**	**100%**	**98**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	61	76%	70	71%
TAYA (16-25)	19	24%	28	29%
Adult (26-59)	0	0%	0	0%
Older Adult (60+)	0	0%	0	0%
Unknown	0	0%	0	0%
Total:	**80**	**100%**	**98**	**100%**

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	71	89%	84	86%
Spanish	*	11%	14	14%
Other	0	0%	0	0%
Unknown	0	0%	0	0%
Total:	**80**	**100%**	**98**	**100%**

**Due to privacy any value <10 has been removed*

PROGRAM UPDATES:

FY 18/19:

- Funding issues to obtain and retain staff was challenging, prompting the agency to create hybrid work shifts in order to continue providing services. Staff has transitioned to working part time on-call shifts.

FY 19/20:

- Aspiranet's Triage, Linkage, and Coordination (TLC) program has been implemented. TLC offers co-response with the Community Emergency Response Team (CERT) to all youth and children being assessed for a psychiatric hold at Doctor's Medical Center (DMC). Staff provides brief de-escalation and linkage to children and families for appropriate services through a referral process.

OUTCOMES:

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	80	98
Average number of clinical services per individual*	1 (119/80)	1 (129/98)
Average number of support services per individual*	0	0
How Well?		
% of annual target of individuals served*	80% (80/100)	98% (98/100)
Average length of GSD services – days*	1 (92/80)	133 (130/98)

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES:

FY 18/19

- CIP's primary source of referrals is clients receiving emergency psychiatric evaluation from the Community Emergency Response Team (CERT). The CIP program has experienced a lower volume of referrals from CERT than the CIP program has capacity for.
- Aspiranet's management team has taken steps to address these challenges by improving communication with partnering agencies. Monthly meetings were established to identify difficulties in the prior month's encounters to brainstorm solutions to reduce reoccurrence. Attendance at partnering agency staff meetings to provide education and understanding how Aspiranet's Children's Crisis Intervention Program supports and links clients to continuous quality care would also be helpful. Aspiranet's management will continue to reach out to enact regular attendance to discuss improvements in process and treatment.
- CERT reports caregivers are exhausted after being in the emergency room for long periods and are unwilling to continue additional services. To address this issue CIP reaches out to the family within 24 hours to detail and extend services, alleviating the pressure to accept services immediately.

FY 19/20

- A global pandemic proved to be a challenge in providing services. Management worked to alleviate the impacts by implementing an aggressive COVID-19 response plan. Plan includes protocols to safely and effectively provide services through staff use of Personal Protective Equipment (PPE), counseling areas that allow staff and clients to remain 6ft+ apart, telemedicine when appropriate, consistent disinfecting of premises, and COVID-19 screeners prior to services.

PROPOSED CHANGES:

FY 18/19

- An anticipated change for the upcoming fiscal year is including an additional program, the Aspiranet Triage, Linkage and Coordination (TLC) program. Through co-response with the CERT and in conjunction with CIP, TLC will provide a variety of community supports available in Stanislaus County including resources beyond mental health.

FY 19/20

- With the implementation of Aspiranet's TLC program, CIP's services will work in partnership with the TLC program by co-coordinating services for youth and their families.

SHORT TERM RESIDENTIAL THERAPEUTIC PROGRAM GSD-09

Operated by Stanislaus County Behavioral Health and
Recovery Services Contractor

PROGRAM DESCRIPTION

Short-Term Residential Therapeutic Program (STRTP) formerly known as group home, STRTP was established effective January 1, 2017 by Assembly Bill 403 (Chapter 773, Statutes of 2015). STRTP is a residential facility operated by a public agency or private organization and is licensed by California Department of Social Services (CDSS) pursuant to California Health and Safety Code Section 1562.01 which requires an integrated program of specialize and intensive care and supervision, services and supports, treatment, and short-term 24-hour care and supervision to wards and dependents of the Court and/or Non Minor Dependents (NMDs) with the aim of moving the youth to a less restrictive environment within six months.

The key to STRTPs is the provision of short-term, specialized and intensive behavioral health treatment to wards and dependents of the Court and NMDs whose needs cannot be safely met initially in a family setting. These core behavioral health services will be provided by STRTP staff through a required Medi-Cal agreement with BHRS. Behavioral health services will include, at minimum, medication support services, case management, crisis intervention, and mental health services.

Stanislaus County has a total of three STRTPs:

- Aspiranet STRTP: 4 Homes, 46 Beds Capacity
- Creative Alternative STRTP: 8 Homes, 57 Beds Capacity
- Sierra Vista STRTP: 2 Homes, 16 Beds Capacity

TARGET POPULATION

- Children and Youth – age range 0 to 16
- Transitional Age Youth (TAY) – age range for TAY is 16-25

SERVICE AND ACTIVITIES

STRTPs provide covered Specialty Mental Health Services (SMHS) for Medi-Cal beneficiaries who meet criteria for placement in an STRTP. Services include the following mental health services: individual and group therapy, targeted case management, medication support, collateral and individual and group rehabilitation, intensive care coordination (ICC), intensive home-based services (IHBS), crisis intervention and medication support.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 is 220; 80 Children/Youth and 140 Transition Age Youth.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$461,190	84	$5,490

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Participant FY 2019/2020
$1,289,415	109	$11,829

PROGRAM DEMOGRAPHICS SERVED:

Unique Counts for GSD-09

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	15	18%	23	21%
Asian	0	0%	0	0%
Hispanic	*	10%	14	13%
Native American	0	0%	*	<1%
Pacific Islander	0	0%	0	0%
White	34	40%	33	30%
Other	*	*	*	*
Unknown	25	30%	34	31%
Total:	**84**	**100%**	**109**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	60	59%	65	60%
TAYA (16-25)	34	41%	44	40%
Adult (26-59)	0	0%	0	0%
Older Adult (60+)	0	0%	0	0%
Unknown	0	0%	0	0%
Total:	**84**	**100%**	**109**	**100%**

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	79	94%	105	96%
Spanish	*	*	0	0%
Other	0	0%	0	0%
Unknown	*	*	*	*
Total:	**84**	**100%**	**109**	**100%**

**Due to privacy any value <10 has been removed*

Data Source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for F Y19/20 (calculation) Access database

PROGRAM UPDATE:

FY 18/19

- Two of the three STRTPs began to provide services in FY18/19. They were Aspiranet STRTP and Creative Alternative STRTP.
- Each STRTPs couldn't provide services until they receive a Mental Health Program Approval from the state to provide Specialty Mental Health Services per the STRTP Regulations.

FY 19/20

- Sierra Vista STRTP was operational during this fiscal year after obtaining Mental Health Program Approval from the state. They have the unique capacity to serve children as young as six-years old.

OUTCOMES:

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	84	109
Average number of clinical services per individual*	0	.30 (33/109)
Average number of support services per individual*	0	.06 (7/109)
How Well?		
% of annual target of individuals served*	76% (84/110)	99% (109/110)
Average length of GSD services – days*	17 (1,449/84)	25 (2,679/109)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES:

FY 18/19

- The Mental Health Program approval was a lengthy process. It impacted STRTP Providers ability to fully launch the programs. Staff were not hired until the STRTP Providers received the Mental Health Program approval.

FY 19/20

- Due to the pandemic there was a significant decrease in services across all three STRTP Providers. STRTP Providers had to reduce their census to allow space for quarantine.

PROPOSED CHANGES:

FY 18/19

- No program changes proposed.

FY 19/20

- No program changes proposed.

CRISIS RESIDENTIAL UNIT GSD 10

Operated by Central Star

PROGRAM DESCRIPTION

The Crisis Residential Unit (CRU) is a 30-Day residential program. Clients may apply after the first 30 days with a 90-day maximum stay. Clients MUST be at risk of experiencing a crisis (but not in need of psychiatric hospitalization.

TARGET POPULATION

- Transitional Age Young Adults – age range is 18-25.
- Adults – age range 26-59

SERVICES AND ACTIVITIES

The CRU helps consumers practice real world recovery by participating in the day to day activities of running a household including basic living skills and social/interpersonal skills. Services are available 24 hours a day including assessment, physical and psychological evaluation and services. Assistance locating permanent housing by helping clients learn how to access community services for housing. Therapeutic and mental health services are provided including rehabilitation/recovery services for substance use. Medication evaluation and support services (physician, nurse, and psychiatrist) are also available. Crisis intervention: Assistance to de-escalate/calm clients and the ability to refer out to Merced if a 5150 evaluation is needed.

BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$85,702	9	$9,522

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$113,403	25	$4,536

PROGRAM DEMOGRAPHICS SERVED:

Unique Counts for GSD-10 (No data for FY 18/19)

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	*	11%	*	8%
Asian	0	0%	*	*
Hispanic	*	11%	*	24%
Native American	0	0%	0	0%
Pacific Islander	0	0%	0	0%
White	*	78%	15	60%
Other	0	0%	0	0%
Unknown	0	0%	0	0%
Total:	**9**	**100%**	**25**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	0	0%	0	0%
TAYA (16-25)	*	11%	*	20%
Adult (26-59)	*	89%	20	80%
Older Adult (60+)	0	0%	0	0%
Unknown	0	0%	0	0%
Total:	**9**	**100%**	**25**	**100%**

**Due to privacy any value <10 has been removed*

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	9	100%	25	100%
Spanish	0	0%	0	0%
Other	0	0%	0	0%
Unknown	0	0%	0	0%
Total:	**9**	**100%**	**25**	**100%**

**Due to privacy any value <10 has been removed*

Data Source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY19/20 (calculation) Access database

PROGRAM UPDATE:

FY 18/19:

- New procedures were set in place for referring clients to the CRU.

FY 19/20:

- Start of Covid-19, impact of clients needing covid-19 testing prior to being accepted at CRU; problems with CRU being placed on quarantine due to Covid-19 cases; and decrease of number of clients at the CRU due to staffing and illness.

OUTCOMES:

MHSA Outcomes for GSD-10 / CRU

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	9	25
Average number of clinical services per individual*	18 (163/9)	34 (847/25)
Average number of support services per individual*	N/A	N/A
How Well?		
% of annual target of individuals served*	Unknown	Unknown
Average length of GSD services – days*	20 (178/9)	38 (962/25)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES

FY 18/19

- Learning new program and exclusionary criteria.

FY19/20

- New procedures being implemented due to COVID-19 mitigation; clients needing to be tested for COVID-19 within 10 days of admission.
- CRU intermittent closures due to COVID-19 infections among staff and clients.

PROPOSED CHANGES

FY 18/19

- No program changes proposed.

FY 19/20

- Add COVID-19 testing to the application process.

THERAPEUTIC FOSTER CARE GSD-11

PROGRAM DESCRIPTION

Therapeutic Foster Care (TFC) is a short-term, intensive, highly coordinated, trauma- informed, and individualized intervention, provide by a TFC parent to a child or youth who has complex emotional and behavioral needs.

TARGET POPULATION

- TFC is intended for children and youth who require intensive and frequent mental health support in a family environment.
- TFC is available to children and youth, under the age of 21, who are Medi-Cal eligible and meet medical necessity criteria.

SERVICES AND ACTIVITIES:

TFC consists of one or more of the following: plan development, rehabilitation, and collateral and it is to be provided by a TFC Parent.

BUDGET:

FY 18/19:

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
N/A	N/A	N/A

FY 19/20:

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
N/A	N/A	N/A

PROGRAM DEMOGRAPHICS SERVED:

N/A

PROGRAM UPDATE:

FY 18/19:

BHRS Children's System of Care/TAY (CSOC/TAY) collaborated discussions with partner agencies (Child Welfare and Juvenile Probation) and Foster Family Agencies (FFA) in the community.

FY 19/20:

The implementation of a TFC Workgroup started in June 22, 2020 and Child Welfare participates. The plan would be to contract with an FFA for TFC.

Child Welfare and CSOC/TAY continued to meet with FFA administrators to discuss the need for TFC in Stanislaus County. There were FFAs express interested. Planned to schedule further meetings to have more in depth conversations with the FFAs that showed an interest in TFC.

OUTCOMES:

N/A

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES:

FY 18/19

- Presented to BHRS the need for TFC Program and outlined the state mandate with the goal to obtain a budget approval.

FY 19/20

- FFA administrators have expressed challenges in being able to recruit both TFC parents, as well as a licensed mental health professional to supervise the TFC parents.
- Challenges related to infrastructure in being able to provide the required oversight and Medi-Cal certification, with no additional funding.
- Multiple requirements at this time, including Continuum of Care Reform, Presumptive Transfer, POS (CANS, PSC-35), Family Urgent Response System (FURS) implementation which causes competing priorities when also needing to maintain day to day operations in programs.
- Child Welfare partner has encountered the following barriers in their discussions with the FFAs: cost of implementing TFC with no upfront funds (wait for reimbursement), liability for licensed LPHA to sign off on the TFC parent's notes, concern of continued costs to maintain the licensed LPHA during times when there is no TFC placement (homes could be lost when a child steps down from this level of service), concern regarding the direction that TFC is moving statewide and wanting to wait until further guidance is received, and current challenges in finding resource families in general (with an increased challenge in finding homes for teenagers or those needing this higher level of care).
- COVID-19 has also impacted the continued coordination and implementation of the TFC Program.

PROPOSED CHANGES

FY 18/19

- No program changes proposed.

FY 19/20

- No program changes proposed.

GARDEN GATE RESPITE/HOUSING & EMPLOYMENT O&E 02

Operated by Turning Point Community Programs

In the Consumer Family Affairs System of Care

PROGRAM DESCRIPTION

Garden Gate Respite (GGR) is an 11-bed facility open 24-hours a day, seven days a week, 365 days a year. It is a short-term residential program based on a "harm reduction" model for individuals who may be in crisis and in need of immediate shelter intervention and support services. Resources and linkages are provided such as mental health and SUD assessments, MH/SUD treatment, housing, case management, etc. Stanislaus County Behavioral Health & Recovery Services (SCBHRS), their contractors, and all local law enforcement agencies are the primary referral source. Behavioral Health & Recovery Services (BHRS) Housing and Employment Supportive Services program provides supportive services to individuals in transitional and permanent supportive housing. Housing sites consists of:

- Granger
- Bennett Place
- Miller Pointe
- Kansas House
- Palm Valley
- Garden Gate
- Courtney Manor
- Rest House
- Hope House

BHRS also houses and provides supportive service to clients in the following Transitional Board and Care facilities:

- Davis Guest Home
- Ever Well Health Systems
- Mar-Ric
- Turner Residential
- Woods Board and Care Home

BHRS provides short term shelter for clients experiencing homelessness through partnerships with the Salvation Army Berberian Low Barrier Shelter and Community Housing and Shelter Services. BHRS leveraged community strategies to reduce and prevent homelessness, increase access to shelter and housing, and improve coordination of services to individuals with SMI by partnering with the Community Services Agency and other community partners on the start-up of an Access Center and creation of the Housing and Homeless Division.

TARGET POPULATION

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

Additional target population information:

- Able to live independently
- Homeless or at risk of homelessness
- Known or suspected mental illness (GGR only) and/or co-occurring substance use disorder
- At risk for victimization, incarceration and/or psychiatric hospitalization (GGR only)

SERVICES AND ACTIVITIES

Garden Gate Respite (GGR) provides food, clothing, and shelter in a safe home-like environment to engage individuals into services through a need's assessment. GGR provides on-site case management, linkage services and coordinates access to mental health, SUD and community resources. Peer support, and groups are offered to individuals staying at the facility.

Housing supportive services provides a housing first model approach which includes an individualized housing plan. Support services may include money management, shopping/cooking, how to be a good neighbor, communicating with your landlord, etc. Additionally, the program employs a variety of outreach and engagement strategies with the overall goal to support housing retention.

Employment support services provides job readiness skills, job development and on/off site job coaching. This may include interview clothing, transportation planning, and job related tools.

BUDGET:

O&E 02 – Garden Gate Respite/Housing & Employment

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$2,788,352	890	$3,133

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$4,723,482	1014*	$4,658

**The total number served includes 64 unduplicated clients served through the Salvation Army Berberian Low Barrier Shelter and Community Housing and Shelter Services. This data was provided through our partnership with these organizations and the demographic data is not currently available. Please reference 950 unique counts as the total for demographic data provided below.*

FY 2018/2019 DEMOGRAPHICS:

Unique Client counts for OE-02 (All)

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	108	12%	113	12%
Asian	27	3%	31	3%
Hispanic	214	24%	214	23%
Native American	27	3%	27	3%
Pacific Islander	10	1%	*	<1%
White	479	54%	535	56%
Other	13	2%	15	2%
Unknown	12	1%	*	<1%
Total:	**890**	**100%**	**950**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	0	0%	0	0%
TAYA (16-25)	83	9%	88	9%
Adult (26-59)	714	80%	772	81%
Older Adult (60+)	93	11%	90	10%
Unknown	0	0%	0	0%
Total:	**890**	**100%**	**950**	**100%**

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	861	97%	929	98%
Spanish	18	2%	13	1%
Other	*	<1%	*	<1%
Unknown	*	<1%	*	<1%

Total:	**890**	**100%**	**950**	**100%**

**Due to privacy any value <10 has been removed*

PROGRAM UPDATE

FY 2018/2019:

- GGR facilitated internships and participated in the Turning Point "Career Exploration" Program to train consumers who seek careers in human services.
- In 2019, GGR supported the transition of the Modesto Outdoor Emergency Shelter (MOES) project in 2019-2020 to the new homeless program housed in the Salvation Army facility.

Housing Support Services:

- New position created for a Residential Placement Coordinator to manage placement needs and budget.
- Housing Authority allocated 30 Shelter Plus Care vouchers to SCBHRS for permanent supportive housing referrals.
- No Place Like Home round one application completed and submitted for funding for permanent supportive housing units.
- Planning began for Granger apartments (four one-bedroom units) which includes a Community Resource Center.
- Entered into agreement with Stanislaus Regional Housing Authority to rehab 15 units at Palm Valley apartments (one and two bedroom units).
- Department approved two new BHS positions due to the upcoming expansion of the housing program, additional permanent supportive housing units and increased caseloads.

Employment Services:

- No program updates to report.

FY 2019/2020:

Garden Gate:

- Managing the safety of the staff and guests during the COVID-19 pandemic
    - Created social distancing protocols – limited rooms to 2 persons max
    - Quarantined guests who showed signs/symptoms of COVID-19
    - Sanitizing procedures increased within the facilities at regular intervals
    - Posted maximum capacity of each room, in common areas

Housing Supportive services:

- Increased Transitional Board and Care placement capacity.
- Increased emergency shelter placement capacity for individuals with SMI through the Salvation Army Berberian Low Barrier Shelter. Data provided by our partnership included 89 clients that were open to BHRS services from December 2019 to June 2020. This data also indicated that clients stayed an average of 194 days per client and a total of 17,294 days.
- Began to coordinate entry to housing services for individuals with SMI through a partnership with the Community Services Agency and other community partners through the Access Center and the Housing and Homeless Division.
- Introduced the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT). This is a triage assessment tool to help objectively determine who most needs help with housing in the community.
- Opened Hope House, a four-bed short-term 28-day emergency shelter for women.
- Completed development of the Granger apartments (four one-bedroom units) which includes a Community Resource Center.
- Partnered with Wellness Peer Recovery program to provide program services at the Granger Community Resource Center.
- No Place Like Home round two application submitted and approved for funding for Kansas House housing project which included 103 units (48 BHRS designated studio apartments)
- Contracted with Turning Point's H.O.M.E. Team for landlord engagement and housing retention strategies.
- Housing staff increase, filled two vacant BHS positions and three staff reassignments to assist with increased housing inventory and client caseloads.
- Staff provided support services via phone and zoom video conference due to COVID-19 pandemic.
- HOPE House opened its door on September 5, 2019.

FY 20/21:

Garden Gate Respite:

- Continue to manage the safety of the staff/guests during COVID-19 pandemic
- Continue social distancing protocols – limited rooms to two persons max
- Forehead temperature self-check stations at the entrances of each house
- Encourage the use of, and provide masks to all incoming visitors and guests
- Provide hand sanitizer and sanitation wipes and entrances
- Survey all referred guests for COVID-19 symptoms as intake protocol
- Quarantine guests showing signs and symptoms of COVID-19, per public health

Housing Supportive Services:

- Staff continued with remote work due to COVID-19
- Staff went back to providing site hours at housing site with appropriate PPE

OUTCOMES:

MHSA Outcomes for O&E-02 / GGR, Housing & Employ Combined

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	890	950
Average number of clinical services per individual*	2 (2,016/890)	3 (2,707/950)
Average number of support services per individual*	1 (2,207/890)	3 (2,963/950)
How Well?		
% of annual target of individuals served*	481% (890/185)	513% (950/185)
Average length of GSD services – days*	292 (260,036/890)	305 (290,208/950)
% of surveyed individuals were satisfied with services**	98% (51/52)	89% (40/45)
% of surveyed individuals said that "staff believed I could change"**	98% (47/48)	88% (36/41)
Better Off?		
% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**	90% (45/50)	64% (27/42)
% of surveyed individuals indicated that as a result of services, they feel they belong to their community**	58% (30/52)	51% (24/47)
% of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services**	88% (262/297)	80% (203/254)

Data sources:
*Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database
**State Satisfaction survey results from November 2018 & May 2019 survey period and November 2019 & June 2020

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES

FY 18/19

Garden Gate Respite:

- Scheduling all-staff meetings/trainings while never closing the program.
    - We have partnered with Turning Point Peer Navigator Team to help support our guests while 2-hour all-staff meeting is conducted twice monthly.
- Lack of private space for intakes, clinical discussions, staff paperwork and conversations, outside agency documentation and conversations, and staff to guest 1:1 conversation.
    - Exploring/ looking for potential new space for the program to move to.
- Managing exposure to bedbugs while maintaining high volume of guest turnover rate.
    - Incorporated a bedbug oven into the intake system at GGR, heating items unable to be laundered to 122 degrees for two to four hours before allowing those items to be brought into the guest's bedroom.

Housing Supportive Services:

- Individuals with subsidies can't find vacant units due to the shortage of affordable housing

Employment Supportive Services:

- Clients couldn't seek employment opportunities due to Shelter in Place Order

FY19/20

Garden Gate Respite:

- Covid-19 – Mitigating risks
    - Provided masks to all incoming visitors and guests
    - Taking all visitors and guests' forehead temperatures
    - Survey all referred guests for COVID-19 symptoms
    - Quarantined guests testing positive for COVID-19, per public health direction
    - Created a separate quarantine room in one house in case a guest begins to show signs/symptoms of COVID-19

Housing Supportive Services:

- Clients could not seek permanent housing units in the community due to shelter in place order.

Employment Supportive Services:

- Clients couldn't seek employment opportunities due to shelter in place order.

PROPOSED CHANGES

FY 18/19

Garden Gate

- Adjusted staff meeting coverage
- Incorporated beg bug protocol

Housing Supportive Services

- Design and fund a HOME team for additional support
- Hire additional staff to meet client needs
- Develop position for monitoring IMD/Transitional Board & Care placements
- Propose plan for women's SHORT-TERM transitional shelter

FY 19/20

Garden Gate Respite

- Implemented protocols for COVID-19

Housing Supportive Services

- Implemented protocols for COVID-19
- HOME team-initiated landlord engagement strategies

Employment Supportive Services

- Resume job development

PROPOSED CHANGES

FY 18/19

Garden Gate

- Adjusted staff meeting coverage
- Incorporated beg bug protocol

Housing Supportive Services

- Design and fund a HOME team for additional support
- Hire additional staff to meet client needs
- Develop position for monitoring IMD/Transitional Board & Care placements
- Propose plan for women's SHORT-TERM transitional shelter

FY 19/20

Garden Gate Respite

- Implemented protocols for COVID-19

Housing Supportive Services

- Implemented protocols for COVID-19
- HOME team-initiated landlord engagement strategies

Employment Supportive Services

- Resume job development

Outreach and Engagement O&E 03

Operated by Telecare Corporation in the
SCBHRS Adult/Older Adult System of Care

PROGRAM DESCRIPTION

The Outreach and Engagement Team provides brief counseling intervention and engagement services that actively seek out, engage, assess, and refer individuals with serious mental illness to appropriate service providers and community supports within Stanislaus County's rural communities.

TARGET POPULATION

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

SERVICES AND ACTIVITIES:

Outreach & Engagement (rural access)team provides services to individuals in rural areas of Stanislaus County. This team provides brief individual counseling intervention and engagement services that actively seek out, engage, assess, and refer individuals with serious mental illness to appropriate service providers and community supports. Clients engaged by the O&E team will be opened to a tracking unit and will have direct access and referrals to all levels of care within BHRS programs.

Latino Access program team provides community access and supports as well as assessment and brief counseling interventions. The team uses outreach and engagement strategies to serve the Spanish speaking community. The Latino Access team closely collaborates with the Stanislaus County Promotores Network, ethnic/cultural mental health service providers, and integrated health/behavioral health partners. The Latino Access team prioritizes services to this network of partners.

The CARE initiative team is the newest addition to the Outreach and Engagement program. The CARE team is a cross-sector, cross-agency, multi-disciplinary team. This team focuses on helping to restore the individuals in our community causing the most significant distress in our community and for themselves. This team targets those individuals not connected or engaged in services, often struggling with; high-risk health and safety behaviors, vagrancy-related criminal behavior, severe and persistent mental illness and substance use disorders. Multiple agencies will be partaking in this initiative such as police officers, firefighters-paramedics, probation officers, public health nurses, deputy district attorneys, public defenders, clinicians and case managers among other agency collaborates.

In the FY 19-20, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 19-20 is 110 individuals.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

BUDGET (TABLE FORMAT):

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$457,772	644	$711

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$394,904	762	$518

PROGRAM DEMOGRAPHICS SERVED:

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
African American	37	6%	52	7%
Asian	14	2%	16	2%
Hispanic	104	16%	112	15%
Native American	11	2%	13	2%
Pacific Islander	*	<1%	*	<1%
White	249	39%	293	38%
Other	*	<1%	*	1%
Unknown	222	35%	266	35%
Total:	**644**	**100%**	**762**	**100%**

**Due to privacy any value <10 has been removed*

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	*	<1%	*	<1%
TAYA (16-25)	62	10%	57	7%
Adult (26-59)	535	83%	645	85%
Older Adult (60+)	44	7%	58	8%

Unknown	0	0%	0	0%
Total:	**644**	**100%**	**762**	**100%**

**Due to privacy any value <10 has been removed*

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	449	70%	538	71%
Spanish	*	*	*	*
Other	*	<1%	*	<1%
Unknown	184	29%	208	27%
Total:	**644**	**100%**	**762**	**100%**

**Due to privacy any value <10 has been removed*

Data Source:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database

PROGRAM UPDATE:

FY 18/19:

- Co-creators of the CARE Team which was a new strategy of outreach and engagement deployed into the rural areas.

FY 19/20:

- No program updates.

OUTCOMES:

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
Individuals served*	644	762
Average number of clinical services per individual*	.2 (126/644)	.15 (113/762)
Average number of support services per individual*	2 (1,271/644)	1 (895/762)

How Well?		
% of annual target of individuals served*	586% (644/110)	693% (762/110)
Average length of O&E services – days*	177 (114,203/644)	230 (218,009/762)

Data sources:

- *Anasazi Data Warehouse 03/11/2020 for FY 18/19 and 12/2/2020 for FY 19/20 (calculation) access database

CHALLENGES/BARRIERS & STRATEGIES TO MITIGATE

FY 18/19

- The Mental health/SUD connection is a continual challenge for some clients. For clients where there is co-occurring mental health and SUD challenges, when clients refuse to receive SUD services, their mental health outcomes are affected.
- Additionally, for those who are willing to participate in SUD treatment, there is a shortage of SUD placement opportunities and a need for ongoing placement services after they complete. Often without additional supportive housing/treatment services, these clients can have more barriers to maintaining their sobriety and program success.

FY19/20

- Challenges existed for clients concerned about around receiving services due to fear of contracting COVID-19. For clients who may have been willing to receive supportive services but didn't have access to a phone. Teams continued to do their best to stay engaged with clients despite the challenges.
- Once linked to mental health treatment, clients referred to mild to moderate services by the Outreach Team express that childcare and transportation were barriers to them remaining in treatment.
- A larger number of T-Cons and permanent conservatorships entered the SHOP program and it made difficult to find placement for these individuals due to the high demand for adult residential facility placements.

PROPOSED CHANGES

FY 18/19

- No program changes proposed.

FY 19/20

- No program changes proposed.

Prevention and Early Intervention (PEI)

PROGRAM DESCRIPTION

Prevention & Early Intervention is the second-largest component of MHSA and represents 20% of MHSA funding. Per MHSA regulations, at least 51% of PEI funding must be dedicated to serving individuals 25 years or younger (California Code of Regulations, Title 9, § 3706 (b)). The programs are designed to prevent mental illness from becoming severe and disabling by recognizing the early signs and symptoms and improving access to services and programs. PEI's work is guided by MHSA values, the PEI regulations and the community planning process which includes stakeholder input. Each PEI program has a unique approach that incorporates community-based, promising practices or evidence-based strategies and the MHSA values of cultural competency, community collaboration, wellness, recovery/resiliency, client/family-driven services, and integrated service experience.

Prevention and Early Intervention programs provide a full spectrum of services for children/youth, adults and older adults who are either at-risk for or experiencing mental illness early in its emergence. These services collectively work to prevent mental illness from becoming severe and disabling through early recognition, and access and linkage to appropriate levels of services within the mental health system.

As noted in previous MHSA Annual Updates and Three-Year Program and Expenditure Plans, BHRS has continuously worked towards ensuring that required state policy and process changes, specifically affecting PEI, are aligned within PEI programs. As such, PEI structured and redesigned programs to be focused on coordinated and consistent program results and outcomes to strengthen all MHSA PEI programs. The restructuring plan also included changes on how programs report data. These processes and structures are continuous and driven by required state policy and process changes along with community need.

Recent change in state law by Senate Bill 1004 (Chapter 843, Statutes of 2018) established priorities and a statewide strategy for prevention and early intervention services. The goal of this effort was to create a more focused approach to delivering effective prevention and early intervention services and increasing coordination and collaboration across communities and mental healthcare systems. The following priorities were established:

- Childhood trauma prevention and early intervention at the origins of mental health needs
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention across the lifespan
- Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnerships with college mental health programs

- Culturally competent and linguistically appropriate prevention and intervention services and strategies
- Strategies targeting the mental health needs of older adults

Outreach, engagement, and access and linkage activities are integrated into PEI programs to increase the effectiveness of the services. PEI regulations require that at least one program is dedicated to access and linkage. Aging and Veteran Services has been identified as the program with this focus and is described within this section. However, all PEI programs incorporate access and linkage activities and strategies.

In addition, all PEI programs are committed to providing services that embrace the MHSA general standards:

- Community Collaboration
- Cultural Competence
- Client Driven
- Family Driven
- Wellness, Recovery, and Resiliency Focused
- Integrated Service Experiences for clients and their families

In Stanislaus County, the majority of PEI funded services are contracted out to our local community-based service providers, and many providers have more than one contracted PEI program to implement in communities across Stanislaus County.

The following illustrates how PEI programs are structured and categorized based on PEI regulations, in addition to what strategies and methods are required:

Prevention Programs are a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Universal prevention may be used in prevention programs if there is evidence to suggest that universal prevention is an effective method for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average.

Early Intervention Programs means treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness (suicide, incarcerations, school failure or dropout, unemployment, homelessness, and removal of children from their homes).

- Services shall not exceed 18 months (with exception of first onset of SMI/SED with psychotic features – 4 years)
- Early Intervention services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness

- An Early Intervention program may be combined with a Prevention program
- All strategies listed in "required strategies" must be included

Outreach for Increasing Recognition of Early Signs of Mental Illness Program(s) is a process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness." Outreach may include reaching out to individuals with signs and symptoms of a mental illness, so they can recognize and respond to their own symptoms. It may also be a stand-alone program, a strategy within a prevention program, a strategy within an early intervention program, or a strategy within another program funded by PEI funds, or a combination thereof potential responders such as families, employers, primary health care providers, visiting nurses, school personnel, community service providers, peer providers, cultural brokers, law enforcement personnel**,** emergency medical service providers, people who provide services to individuals who are homeless, family law practitioners such as mediators, child protective services, leaders of faith-based organizations, and others in a position to identify early signs of potentially severe and disabling mental illness, provide support, and/or refer individuals who need treatment or other mental health services.

Stigma and Discrimination Reduction Programs means the County's direct 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 to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families. This must include approaches that are culturally congruent with the values of the populations for whom changes in attitudes, knowledge, and behavior are intended. Some examples of stigma and discrimination reduction programs include, social marketing campaigns, speakers' bureaus and other direct-contact approaches, targeted education and training, anti-stigma advocacy, web-based campaigns, efforts to combat multiple stigmas that have been shown to discouraged individuals from seeking mental health services, efforts to encourage self-acceptance for individuals with a mental illness.

Suicide Prevention Programs (optional per regulations) means organized activities that the County undertakes to prevent suicide as a consequence of mental illness. This category of programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness. Suicide prevention activities that aim to reduce suicidality for specific individuals at risk of or with early onset of a potentially serious mental illness can be a focus of a Prevention or an Early Intervention program. Examples of suicide prevention programs include, public and targeted information campaigns, suicide prevention networks, capacity building programs, culturally specific approaches, survivor-informed models, screening programs, suicide prevention hotlines, web-based suicide prevention resources, and training and education.

Access and Linkage to Treatment means connecting children with severe mental illness, and adults and seniors with severe mental illness 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. Examples of access and linkage to treatment programs include, programs with a focus on screening, assessment, and referrals, telephone help lines, or with a focus on mobile response.

Required Strategies and Methods for PEI Programs:

Required Strategies in prevention, early intervention, outreach for increasing recognition of early signs of mental illness, stigma and discrimination reduction, access and linkage to treatment, and suicide prevention (optional) programs include designing and implementing programs to help create access and linkage to treatment. Programs must also be promoted in ways that improve timely access to mental health services for individuals and/or families from underserved populations. Additionally, programs must be implemented and promoted using strategies that are non-stigmatizing and nondiscriminatory. Services shall be provided in convenient, accessible, acceptable, culturally appropriate settings (public settings) unless a mental health setting enhances access to quality services and outcomes for underserved populations.

Required methods must be likely to bring about intended outcomes, based on one or more of the following standards: evidence-based practice, promising practice, and community and/or practice-based evidence.

PEI BUDGET:

FY 18/19

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$4,134,395	5,092	$812

FY 19/20

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$4,929,733	5,909	$834

PREVENTION

PREVENTION PROGRAM DESCRIPTION

Prevention programs provide services to children/youth, adults and older adults who are either at-risk for or experiencing mental illness early in its emergence or who are at-risk for developing a serious mental illness. Prevention programs provide a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of prevention programs is to provide mental health resources, support, and services.

Prevention programs focus on the following:

- Implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness
- Pursue policy and community change that supports positive cognitive, social and emotional development and encourages a state of well-being
- Champion efforts to train individuals to be able to recognize and support fellow community members impacted by mental health
- Foster communities free of stigma in which persons affected by mental illness are able and willing to seek services

Prevention outcomes include reducing the applicable adverse effects as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is significantly greater than average and, as applicable, their parents, caregivers, and other family members.

TARGET POPULATION

- Children and Youth – age range 0 to 15
- Transitional Age Young Adults – age range 16-25
- Adults – age range 26-59
- Older Adults – age 60+
- Individuals at-risk for serious mental illness or exhibiting onset of serious mental illness or displaying mental illness early in its emergence and/or;
- Families of individuals in the underserved/unserved, at-risk population;
- Additional target populations include: Latino/Hispanic, Asian Pacific Islander, African American, Assyrian, Middle Eastern, the refugee community, and Lesbian, Gay, Bi-Sexual, Transgender, and Questioning (LGBTQ) individuals.

SERVICES AND ACTIVITIES

Prevention programs provide services that reduce risk factors and increase protective factors. These services include one-to-one support, screenings, referrals and behavioral health navigation assistance, presentations, training, and other engagement and outreach activities. Similar to

early intervention programs, all prevention programs are designed and implemented to help create access and linkage to treatment and improve timely access to mental health services for individuals and families from underserved populations when appropriate. Services are provided in convenient, accessible, and culturally appropriate settings using strategies that are non-stigmatizing and non-discriminatory.

PREVENTION PROGRAMS FY 2018-2019

- RAIZ Promotores Programs Operated By:
    - AspiraNet
    - Center For Human Services
    - Sierra Vista
    - West Modesto King Kennedy Center
    - Oak Valley Hospital-Family Support Network
    - Riverbank Unified School District-Casa De Rio Healthy Start Program
- Friends Are Good Medicine Operated By:
    - Stanislaus County Behavioral Health and Recovery Services
- Prevention Operated By:
    - Resiliency and Prevention Program (RaPP) operated by Center for Human Services

PREVENTION PROGRAMS FY 2019-2020

- RAIZ Promotores Programs Operated By:
    - AspiraNet
    - Center For Human Services
    - Sierra Vista
    - Oak Valley Hospital-Family Support Network
    - Parent Resource Center
- Friends Are Good Medicine Operated By:
    - Stanislaus County Behavioral Health and Recovery Services
- Prevention Operated By:
    - Youth Assessment Center (YAC) operated by Sierra Vista
- Child and Youth Resiliency
- Community Faith Based Mental Health*
- Afghan Path Towards Wellness Operated By:
    - International Rescue Committee

PREVENTION PROGRAMS DESCRIPTIONS:

RAIZ Promotores Program

The County defines RAIZ ("roots") as *Realizando Alizanzas e Inspirando Sabiduría*, which translates to "*Creating Alliances and Inspiring Wisdom*." Promotores focus on various strategies to work particularly closely with the Latino communities throughout Stanislaus County. The program also has a strong focus on promoting prevention focused and community based behavioral health education and activities, particularly in communities historically underserved/unserved for individuals and families of individuals at risk of exhibiting onset of serious mental illness or displaying mental illness early in its emergence. The Promotores promote behavioral health and well-being, build protective factors to reduce the risk of developing a potentially serious mental health condition, and link those experiencing early onset of serious mental illness to appropriate services. A Promotor represents a rich spectrum of characteristics that facilitate natural communities of support as leaders in their communities and non-clinical providers. Promotores are the bridge between behavioral health care institutions, professional providers, and community residents.

Friends are Good Medicine

A county-wide directory to publicize support groups and encourage emotional health. The directory's focus is to provide updated peer support information and promote the concept of self-help in both the general and professional community. Friends Are Good Medicine provides a wide range of support groups including, Spanish speaking well-being groups and mental and emotional health groups. Resources are continuously changing, given it is a peer-led network. The directory is offered as an online resource. It is printed and distributed throughout Stanislaus County. Stanislaus County BHRS supports the printing in both English and Spanish as the reproduction of this valuable guide.

Prevention

Operated by Center for Human Services and Sierra Vista Youth Assessment Center:

- **Resiliency and Prevention Program (RaPP)** operated by the Center for Human Services Agency: The RAPP program is designed to facilitate classroom-based prevention practices, individual student support sessions, parent-based presentations, parent engagement processes, parent support sessions, and parent/community activities focused on the capacity-building of well-being focused groups in Stanislaus County.
- **Youth Assessment Center (YAC)** operated by Sierra Vista: The YAC program is a joint three-year pilot project partnership between Stanislaus County Behavioral Health and Recovery Services Prevention and Early Intervention, Stanislaus County Juvenile Probation Department, and Sierra Vista Child & Family Services Family Resource Center. The projects' goal is to engage identified youth from

targeted communities who are involved in the juvenile justice system with low criminal offenses, and to prevent youth and their families from formally entering into the justice system by providing effective, community-based prevention services.

Child and Youth Resiliency

When a provider is determined, the program will serve youth ranging from ages 12-25 from culturally and geographically unserved, underserved and at-risk populations throughout Stanislaus County. The program will target youth who are at risk of school failure, substance abuse, mental illness, social inequality, exposed to violence and/or involvement with the juvenile justice system. The program will create opportunities that promote bonding, foster resilience, strengthen social and emotional competence and develops relationships/partnerships with the larger community.

Note: Pending provider for Child and Youth Resiliency to be determined in FY 2020-2021

Afghan Path Towards Wellness

The program serves Special Immigrant Visa (SIV) holder adult women from Afghanistan and mothers of families who are experiencing some level of psychosocial challenges. The program provides screenings for post-traumatic stress disorder (PTSD), anxiety, and/or depression, emotional distress, social adjustment and more. Support groups and referrals are offered to behavioral health services. Efforts in the areas of mental health and stigma play a large role in the program and a cultural broker model is also part of this framework. To date, SCBHRS has not identified any other organization(s) that have the capacity or history in providing this specific culturally congruent service to the Afghan refugee residents of Stanislaus County.

***Community Faith-Based Mental Health Prevention Program**

Initially, added for funding in FY 2019-2020 then concluded in the same year due to planning efforts listed in the Executive Summary.

PREVENTION PROGRAMS BUDGET:

FY 2018-2019

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$1,089,492	1,582	$689

FY 2019-2020

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$1,248,027	1,661	$751

Prevention Program Demographics
FY 18/19 AND FY 19/20

Race	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
American Indian/Alaska Native	*	<1 %	*	<1%
Asian	*	<1%	52	3%
Black/African American	19	1%	*	<1%
Native Hawaiian/Pacific Islander	-	0%	-	0%
White	923	58%	903	54%
More than one race	*	<1%	11	1%
Other	321	20%	369	22%
Unknown	308	20%	318	19%
Total:	**1,582**	**100%**	**1,661**	**100%**

**Due to privacy any value <10 has been removed*

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Hispanic or Latino	1527	96%	1,578	95%
Non-Hispanic or Latino	42	3%	67	4%
Declined/Unknown	13	1%	16	1%
Total:	**1,582**	**100%**	**1,661**	**100%**

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	97	6%	169	10%
TAYA (16-25)	71	5%	68	4%
Adult (26-59)	806	51%	850	51%
Older Adult (60+)	114	7%	115	7%
Unknown	494	31%	459	28%
Total:	**1,582**	**100%**	**1,661**	**100%**

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	148	9%	124	7%
Spanish	1421	90%	1477	89%
Other	*	<1%	53	3%
Unknown	10	1%	*	<1%
Total:	**1,582**	**100%**	**1,661**	**100%**

**Due to privacy any value <10 has been removed*

Gender	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Male	48	3%	97	6%
Female	1441	91%	1485	89%
Genderqueer	0	0%	0	0%
Questioning/Unsure	0	0%	*	<1%
Transgender	0	0%	0	0%
Another	0	0%	0	0%

Unknown	93	6%	78	5%
Total:	**1582**	**100%**	**1661**	**100%**

**Due to privacy any value <10 has been removed*

PROGRAM UPDATE:

FY 18/19:

- An additional RAIZ Promotores Program, the Center for Human Services, was added in response to the stakeholders' feedback to promote prevention focused and behavioral health education in the Modesto Airport neighborhood community. As a result, the added RAIZ Promotores Program will allow for a geographical expansion in the rural areas of the County.

FY 19/20:

- PEI partnered with the Juvenile Probation Department to pilot a statewide model known as the Youth Assessment Center. The primary goal of this program is to engage with youth and provide mental health support services. The initiative was launched in November 2019. This effort is in alignment with priority areas listed in Senate (SB) Bill 1004.

OUTCOMES:

PREVENTION

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
# Promotores Program Participants	1,582	1,607
# Services Provided	25,076	20,646
# Services Dedicated to Promotores Development	1,434	386
# Services Focused on Leadership	1,200	306
# One-on-one Support Sessions	1,736	1,595
# Information & Referral Services	1,006	1,009
# Presentations Given Through All PEI Programs	636	769
How Well?		
# Referrals Made by Promotores Programs	346	499

#/% Presentations Covering the Topic of Accessing Behavioral Health Services	531/83%	706/92%

Better Off?

As a result of participating in these programs, individuals have reported:

- Becoming more involved in their community
- Improvement in their wellbeing
- Creating meaningful relationships

CHALLENGES/BARRIERS & STRATEGIES TO MITIGATE

FY 18/19

- The Prevention Program outlined Youth Resiliency which due to Departmental priorities in FY 2018-2019 remained without the determination of a contracted partner.

FY 19/20

- During the last quarter of 2019-2020, COVID-19 created an increased need to support the PEI target populations, specifically, the Latino community. During this time the Latino community was testing positive for COVID-19 at a disproportioned rate in comparison to all other groups in Stanislaus County. The Promotores faced multiple challenges engaging this hard to reach community. Due to distancing requirements "In person" engagement was impacted and the transition to provide a virtual platform proved to be challenging. Despite the many challenges, the Promotores strived to overcome these barriers by demonstrating passion, creativity, and dedication to their communities.

PROPOSED CHANGES:

FY 18/19

- Expanded partnerships with Community Based Cultural Collaboratives for the purpose of learning further about the mental health needs of our culturally and ethnically diverse community. SCBHRS relied on the community planning process to inform the next steps related to this work.

FY 19/20

- The Executive Summary, in this Plan and Update, provides departmental strategies that were utilized to align PEI and other service delivery components.

EARLY INTERVENTION

EARLY INTERVENTION PROGRAM DESCRIPTION

Early Intervention (EI) programs provide treatment and other services and interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence. The services can include relapse prevention and outcomes encompass the decrease of applicable negative outcomes that may result from untreated mental illness such as suicide, incarcerations, school failure or dropout, unemployment, homelessness, and removal of children from their homes.

Treatment services are designed for adolescents that are accessing mental health services for the first time or have had an undertreated severe emotional disturbance episode. The program provides intensive treatment services for up to 18 months, with the aim of supporting program participants move to a lower level of care and access community supports. For clients that need treatment services beyond the 18 months, they will are referred to and continue services through an appropriate level of care. Early Intervention Programs include the following:

TARGET POPULATION

- Children and Youth – age range 0 to 15
- Transitional Age Young Adults – age range 16-25
- Adults – age range 26-59
- Older Adults – age 60+
- Individuals at-risk for serious mental illness or exhibiting onset of serious mental illness or displaying mental illness early in its emergence and/or;
- Families of individuals in the underserved/unserved, at-risk population;
- Additional target populations include: Latino/Hispanic, Asian Pacific Islander, African American, Assyrian, Middle Eastern, the refugee community, and Lesbian, Gay, Bi-Sexual, Transgender, and Questioning (LGBTQ) individuals

SERVICES AND ACTIVITIES

Early Intervention (EI) services are time-limited services that should not exceed 18 months, except for the first onset of SMI/SED with psychotic features (4 years). EI can also include services to parents, caregivers, and other family members of the person with early onset of mental illness. Also, all EI programs are designed and implemented to help create access and linkage to treatment and improve timely access to mental health services for individuals and families from underserved populations when appropriate. EI support services are for individuals with early onset of serious mental illness to promote mental health outcomes including recovery, wellness, and resilience. Services are provided in convenient, accessible, and culturally appropriate settings using strategies that are non-stigmatizing and non-discriminatory.

One of the primary services in all the Stanislaus County EI programs is Brief Intervention Counseling (BIC). Brief Intervention Counseling is short duration and low intensity and can be provided via individual sessions or group sessions. Collateral services to parents or other family members may also be part of BIC. Most Early Intervention programs provide services focusing on depression and anxiety through Brief Intervention Counseling, and the PHQ-9 is used to help determine depression symptoms. However, LIFE Path services target those with early onset of psychosis (prodromal), and ART also targets students with early onset of SED. LIFE Path uses the Structured Interview for Prodromal Symptoms and Scale of Prodromal Symptoms (SIPS/SOPS) to determine the early onset of psychosis.

EARLY INTERVENTION PROGRAMS FY 2018-2019

- Brief Intervention Counseling (BIC) Operated By:
    - Sierra Vista Child and Family Services – serving Central and West Modesto, Denair, Empire & Key, and South Modesto
    - El Concilio – serving Waterford, Oakdale, and Riverbank
    - Golden Valley Health Centers
    - Catholic Charities – serving Newman, Crows Landing, Grayson and Patterson
    - International Rescue Committee: Afghan Pathway to Wellness
- Expanded Child Sexual Abuse Prevention Early Intervention Operated By:
    - Parents United – Child Sexual Abuse Treatment Services, Dr. Debra Johnson
- Sierra Vista- LIFE Path, Early Psychosis Operated By:
    - Sierra Vista Child and Family Services
    - Center for Human Services
- School Behavioral Health Integration Operated By:
    - Aggression Replacement Training (A.R.T.) operated by Stanislaus County Behavioral Health and Recovery Services
    - School Based Consultation Services operated by Stanislaus County Behavioral Health and Recovery Services
    - School Consultation Behavioral Health Integration (SCBHI) Operated by Center for Human Service

EARLY INTERVENTION PROGRAMS FY 2019-2020

- Brief Intervention Counseling (BIC) Operated By:
    - Sierra Vista Child and Family Services – serving Central and West Modesto, Denair, Empire & Key, and South Modesto
    - El Concilio – serving Waterford, Oakdale, and Riverbank
    - Golden Valley Health Centers
    - Catholic Charities – serving Newman, Crows Landing, Grayson and Patterson
    - International Rescue Committee: Afghan Pathway to Wellness
- Parents United – Child Sexual Abuse Treatment Services Operated By:

    - Parents United – Child Sexual Abuse Treatment Services, Dr. Debra Johnson
- Sierra Vista- LIFE Path, Early Psychosis Operated By:
    - Sierra Vista Child and Family Services
    - School Consultation Behavioral Health Integration (SCBHI) Operated by Center for Human Service
- School Behavioral Health Integration
    - Aggression Replacement Training (A.R.T.) operated by Stanislaus County Behavioral Health and Recovery Services
    - School Based Consultation Services operated by Stanislaus County Behavioral Health and Recovery Services
    - School Consultation Behavioral Health Integration (SCBHI) Operated by Center for Human Service
    - Center for Human Services - Resiliency and Prevention Program (RAPP) and School Consultation Behavioral Health Integration (SCHBI)
- Homeless Prevention and Early Intervention Team*

EARLY INTERVENTION PROGRAMS DESCRIPTIONS:

Brief Intervention Counseling (BIC)

BIC is short duration and low intensity and can be provided via individual sessions or group sessions. Collateral services to parents or other family members may also be incorporated in BIC services. Treatment and other services, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Services may be provided to individuals with early onset mental illness and/or their family members and typically do not exceed 18-month duration. BIC serves target groups including adults, older adults, children, youth, and transitional age youth, including Latino and Spanish speaking, and the homeless population.

Parents United - Child Sexual Abuse Treatment Services

This program provides sexual abuse treatment services to address the trauma associated with child sexual abuse primarily to underserved/unserved cultural populations (trauma exposed individuals, adults sexually abused as children, and sexual abuse offenders, including Latino and Spanish speaking). Parents United offers one-on-one and group therapy, family treatment when appropriate, and a variety of classes ranging from positive parenting, anger management, assertiveness training and domestic violence. The program also operates a 24/7 warm line in English and Spanish for individuals and families affected by child sexual abuse.

LIFE Path, Early Psychosis

Life Path provides early psychosis and mood disorder detection, and early intervention services in accordance with SB 1004. Services focus on staff training and community outreach and

engagement. Target population individual/family/couples' therapy, multi-family group, social skills groups, collateral services for family members, case management; and clinical screenings, and psychoeducational presentations. Targeted population served includes ages 14 to 25 experiencing symptoms of clinical high-risk for psychosis or within the first year of a psychotic break, and their family members.

Aggression Replacement Training (A.R.T.)

A.R.T is a cognitive behavioral intervention program to help children and adolescents improve social skill competence and moral reasoning, better manage anger, and reduce aggressive behavior. The program specifically targets chronically aggressive children and adolescents. ART has been implemented in schools and juvenile delinquency programs across the United States and throughout the world. The program consists of 10 weeks (30) sessions of intervention training and is divided into three components --- social skills training, anger-control training, and training in moral reasoning. The program was first developed for aggressive and violent adolescents aged 12 to 17 who were incarcerated in juvenile institutions. ART has now been adapted for children and youth in schools and mental health centers to reduce aggressive and antisocial behavior and to promote anger management and social competence.

Resiliency and Prevention Program (RaPP)

RaPP program services focus on student assistance services which include facilitating classroom-based prevention practices, individual student support sessions, parent-based presentations and parent engagement processes, parent support sessions, and parent/community engagement activities focused on capacity-building of well-being/resilience focused groups. This program focuses on mental health and well-being, resiliency and promoting protective factors. The program serves the following school districts in Stanislaus County: Bret Harte Elementary School and Shackelford Elementary School and the surrounding community.

School Based Consultation Services

This program provides onsite mental health services by SCBHRS Mental Health clinicians at Empire Union School District and Orville Wright Elementary. SCBHRS Mental Health clinicians provide mental health consultation services and training for school site staff to support them in addressing individuals and school-wide mental health concerns and issues. Mental Health Clinicians also provide individuals and groups brief intervention counseling for students. These two schools' sites are located within unserved/underserved priority population communities.

School Consultation Behavioral Health Integration (SCBHI)

SCBHI school consultation is a comprehensive approach to school based mental health services. Services include consultation for TK-12 grade students, their parents, and other family members, teachers, student support individuals, and other school-based staff; brief intervention counseling, individual and small groups with students; community and engagement with the surrounding school/district community. Integrated access and linkage strategies include

connecting students, parents, caregivers, guardians and other family members to appropriate mental health agencies, community support, and resources.

***Homeless Prevention and Early Intervention Team**

Initially, added for funding in FY 2019-2020 then concluded in the same year due to planning efforts listed in the Executive Summary.

EARLY INTERVENTION PROGRAM BUDGET

FY2018-2019

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$1,688,447	3,245	$520

FY 2019-2020

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$2,261,917	4,039	$560

Early Intervention Program Demographics
FY 18/19 AND FY 19/20

Race	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
American Indian/Alaska Native	17	1%	18	<1%
Asian	27	1%	27	1%
Black/African American	105	3%	84	2%
Native Hawaiian/Pacific Islander	*	<1%	*	<1%
White	1732	53%	2,325	57%
More than one race	25	<1%	15	<1%
Other	496	15%	485	12%
Unknown	837	26%	1,076	27%
Total:	**3,245**	**100%**	**4,039**	**100%**

**Due to privacy any value <10 has been removed*

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Hispanic or Latino	2,155	66%	2,546	63%
Non-Hispanic or Latino	635	20%	709	18%
Declined/Unknown	455	14%	784	19%
Total:	**3,245**	**100%**	**4,039**	**100%**

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	973	30%	922	23%
TAYA (16-25)	348	11%	449	11%
Adult (26-59)	1,120	34%	1502	37%
Older Adult (60+)	163	5%	200	5%
Unknown	641	20%	966	24%
Total:	**3,245**	**100%**	**4,039**	**100%**

Language	**Individuals Served FY 18/19**		**Individuals Served FY 19/20**	
	Number	**Percentage**	**Number**	**Percentage**
English	**1,632**	**50%**	**1875**	**46%**
Spanish	**1,410**	**43%**	**1668**	**41%**
Other	**21**	**1%**	**22**	**1%**
Unknown	**182**	**6%**	**474**	**12%**
Total:	**3245**	**100%**	**4,039**	**100%**

Gender	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Male	845	26%	1045	26%
Female	1667	51%	2359	58%
Genderqueer	0	0%	*	<1%
Questioning/Unsure	*	<1%	*	<1%
Transgender	*	<1%	*	<1%
Another	*	<1%	*	<1%
Unknown	723	22%	627	15%
Total:	**3,245**	**100%**	**4,039**	**100%**

Program Update:

FY 18/19:

- Stanislaus County issued a Request for Proposal for the provision of Community-Based Early Intervention Services to establish Mental Health Prevention and Early Intervention Brief Counseling (BIC) programs in five (5) different geographical areas. The BIC contracted services began providing a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity.
- An agreement with International Rescue Committee (IRC) for Afghan Path Towards Wellness program was contracted in response to the stakeholder's interest in supporting the Afghan Community. As a result, the intersection of mental health and well-being within the Afghan community allowed for individual and social adjustment groups. IRC was the only program of its kind within Stanislaus County providing this type of support.

FY 19/20:

- During FY 2019-2020, School Consultation Behavioral Health Integration expanded through an RFP process. Additional services are now available through a contracted agency that provides family-focused, culturally and linguistically competent, strength-based, comprehensive, data-driven, and integrated mental health services to more children, youth and their families in the Airport, Empire, Turlock, Chatom, and Newman-Crowslanding school districts.
- Resiliency and Prevention Program (RaPP) was included with Brief Intervention Counseling (BIC) then was moved to the Early Intervention category (reported through the ARER). The shift was made as a response to activities focused on capacity building of well-being and resilience focused groups.

OUTCOMES:

EARLY INTERVENTION

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
# Unique Individuals Served	3,245	4,039
# Services Provided	14,198	16,966
# Brief Intervention Counseling Services Provided	3,982	3,470
How Well?		
# Services Provided to Family Members	691	1,027
#/% Early Intervention Services Provided Outside of the Office	8,244/64%	8,198/60%
Average # of Counseling Services per Individual	3	3
Better Off?		
#/% Individuals that Indicated a Decrease in Depression Severity After Receiving Brief Intervention Counseling	147/69%	150/68%
#/% Youth that Demonstrated an Improvement in Resilience	112/44%	63/46%

CHALLENGES/BARRIERS & STRATEGIES TO MITIGATE:

FY 18/19

- There are ongoing and increasing requests from school districts throughout the county for school behavioral health services, and Early Intervention programs has not been able to fulfill this at the level requested. Stakeholder feedback was requested and will be used to inform next steps.

FY 19/20

- Brief Intervention Counseling providers started facing challenges in no-shows as well as a decrease in client referrals prior to the pandemic. Additional challenges emerged during the last reporting quarter from COVID-19, including low client participation due to lack of knowledge of how to utilize virtual platforms, limited or no access to internet resources, or struggle to find a confidential space without interruptions.

PROPOSED CHANGES:

18/19

- Early Intervention programs continue to explore the increased interest of school behavioral health consultation through strengthening partnerships with education partners county-wide as well as SCBHRS Children's System of Care Division. The proposed change was to increase messaging to the public on how to access behavioral health services overall. This would most likely be done though a consistent outreach effort and community relations effort leveraging the current Early Intervention structure.

19/20

- Continued efforts related to strategize on how to provide Early Intervention services in an effective way in response to the COVID-19 pandemic. Increase client participation and trust by utilizing telehealth services and provide education for virtual platforms.

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS
STIGMA AND DISCRIMINATION REDUCTION
SUICIDE PREVENTION

The PEI programs in the categories below, overlap and are embedded and addressed by multiple programs across the PEI system of care. However, there are specific programs dedicated to each of these categories.

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS PROGRAM DESCRIPTION

Programs and strategies focused on outreach for increasing recognition of early signs of mental illness utilize outreach**,** which is a process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

STIGMA AND DISCRIMINATION REDUCTION PROGRAM DESCRIPTION

Stigma and discrimination reduction programs encompass the direct 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 to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

SUICIDE PREVENTION PROGRAM DESCRIPTION

Suicide prevention programs are those that organize activities to prevent suicide as a result of mental illness. This category of programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.

TARGET POPULATION

- Children and Youth – age range 0 to 15
- Transitional Age Young Adults – age range is 16-25
- Adults – age range 26-59
- Older Adults – age 60+
- Individuals at-risk for serious mental illness or exhibiting onset of serious mental illness or displaying mental illness early in its emergence and/or;
- Families of individuals in the underserved/unserved, at-risk population;
- Additional target populations include: Latino/Hispanic, Asian Pacific Islander, African American, Assyrian, Middle Eastern, the refugee community, and Lesbian, Gay, Bi-Sexual, Transgender, and Questioning (LGBTQ) individuals

SERVICES AND ACTIVITIES

Outreach includes activities such as presentations, training, and events. Activities encourage, educate, or train individuals and potential responders about ways to recognize and respond effectively to early signs of mental illness. Outreach services are provided throughout all PEI programs at varying degrees.

PEI staff, other BHRS staff, and contracted partners are trainers for the following trainings that are provided free of cost to the community and targeted populations across the county:

- Mental Health First Aid (MHFA)
- Youth Mental Health First Aid
- Applied Suicide Intervention Skills Trainings (ASIST)
- NAMI Provider Education Course
- Toward Effective Self-Help Group Facilitator training

PEI also provides staff support to several cross-cultural community-based collaborative/partnerships that help promote emotional health and wellbeing by decreasing stigma, disparities, and barriers to mental health resources.

Stigma and discrimination reduction activities also include presentations, training, and events, marketing campaigns, speakers' bureaus, and efforts to encourage self-acceptance for individuals with a mental illness. All PEI programs integrate one or more of these activities in their program delivery.

A primary suicide prevention service offered through PEI is the suicide hotline provided by the Central Valley Suicide Prevention Hotline (CVSPH). CVSPH is nationally accredited by the American Association of Suicidology and operates the hotline 24 hours a day, 7 days a week, ensuring that our county residents have access to suicide prevention support and emergency services when appropriate. The Each Mind Matters material is operated statewide by CalMHSA which provides support in the areas of suicide prevention and stigma and discrimination reduction. Other suicide prevention activities include campaigns, training, and education focused on suicide information and prevention.

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS FY 2018 – 2019 AND FY 2019 - 2020 Programs

- Outreach Programs for Increasing Recognition of Early Signs of Mental Illness :
    - Community trainings are operated by Stanislaus County Behavioral Health and Recovery Services
    - Mental health education and trainings operated by NAMI (National Alliance on Mental Illness)

STIGMA AND DISCRIMINATION REDUCTION PROGRAMS FY 2018 – 2019 AND FY 2019 – 2020 PROGRAMS

- Stigma and Discrimination Reduction Programs Operated By:
    - Each Mind Matters Campaign/Know the Signs
    - CalMHSA

SUICIDE PREVENTION PROGRAMS FY 2018 – FY 2019 AND FY 2019 – 2020 PROGRAMS

- Suicide Prevention programs operated by:
    - Kingsview – Central Valley Suicide Prevention Hotline (individuals with suicidal ideation or at-risk).

PROGRAM DESCIPTIONS:

Community Trainings

Community trainings are comprised of PEI staff, other Stanislaus County BHRS staff, contracted partners and community collaboratives. They serve as trainers for the following trainings that are provided free of cost to the community to targeted PEI populations across the county:

- Mental Health First Aid (MHFA)
- Youth Mental Health First Aid
- Applied Suicide Intervention Skills Trainings (ASIST)
- NAMI Provider Education Course
- Toward Effective Self-Help Group Facilitator training

National Alliance on Mental Illness (NAMI)

NAMI provides mental health education and trainings throughout the County primarily in the school classroom setting to reduce stigma related to mental illness. NAMI has five primary areas of focus including outreach, engagement, access and linkage, improve timely access to mental health services, and promoting, designing, and implementing programs related to mental illness. NAMI provides presentations to diverse communities, potential responders, and individuals at-risk by utilizing individuals with lived experience to present and better connect with community. The ultimate goal of providing education and training, is to strengthen individual and community wide mental health protective factors and provide access to mental health services.

Each Mind Matters Campaign and Know the Signs

Each Mind Matters Campaign and Know the Signs are statewide social marketing campaigns built on three key messages: Know the signs. Find the words. Reach out. This campaign is intended to educate Californians on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis and where to find professional help and resources. Each Mind Matters is a mental health awareness campaign focused on creating a

platform to reduce stigma and discrimination related to mental health. These campaigns are funded through counties by the voter approved Mental Health Services Act (MHSA) (Prop. 63) and operated statewide by the California Mental Health Services Authority (CalMHSA), an organization of county governments working to improve mental health outcomes for individuals, families and communities with a focus on bringing together all counties throughout California working on Prevention and Early Intervention mental health efforts.

Central Valley Suicide Prevention Hotline (CVSHP)

CVSHP provides 24/7 hotline assistance to individuals who are looking for resources and education regarding a loved one or a friend, provides support for those in crisis and keeps people safe who have suicidal ideation or that are in the process of harming themselves. CVSPH serves California's Central Valley which is a culturally diverse group of seven counties. The hot line is also a member of the National Suicide Prevention Lifeline which provides interpreters for 150 different languages.

OUTREACH PROGRAMS FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS, STIGMA AND DISCRIMINATION REDUCTION, AND SUICIDE PREVENTION PROGRAMS BUDGET

FY 2018-2019

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$258,365	621	$416

FY 2019-2020

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$287,107	1,460	$197

OUTREACH PROGRAMS FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS, STIGMA AND DISCRIMINATION, AND SUICIDE PREVENTION REDUCTION DEMOGRAPHICS

FY 18/19 AND FY 19/20

Race	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
American Indian/Alaska Native	0	0%	0	0%
Asian	*	*	*	<1%
Black/African American	*	<1%	*	<1%
Native Hawaiian/Pacific Islander	0	0%	0	0%
White	66	11%	33	2%
More than one race	*	<1%	0	0%
Other	*	*	*	<1%
Unknown	536	86%	1418	97%
Total:	**621**	**100%**	**1460**	**100%**

**Due to privacy any value <10 has been removed*

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Hispanic or Latino	21	3%	19	1%
Non-Hispanic or Latino	49	8%	22	2%
Declined/Unknown	551	89%	1,419	97%
Total:	**621**	**100%**	**1,460**	**100%**

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	26	4%	37	3%
TAYA (16-25)	63	10%	118	8%
Adult (26-59)	77	13%	108	7%
Older Adult (60+)	13	2%	10	<1%
Unknown	442	71%	1187	81%
Total:	**621**	**100%**	**1,460**	**100%**

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	452	72%	598	40%
Spanish	*	<1%	0	0%
Other	0	0%	*	<1%
Unknown	168	27%	861	59%
Total:	**621**	**100%**	**1,460**	**100%**

**Due to privacy any value <10 has been removed*

Gender	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Male	31	5%	39	2%
Female	67	11%	64	4%
Genderqueer	*	<1%	*	<1%
Questioning/Unsure	0	0%	*	<1%
Transgender	*	<1%	0	0%
Another	0	0%	0	0%
Unknown	519	83%	1,354	93%

Total:	**621**	**100%**	**1,460**	**100%**

**Due to privacy any value <10 has been removed*

PROGRAM UPDATE

FY18/19

- The previous contracted services under Stanislaus County of Education (SCOE) for suicide prevention initiatives term was fulfilled and funding ended.

FY19/20

- In response to stakeholder input and impacts to the COVID-19 pandemic, the Friends are Good Medicine program will be reallocated to Outreach for Increasing Early signs of Mental illness. Additionally, the National Alliance for Mental Illness (NAMI) program will be moved from Outreach for Increasing Early signs of Mental illness to Prevention starting in fiscal year 2020-21.

OUTREACH PROGRAMS FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS, STIGMA AND DISCRIMINATION, AND SUICIDE PREVENTION REDUCTION OUTCOMES

FY 18/19 AND FY 19/20

OUTREACH

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
# NAMI presentations, specifically focused on recognizing early signs of mental illness and reducing stigma and discrimination	93	65
# Potential responders attending NAMI presentations	2,277	2,296
How Well?		
# Community members reached through NAMI presentations	2,826	2,345
#/% of Presentations covering issues of stigma	399/63%	568/76%

#/% Presentations outside of the office environment	485/76%	520/68%
Better Off?		
#/% Individuals reporting having a good understanding of mental illness and its symptoms after NAMI presentation	760/92%	845/92%
#/% Individuals reporting wanting to learn more about mental illness as a result of a NAMI presentation	736/89%	835/92%

OUTREACH SUICIDE HOTLINE DATA

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
# Calls responded to through the Central Valley Suicide Prevention Hot Line	609	1,448
# Crisis Calls to Central Valley Suicide Prevention Hotline	178	368
How Well?		
#/% Calls concerned with mental health, social issues, or suicide	450/74%	1,115/77%
# Crisis calls	178	368
# "Active Rescues" when emergency services were contacted for the caller's safety	3	4
Better Off?		
# Talk downs during which a high-risk caller was deterred from completing suicide	5	5
Estimated cost savings to Stanislaus County for crisis calls	$477,156	$986,479

CHALLENGES/BARRIERS & STRATEGIES TO MITIGATE:

FY 18/19

- Providing community trainings are a continuous challenge to provide to the community. There are limited certified trainers in English and Spanish which is a challenge. The strategy to work closely with other contracted partners to provide trainings such as Mental Health First Aid and Rotafolio, a Suicide Prevention training offered in Spanish, is a main focus. The goal is to increase awareness and understanding of suicide as an illness and how to connect mental health services to our community.

FY 19/20

- Outreach efforts continue to yield challenges due to the COVID-19 pandemic restrictions specifically for gatherings. In person gatherings that were once allowed offered our contracted programs and community partners the ability to reach underserved communities and achieve mental health related goals. In response to the pandemic, programs focused on strategies to identify alternative option to deployed virtual strategies and continues to improve these efforts.

PROPOSED CHANGES

FY 18/19

- There were no reported changes for this fiscal period.

FY19/20

- Many of the existing and ongoing PEI efforts have been successful in reaching underserved communities and achieving mental health related goals. In response to stakeholder input, the pandemic, contract monitoring, and gaps identified, some of the ongoing programs will be changed and reallocated starting in FY 2020-21.

ACCESS AND LINKAGE PROGRAM

ACCESS AND LINKAGE PROGRAM DESCRIPTION

Access and Linkage to treatment means connecting individuals with severe mental illness, adults, and seniors with severe mental illness 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. Examples include focusing on screening, assessment, referral, and/or mobile response. This Access and Linkage program provides confidential peer-staffed outreach, education, referral, and support services to the veteran and aging community, their families, and the service providers. The program increases awareness of the prevalence of mental illness in Stanislaus County, reduces mental health risk factors or stressors, and improves access to mental health and PEI services, information, and support.

TARGET POPULATION:

Aging and Veteran Services program primarily serves the geographic community of Modesto and the underserved/unserved populations within it. The program serves mostly adults and adults older than 60 years of age, including all races and ethnicities, and veterans and their family members. The primary target population includes older adults with mild depression, at risk of depression or worsening depression.

All programs target Stanislaus County's underserved/unserved populations in the following categories:

- Individuals at-risk or exhibiting onset of serious mental illness
- Individuals displaying mental illness early in its emergence
- Families of individuals in the above populations

This Access and Linkage program specifically targets adults and older adults who are also at high risk for having or developing mental illness due to risk factors:

- Isolation – social, geographic, cultural, linguistic
- Losses- deaths, financial, independence
- Multiple chronic medical conditions including substance abuse
- Elder abuse and neglect

SERVICES AND ACTIVITIES:

Aging and Veteran Services (AVS) provides specific home and community-based services. Efforts are made via a network of older adult service providers, including home health agencies, adult

protective services, and community service organizations (home-delivered meals, in-home service providers, and transportation programs.

This program primarily serves adults and older adults with an emphasis on MHSA underserved and unserved populations. The program provides individual and group engagement activities and services, identifies at-risk individuals and potential responders, and provides referrals, navigation, and other support through the Friendly Visitor program. All PEI programs are designed and implemented to help create access and linkage to treatment and improve timely access to mental health services for individuals and families from underserved populations when appropriate, but this program has a strong focus in this area.

PEI regulations require that at least one program is dedicated to access and linkage, and Aging and Veteran Services has been identified as the program with this focus. However, all PEI programs incorporate access and linkage activities and strategies, and Aging and Veteran Services is also a program providing Brief Intervention Counseling (BIC) services.

ACCESS AND LINKAGE PROGRAM BUDGET:

FY 2018-2019

Actual FY 2018/2019	Total Number Served FY 2018/2019	Estimated Cost Per Participant FY 2018/2019
$312,000	253	$1,233

FY 2019-2020

Actual FY 2019/2020	Total Number Served FY 2019/2020	Estimated Cost Per Participant FY 2019/2020
$365,558	197	$1,856

ACCESS AND LINKAGE PROGRAM FOR FY 2018 – 2019 AND FY 2019 – 2020

- **Access and Linkage Program**
    - Stanislaus County Area Agency on Aging & Veterans Services

PROGRAM UPDATE

FY 18/19

- There were no reported changes for this fiscal period.

FY19/20

- Stanislaus County remained focused on addressing COVID-19 and the challenges in ensuring AVS clients could continue to access services. PEI has been responsive with partners in exploring solutions to the problems presented. Working towards solutions to support efforts to maintain access and linkage continues to address challenges associated with COVID-19 pandemic. There is additional information speaking to this in the Executive Summary of this Plan and Update.

ACCESS AND LINKAGE DEOMOGRAPHICS

Race	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
American Indian/Alaska Native	*	<1%	*	*
Asian	*	*	*	<1%
Black/African American	10	4%	12	6%
Native Hawaiian/Pacific Islander	*	*	*	*
White	193	76%	136	69%
More than one race	26	10%	*	<1%
Other	18	7%	*	4%
Unknown	*	<1%	33	17%
Total:	**253**	**100%**	**197**	**100%**

**Due to privacy any value <10 has been removed*

Ethnicity	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Hispanic or Latino	43	17%	39	20%
Non-Hispanic or Latino	188	74%	129	65%
Declined/Unknown	22	9%	29	15%
Total:	**253**	**100%**	**197**	**100%**

Ages	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Child/Youth (0-15)	*	<1%	*	*
TAYA (16-25)	*	<1%	*	<1%
Adult (26-59)	*	*	*	<1%
Older Adult (60+)	246	97%	193	98%
Unknown	*	<1%	0	0%
Total:	**253**	**100%**	**197**	**100%**

**Due to privacy any value <10 has been removed*

Language	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
English	236	93%	175	88%
Spanish	15	6%	16	8%
Other	*	<1%	*	*
Unknown	*	<1%	*	*
Total:	**253**	**100%**	**197**	**100%**

**Due to privacy any value <10 has been removed*

Gender	Individuals Served FY 18/19		Individuals Served FY 19/20	
	Number	Percentage	Number	Percentage
Male	71	28%	60	30%
Female	180	71%	136	69%
Genderqueer	0	0%	0	0%

OUTCOMES:

ACCESS AND LINKAGE

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
# Community members reached through dedicated Access and Linkage program	5,606	2,616
# Individuals linked to community based programs	82	25
How Well?		
#/% Services provided outside of the office	1,646/97%	1,175/98%
#/% Referrals with a successful Esngagement	143/59%	64/47%
Better Off?		
Individuals connected to counseling services	73	38

CHALLENGES/BARRIERS & STRATEGIES TO MITIGATE:

FY 18/19

- Senate Bill (SB) 1004 (Chapter 843, Statutes of 2018) established priorities and a statewide strategy for prevention and early intervention services which could significantly impact the AVS provider. The division is continuing to review the Access and Linkage requirement to provide alignment and responsiveness to SB 1004.

FY 19/20

- There was significant decrease in the areas of members being reached through dedicated access and linkage from the previous year for Aging and Veteran Services. Some of these impacts were due to the COVID-19 pandemic as most services are provided in the comfort of the Clients home to reduce barriers including transportation and stigma. Many of the client referrals come from the "Senior Information Line" or through a robust outreach program which are currently limited due to the pandemic. A strategy to increase volunteers to assist with Clients and provide peer support is the future approach.
- The initial interest for the Youth Resiliency and Development initiative was high. The Department's process for organizations to apply for funds was challenging, which resulted in a limited response from potential organizations. Feedback from potential applicants stated that application requirements such as scope of work guidelines and alignment of PEI regulations within the application content seemed difficult to achieve.

The Workforce Education and Training (WE&T)

PROGRAM DESCRIPTION

The Workforce Education and Training (WE&T) component of MHSA provides funding to help improve and build the capacity of the mental health workforce. It is designed to help counties develop and maintain a competent and diverse workforce capable of effectively meeting the mental health needs of the public. WE&T funds are a one-time allocation and do not provide direct service.

The goal is to develop a diverse and well-trained workforce skilled in delivering a culturally competent integrated service experience to clients and their families. Equally important are community collaboration efforts to increase protective factors.

Stanislaus County has four WE&T Programs

- Workforce Development
- Consumer Family Member Training and Support
- Outreach and Career Academy
- Consumer and Family Member Volunteerism

WE&T BUDGET:

Actual FY 2018/2019	Actual FY 2019/2020
$566,941	$455,294

WE&T WORKFORCE DEVELOPMENT

Operated by Stanislaus County Behavioral Health and Recovery Services
Human Resources and Training

PROGRAM DESCRIPTION

The goal of the Workforce Development program is to increase overall and specific competencies in staff throughout the public mental health workforce as well as expand capacity to implement MHSA essential elements. Training for skill building is at the core of Workforce Development. The trainings offered address a variety of key content identified during the stakeholder planning process.

Key among them:

- Community collaboration skills
- Resiliency and recovery
- Treatment of co-occurring disorders
- Welcoming consumers and family members perspective in the workplace to ensure an integrated service experience
- How to work with people from diverse cultures to ensure a culturally competent service experience.

Trainings are designed to include consumer and family member perspectives and include consumer and family member trainers when appropriate. Workshops and trainings are offered to BHRS and organizational provider staff with the overarching goal of enhancing knowledge and skills, especially in the areas of recovery and resilience and evidence-based practices.

PROGRAM UPDATE

FY 18/19

- BHRS hosted the "Opioid Safety Awareness Summit 2019" which offered staff and the community the opportunity to hear from experts in the areas of opioid prevention, unintended consequences, implications of use, treatment strategies, prescriber approaches, tactical diversion, trends in opioid misuse and multi-agency collaborations to combat opioid issues. This summit was offered to be responsive in meeting the needs of staff and the community. BHRS Workforce Development partnered with BHRS Prevention to provide continuing education units for the Opioid Safety Awareness Summit which over 500 staff, contractor staff and community members participated.
- BHRS Workforce Development offers Mental Health First Aid to students through a collaboration with the Stanislaus State University Peer Project, and expanded efforts into the Stockton campus.

- BHRS Workforce Development offered "Trauma-Informed Clinical Supervision for Clinical Supervisors" expanding the opportunity for BHRS Staff to meet the minimum requirements for Clinical Supervision thus expanding the pool of in-program clinical supervisors to SCBHRS Staff.

FY 19/20

- BHRS Workforce Development partnered with Valley Mountain Regional Center (VMRC) for the 2nd annual "Bridging the Gap: Co-Occurring Disorders and Developmental Disability Conference" that offered both behavioral and medical health professionals in the community with the necessary skills to address the needs of individuals with co-occurring mental health and developmental disabilities. Attendance by participants expanded to San Joaquin County this year.

- Telehealth services increased due to the COVID-19 pandemic in early 2019. BHRS Workforce Development developed trainings to increase the skills and knowledge of the workforce to provide behavioral health care services via telehealth platform. The following trainings were developed and provided to staff:
  - Strategies for Working Remotely, Utilizing Telehealth, and Practicing Self-Care
  - Strategies for Working Remotely and Practicing Self-Care for Non-Clinical Staff
  - Telehealth: Case Management & Psychosocial Rehabilitation Strategies and Interventions (BHS & CST's)
  - Telehealth: Best Therapeutic Practices and Intervention (Clinicians)
  - Zoom for Healthcare Training
  - COVID-19 Disaster Crisis Counseling Training

- In addition to providing live trainings, BHRS Workforce Development connected staff with access to free trainings and educational webinars from various nationally-recognized behavioral health organizations that focused on providing sensitive, responsive, and effective services to clients related to cultural competency. Organization include but are not limited to: California Institute for Behavioral Health Solutions (CIBHS), National Council for Behavioral Health, National Association for Alcoholism and Drug Abuse Counselors (NAADAC, the Association for Addiction Professionals), HealthNet and more. SCBHRS Training developed a new webpage for staff and contractors to access these trainings (BHRS Staff and Contractors).

- BHRS Workforce Development transitioned all BHRS organization-specific trainings (i.e., CANS, LOCUS, etc.) to virtual trainings.

OUTCOMES:

FY 18/19

How much?

- 197 Trainings were supported by the BHRS Training Program/ BHRS Workforce Development (n=4033)
- 23 Trainings were paid for through WET money (n=764)
- 31 Trainings were sponsored by the PEI Program (n=501)

How well?

- 97% of the participants felt the content was appropriate to my education/ experience/licensure level. (n= 496)
- 98% of the participants felt the course content was current and relevant to practice. (n= 500)
- 97% of the participants felt the course teaching methods/technology/handouts supported the seminar. (n= 501)

Better off:

A Brief introduction to the Assyrian Culture and providing Culturally Appropriate Services within Stanislaus County: "Very useful and interesting. I was able to learn more about the Assyrian culture here. I love the fact that I now know how to build a relationship with the Assyrian culture."

Caring for Gender Non-Conforming and Transgender Youth: "Great informative training. I learned a lot such as gender noise, coming in, coming out, and empowering language to use when working with trans community and their families."

The Resilient Professional: Self-Care, Stress Management, and Mindfulness: "Great training, I really liked the presenter gave us techniques and practiced them with us during the training. It provided a better understanding."

Motivational Interviewing: "The presenter was knowledgeable with MI and visibly passionate about the material."

Use of Art in Therapy/An Experiential Training: "Amazing Class! I loved learning new techniques to utilize during play therapy with my clients. Facilitator was very helpful."

Applied Suicide Intervention Strategies (ASIST): "This was the best trainings I've been to yet. The trainers did an amazing job and the material was extremely informative."

FY 19/20

How much?

- 125 Trainings were supported by the BHRS Training Program/ BHRS Workforce Development (n=2079).
- 2 Trainings were sponsored by the PEI Program (n=40).
- 1– Outside trainings were supported by BHRS WET either through offering space for the training or collaborating with continuing education hours (n= 258).

How well?

- 95% of the participants felt the content was appropriate to my education/experience/licensure level. (n= 803)
- 95% of the participants felt the course content was current and relevant to practice. (n= 809)
- 95% of the participants felt the course teaching methods/technology/handouts supported the seminar. (n= 809)

Better off:

Telehealth: Best Therapeutic Practices & Interventions
Carlie and Bernadet did a great job with this training. They were so professional and had great speaking voices. I've been watching a lot of webinars and feel this would be a great one to post on YouTube.

Awesome training. A very much needed training given the circumstances at this time. It was informative and provided ways to continue to address and meet client needs. Thanks guys!

An Introduction to Motivational Interviewing
Learned a lot about MI and how to apply it to clients in working field. Very informative. Enjoyed and learned from role-play. Non-judgmental. Videos are helpful for learning. Thank you.

Military Cultural Awareness
Very informative. I had limited knowledge. I enjoyed information on Military Culture but also clinical aspects to treating those in Military.

ASAM Training Part I and Part II
The course was helpful and overall went well. Practice on the use of the breakout sessions. Well done taking into consideration all the technical difficulties everyone has during go to trainings. Excellent as usual Charles in your down to earth explanations.

Principles and Practices of Culturally and Linguistically Appropriate Services: Including Interpreting and Use of Interpreters

I particularly appreciated encouraged participation and that the course was very dynamic with group activities and case simulations. Excellent work!

Expanding Your Psychological Flexibility with Acceptance and Commitment Therapy (ACT)

Good, organized presentation. Optimum use of role-playing. Clear illustration of key concepts.

CHALLENGES/STRATEGIES TO MITIGATE & OPPORUNTIES

FY 18/19

- Nothing to Report.

FY 19/20

- SCBHRS Workforce Development experienced staffing changes and did not have an assigned Coordinator from July 2019 to November 2019.
- SCBHRS Workforce Development was not able to schedule as many trainings that provided Continuing Education Units due to COVID-19 pandemic and transitioning to virtual platforms, Also, due to the number of open positions and staff program demands increasing, in-house training development slowed down.
- SCBHRS Workforce Development trainings offered to local universities to increase our workforce capacity were no longer possible due to the COVID-19 meeting restrictions and limitation from the training developers (Mental Health First Aid, ASIST, etc.).

PROPOSED CHANGES

FY 18/19

- No proposed changes.

FY 19/20

1. SCBHRS organization-specific trainings will be provided on a monthly or quarterly basis (depending on the training) to allow staff the opportunity to take this training multiple times per year versus offering the training just one time per year.
2. SCBHRS Workforce Development will develop and provide web-based trainings that address a range of topics that are responsive to the current COVID-19 crisis and address the needs of our staff and community.

WE&T CONSUMER FAMILY MEMBER TRAINING & SUPPORT

Operated by Stanislaus County Behavioral Health and Recovery Services
Human Resources and Training in partnership with
Modesto Junior College and Community Based Organizations

PROGRAM DESCRIPTION

In partnership with Modesto Junior College (MJC), the California Association of Social Rehabilitation Agencies (CASRA) based program provides a structure to integrate academic learning into real life field experience in the adult public mental health system. Before this partnership, MJC did not have a Psychosocial Rehabilitation (PSR) curriculum. The initiative taken by SCBHRS to purchase the CASRA curriculum signifies the efforts to fill the gaps for employment of consumers and family members. Students who have received their Psychosocial Rehabilitation Skills Recognition Certificate also can become eligible for the State Psychosocial Rehabilitation certification after completing a minimum of 2,500 field experience hours.

The Psychosocial Rehabilitation Program at MJC is a nine (9) unit curriculum that provides individuals with the knowledge and skills to apply goals, values, and principles of recovery-oriented practices to effectively serve consumers and family members. The certificated units also count towards an Associate of Arts Degree in Human Services at MJC.

The CASRA Based Stipend Program includes stipends to assist with school fees, parking passes, and school supply vouchers, as needed to participants. There is also a textbook loan program. In addition, CASRA Program participants receive ongoing peer support and academic assistance to maximize their opportunities for success.

PROGRAM UPDATE

FY 18/19

- The CASRA Program participated in the Career Fair Expo at Modesto Junior College which gave the program more visibility and helped increase the total number of participants in the Program.

FY 19/20

- The CASRA program streamlined its on-site Application Appointments by converting these appointments to a virtual platform.
- The Psychological Rehabilitation program offered at MJC has added additional course requirements from the original 9 Unit to a 12 Unit Program.

OUTCOMES:

FY 18/19

149 Individuals Served

WE&T Consumer Family Member Training and Support

How Much?

- 149 CASRA Based Stipend Program participants representing diverse ethnicities/cultures received education stipends
- 30 participants received field placement with BHRS or our community partner agencies
- 2 Human Services Advisory Board meeting to raise awareness of our Program to various agencies within the community represented at the meetings
- 5 MJC Classroom Presentations were held to raise awareness about the CASRA Program
- 1 meeting with the faculty of the Human Service Department to create a standard for presentations to Human Service courses for the upcoming semester
- Three presentations to BHRS Programs to promote the MJC Practicum

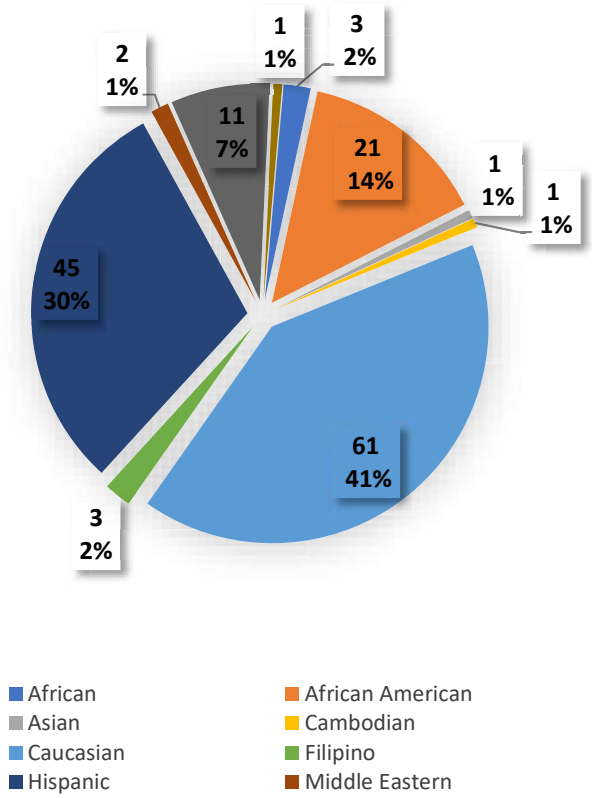
How Well?

- 100% of CASRA Based Stipend Program participants have lived experience as consumers, family members of consumers, or are from diverse cultural backgrounds
- 47 CASRA program participants are bilingual or multi-lingual
- 25 CASRA program participants completed the academic requirements and volunteer/practicum hours needed to receive their Skills Recognition Certificate for the MJC 9-Unit Psychosocial Rehabilitation Program

Better Off?

- 22 CASRA program participants were hired in the public mental health system; 9 by BHRS, 13 by outside facilities working with mental health clientele
- 11 CASRA program participants have received their Associate of Arts Degree in Human Services
- 4 CASRA program participants have chosen to continue their education at California State University, Stanislaus or other Universities

WET CASRA Ethnicity/Race, Participants = 149



OUTCOMES: FY 19/20

160 Individuals Served

WE&T Consumer Family Member Training and Support

How Much?

- 160 CASRA Based Stipend Program participants representing diverse ethnicities/cultures received education stipends
- 3 participants received field placement with BHRS or our community partner agencies
- 2 Human Services Advisory Board meeting to raise awareness of our Program to various agencies within the community represented at the meeting.
- 13 MJC classroom presentations were held to raise awareness about the CASRA program.

How Well?

- 3 Presentations to BHRS Programs to promote the MJC Practicum
- 100% of CASRA Based Stipend Program participants have lived experience as consumers, family members of consumers, or are from diverse cultural backgrounds
- 50 CASRA Program participants are bilingual or multi-lingual.

Better Off:

- 17 CASRA Program participants completed the academic requirements and volunteer/practicum hours needed to receive their Skills Recognition Certificate for the MJC 9-Unit Psychosocial Rehabilitation Program
- 3 CASRA Program participants have received their Associate of Arts Degree in Human Services
- 2 CASRA Program participants have chosen to continue their education at California State University, Stanislaus or other Universities

CHALLENGES/STRATEGIES TO MITIGATE & OPPORUNTIES

FY 18/19

- Expending placement of MJC Practicum students in direct service programs is an area of focus.

FY 19/20

- Due to COVID-19, we deceased of number of presentations at MJC which impacted the number of participants attending MJC during the summer and fall semesters of 2020. In
- addition, to prevent the spread of COVID-19 our BHRS Practicum program sites were not taking any MJC Practicum students except for those who were currently a BHRS employee enrolled in the MJC Practicum.

PROPOSED CHANGES

FY 18/19

- Continue to equip MJC Professors and outreach our program and service offerings in a way they can share with their students who attend classes online.

FY 19/20

- Creating strategies to work with MJC Professors and reach new students who are attending MJC virtually.

WE&T-OUTREACH AND CAREER ACADEMY

Operated by West Modesto King Kennedy Neighborhood Collaborative

PROGRAM DESCRIPTION

Outreach and Career Academies were established in response to strong community input to outreach to junior high and high school students to raise awareness about behavioral health and mental health careers. One community-based organization participated in the project.

The West Modesto King Kennedy Neighborhood Collaborative (WMKKNC) sponsored the Mark Twain Junior High Wellness Project. As part of their learning, students participated in skits, scenarios, and discussions on issues important to them such as stress, self-esteem, and healthy relationships. They also learned how these issues can affect their physical and mental well-being. A total of six (6) students participated in the project which also introduced them to career opportunities in mental health.

PROGRAM UPDATE:

FY 18/19

- As part of their learning, students participated in skits, scenarios, and discussions on issues that are important to them such as stress, self-esteem, and healthy relationships. They also learned how these issues could affect their physical and mental wellbeing.
- A new approach to an important subject matter was incorporating activities that would encourage interactive participation. Skits, doing active research on bullying, brainstorming on ideas to prevent bullying and roleplay. Students discussed how it affects youth mentally, physically and socially. As part of this unit, students were presented information on suicide awareness and how to recognize the signs of suicide.

FY 19/20

- The Program presented a Resident Doctor to the students who shared what it takes to get through school as well as what mental health needs are affecting our community. The Doctor spoke about stigma reduction as well as what mental health is and how to help a peer who is experiencing difficulties.
- The Program presented a student from a Stanislaus State University that is studying for a career in mental health. She shared about her college experience as well as gave feedback on questions that our students had.
- In early March due to COVID-19, our agency shut down. This affected how we reached our program participants as well as what resources and education we shared. For the month of March and April we were working remotely and because some students had not yet received their school lap tops, we had to halt our education sessions.

- The Program continued to help our participants and their families by providing literature on stress management and resources for the family. We also partnered with local restaurants so that we could provide weekly hot meals for their families as well as face coverings. In our communication for what was left of the school year, we focused on helping them access hot spots as well as offering them school supplies that would allow them to their work at home. For our end of the year celebration, we were able buy each family a hot meal for pick up as well as have each student their stipend along with a certificate for participation.

OUTCOMES:

FY 18/19

How Many?

- We had a total of six students participate in the 2018-19 school year/ Academy.

How Well?

- While participating in this program, Students are actively engaged in learning about other areas of mental wellbeing and how it affects their lives and the lives of their family and friends and how to share the information with others. They also have the opportunity to socialize while discussing topics that may affect their daily lives and share ideas on how they can apply healthy changes at school in order to prevent/manage things like stress, anxiety, stigma and bullying.
- The group worked very well together and participated in activities despite being shy at first. Their participation became easier for them as the year progressed because they were able to get to know each other and share experiences, challenges and ultimately made friends that could rely on each other while in school as well.
- All sessions began with an icebreaker that would encourage conversation and getting comfortable in talking with each other while learning of these topics. All participating students did a great job each week of incorporating their own voice to the lesson plan, as well as shared ideas on their perspectives.

Better Off?

- When asked what were the most important things they gained from the program? their responses were; that they had developed friendships they did not have before, that their overall wellbeing had improved, they were more positive about their future and they had an idea about a possible career choice.

FY 19/20

How Many?

- We had a total of six students participate in the 2019-20 school year/ Academy.

How Well?

- Students did very well the first semester with learning components that included an introductory lesson on what is a mental illness, eliminating stigma, addressing bullying and how to put a stop to it and suicide prevention, what are the signs.
- Activities that allowed us to address these topics consisted of the group participating skits that depicting bullying or other scenarios that addressed mental health issues in youth. They were asked to respond how they felt was a realistic approach. After going through a PowerPoint and lessons on these topics, they were asked to participate in the same skits… however, now they were to apply techniques that they had learned in order to use their knowledge and resources to deescalate a situation with a bully or with a peer that was struggling. This activity was successful and one that the students really enjoyed. They were able to give each other feedback and offer each other support. Situations came up in that they shared instances in which they had witnessed bullying. Because they all attend Mark Twain, they shared and offered to support each other.

Better Off?

- When asked how they felt about the program, students expressed feeling more knowledgeable and prepared. Techniques learned were being used to help them manage stress and anxiety. However, in early March our agency shut down due to these unprecedented times in dealing with a pandemic. This affected how we reached our program participants as well as what resources and education we shared. For the month of March and April we were working remotely and because some students had not yet received their school lap tops, we had to halt our education sessions. We continued to help our participants and their families by providing literature on stress management and resources for the family. We also partnered with local restaurants so that we could provide weekly hot meals for their families as well as face coverings. In our communication for what was left of the school year, we focused on helping them access hot spots as well as offering them school supplies that would allow them to their work at home. For our end of the year celebration, we were able buy each family a hot meal for pick up as well as have each student their stipend along with a certificate for participation. Students finished the year expressing relief and uncertainty.
- We continued to support students with Zoom sessions and mindful techniques to lessen anxiety and stress, as many reached out and were worried and uncertain about entering high school.

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES (RELATED TO OUTCOME DATA)

FY 18/19

- Challenges included limited space in the program. More students are interested in being part of the program than we have slots.

FY 19/20

- Challenges included the unprecedented pandemic, as all our participants did not have access to internet services nor a laptop to have remote access to group sessions. Access was later available, once their school was able to issue laptops for remote learning.

PROPOSED CHANGES

FY 18/19

- Will look at the feasibility of having students participate for only one semester. Thus, allowing for 12 participants per school year.

FY 19/20

- Will look at the possibility of providing hotspots for students who do not have available internet services. Will also look at interactive activities that can be done remotely. (example: Creating a short movie that could then be shared).

WE&T CONSUMER AND FAMILY MEMBER VOLUNTEERISM

Operated by Stanislaus County Behavioral Health and Recovery Services
Human Resources and Training

PROGRAM DESCRIPTION

This program addresses the needs of consumers, family members, and diverse community members who wish to volunteer in the public mental health system. It also provides an opportunity to give back to the community as part of their recovery as well as gain valuable experience for future employment endeavors. Volunteers provided an important and valuable service as they worked in countywide BHRS programs.

Volunteer opportunities also continued for California Association of Social Rehabilitation Agencies (CASRA) students from Modesto Junior College, referred to as Volunteers with Practicum assignment. Volunteers were placed in BHRS programs as well as community-based organizations.

PROGRAM UPDATE:

FY 18/19

- The Volunteer Office team-initiated enhancements in communication and customer service expectations with the program sites and volunteers resulting in more clear communication and direct support.
- Additional outreach was provided to volunteer sites, and other BHRS community partners, and organizations, for better awareness of our volunteer services.

FY 19/20

- The Volunteer office team working with the CASRA Team to enhance the number of BHRS sites to participate in potentially becoming a Practicum site.
- Due to COVID-19 restrictions current volunteers are on pause in their volunteer assignments within the sites. Volunteers will remain active and placed as soon as COVID-19 restrictions are lifted.

OUTCOMES:

FY 18/19

- A total of 66 volunteers participated in the programs
- A total of 10 volunteers were hired either by Stanislaus County or other outside community agencies.
- A total of 11,900.61 volunteer hours were accumulated by the program.
- The total dollar value to the department (at $29.09 an hour) equaled $346,188
- Eighteen BHRS sites participated in the program by using volunteers.

FY 19/20

- Outcomes are not available at this time.

CHALLENGES/STRATEGIES TO MITIGATE & OPPORUNTIES

FY 18/19

- There was a loss of a volunteer site that captured a good number of volunteers. Consequently, several of those volunteers did not continue with the program.

FY 19/20

- Due to COVID-19, the Annual Volunteer Celebration was canceled which was a big part of acknowledging and encouraging our volunteers in the Program.

PROPOSED CHANGES:

FY 18/19

- The Volunteer Office has identified the need to initiate a mandatory Safety Orientation training for all volunteers to complete regarding how to remain safe in the workplace and to understand protocols regarding safety concerns.

FY 19/20

- No proposed changes.

CAPITAL FACILITIES (CF)

PROGRAM DESCRIPTION

Capital Facilities/Technological Needs (CF/TN) funding and guidelines were made available to Counties in 2008. Initial CF/TN funding was very limited. By statute, annually, based on an average of the past five years allocation, up to 20% of CSS funds may be used for any one or a combination of Workforce, Education and Training; Capital Facilities/Technological Needs or Prudent Reserve (W&I 5892(b)).

Building projects funded with CF must be permanently affixed to the ground and used for the delivery of MHSA services to individuals with mental illness and their families or for administrative offices. Capital Facility funds may be used by the County to acquire, develop or renovate buildings or to purchase land in anticipation of acquiring/constructing a building. Establishing a capitalized repair/replacement reserve for buildings acquired or constructed with Capital Facilities funds and/or personnel cost directly associated with a Capital Facilities Project, i.e., a project manager is allowable. Other guidelines apply.

SERVICES AND ACTIVITIES

No Capital Facilities Projects are in development at this time.

TECHNOLOGICAL NEEDS (TN)

PROGRAM DESCRIPTION

Technological Needs (TN) Projects focus on providing the necessary technological tools and processes to modernize how our Behavioral Health system securely accesses, uses, and stores information. The projects support the empowerment of behavioral health staff, clients, and families by providing them with greater appropriate access to technology in order to use information to make critical decisions. By keeping information systems updated, technology serves to improve the quality and coordination of care, operational efficiency, and cost effectiveness.

BHRS has four TN projects in various stages of implementation, modification, and updates.
1) Electronic Health Record
2) Consumer Family Access to Computing Resources
3) Electronic Data Warehouse
4) Electronic Document Imaging

SERVICES AND ACTIVITIES

Electronic Health Record

- Support of the Electronic Health Record trainings by coordinating the use of the computer training room, scheduling assistors, and facilitating access
- Technological maintenance of system that supports access to and functionality of EHR
- Maintenance of EHR accounts
- Facilitation of troubleshooting technical issues and connection with Cerner

Consumer Family Access to Computing Services

- Training and support of technicians hired to provide technology assistance to consumers and families
- 1:1 and group sessions to provide computer assistance to resources and information

Electronic Data Warehouse

- Continuous development and use of EHR data to create views for data and reports
- Creation of interactive Sequel Server Reporting Services reports to assist in making decisions

Electronic Document Imaging

- Daily scanning of mental health plan referrals to client charts
- Daily scanning of lab results to client charts

BUDGET:

Actual FY 2018/2019	Actual FY 2019/2020
$918,429	$866,039

PROGRAM UPDATES

FY 18/19

Electronically Prescribed Controlled Substances (EPCS)

- Starting in Jan 2019, BHRS implemented EPCS tokens so appropriate medical staff could prescribe controlled medications electronically.
- To date, there are nine prescribers who are utilizing this electronic feature.
- The EPCS feature provides a streamlined prescribing process, benefitting the clients through efficiency.

Online Electronic Health Record Resources

- EHR forms, instructions, and trainings are all available on the BHRS Intranet (for internal staff) and Extranet (contractors).
- As new information is developed, the resources are posted and searchable.

Technology Updates to Support Electronic Health Record

- Significant improvements were made to the tape backup library, affording a higher capacity and the ability to restore files from longer time periods
- Updates to the remote software were made to address issues causing disconnections for EHR users
- A “HIPAA Notice Disclaimer” was implemented. EHR users are reminded to follow HIPAA policies when accessing the EHR every time they log in.
- Increased security measures were implemented, including the ability to isolate devices instantly when security threats are reported

FY 19/20

These projects were all or in part funded by MHSA or contributing to the MHSA project/goals.

Expansion of Telehealth Capabilities

- BHRS continues to procure and deploy technology resources (laptops, iPads, mobile phones, video conference technologies, Etc.) throughout the area including community centers that support select and specific groups.

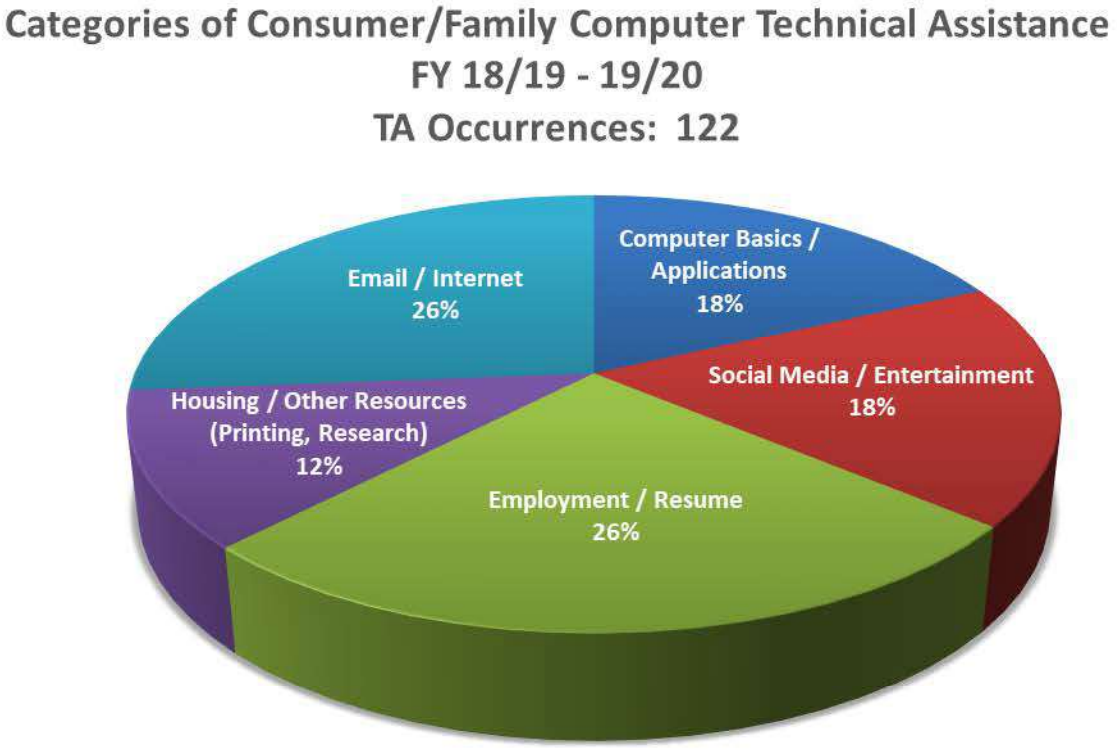
Online Electronic Health Record Resources

- EHR forms, instructions, and trainings are all available on the BHRS Intranet (for internal staff) and Extranet (contractors).
- As new information is developed, the resources are posted and searchable.

Technology Updates to Support Electronic Health Record

- JIRA ticketing system
    - Ability to enter tickets via cloud, allowing swift access to problem resolution when/if they arise
- Microsoft Teams Implementation
    - Ability for users to collaborate within the entire Stanislaus County and others
    - Moving from Skype to MS TEAMS provides a more universally used video conference platform for users of the EHR
- Efax Implementation
    - Implemented eFax cloud solutions for some programs within BHRS giving them the ability to interact with other MHPs via secure Fax
- Sftp upload site Implementation
    - The ability for collaboratives, staff, and vendors to upload files, including EHR files with strong encrypted protection.

OUTCOMES:


Categories of Consumer/Family Computer Technical Assistance
FY 18/19 - 19/20
TA Occurrences: 122
Email / Internet
26%
Computer Basics / Applications
18%
Social Media / Entertainment
18%
Housing / Other Resources (Printing, Research)
12%
Employment / Resume
26%

Outcomes	Number / Percentage FY 18/19	Number / Percentage FY 19/20
How Much?		
# of EHR trainings provided	84	50
# of duplicated staff attended EHR trainings	872	434
# of computer resources sessions provided to consumers	243	96
# of duplicated consumers who used computer labs	1,858	725
How Well?		
# of staff training hours logged for every one hour of EHR training	11	9
% of staff indicating the EHR trainings were effective	93% (312/337)	Not available
% of staff indicating the information in EHR trainings were current and accurate	99% (315/319)	Not available
Better Off?		
Consumers/Family members gained knowledge and skills through a program dedicated to answering their technology questions and assisting with searching for solutions using a computer.		
Consumers benefitted from an efficient electronic health record that provides clinical staff with access to up-to-date client information for better service provision.		
The department utilized data from the data warehouse to make critical decisions that positively affect client programs and services (e.g., adding a program component to meet client needs).		

CHALLENGES/STRATEGIES TO MITIGATE & OPPORTUNITIES

FY 18/19

- In 2018, Cerner alerted their clients of the development of and transition to a new version of the electronic health record, Cerner Millennium. Clients using Cerner Behavioral Health (previously known as "Anasazi"), were advised that full support of the current electronic health record would be reduced, including any revisions or additions that were not a State mandate.

- In 2018, the Data Management Services/ Performance Measures (DMS/PM) Chief left BHRS. The Chief was one of the primary implementers of the department's EHR - managing the details of the full transition from INSYST (previous billing system) and paper charts to an electronic system. The Chief leaving created a significant loss of knowledge related to the management (administration, navigation, support, training, etc.) of the EHR. An Application Specialist dedicated to providing EHR technical support and forms creation also left the division, and an EHR Trainer left Quality Services. Therefore, original and critical resources that previously directly supported the use and maintenance of the EHR were no longer available to the department.

FY 19/20

- Technical teams faced many ongoing challenges during the COVID-19 pandemic including affects to the MHSA techs, computer labs, and EHR trainings.

INNOVATION (INN)

Innovation funding is intended for unique, never-before-tried, time-limited programs to develop new and effective practices and approaches to mental health service delivery. The focus is to make contributions to learning in one or more of the following ways:

- Introduce a new mental health practice/approach that has never been done before
- Make a change to an existing mental health practice/approach, including an adaptation for a new setting or community
- Introduce a new application to the mental health system of a promising, community-driven practice/approach or a practice/approach that's been successful in a non-mental health context or setting

Innovation projects are committed to providing services that embrace the MHSA general standards of community collaboration, cultural competence, a client driven and family driven mental health system, a wellness, recovery, and resiliency focus, and integrated service experiences for clients and family members.

The projects must serve one or more of the following purposes:

- Increase access to mental health services
- Increase access to mental health services to underserved groups
- Increase the quality of mental health services to underserved groups
- Increase the quality of mental health services, including better outcomes
- Promote interagency and community collaboration related to mental health services, supports, or outcomes

The following are BHRS Innovation Project funded for this MHSA component. Each reflected an unmet need and was developed through a community planning process.

FY 18-19

- INN-16: FSP Co-Occurring Disorders (INN Project completed in June 2019)
- INN-17: Suicide Prevention

FY 19-20

- INN-17: Suicide Prevention (INN Project completed in September
- 2019) INN-18: NAMI on Campus High School Model (NAMI on Campus)

FY 21-23 Proposed Innovation Projects pending approval*

- Early Psychosis Learning Healthcare Network Statewide Collaborative
- Full-Service Partnership (FSP) Multi-county Collaborative

**Further detail on the proposed FY 21-23 Innovation Projects is provided at the end of this Innovation section.*

INNOVATION COMBINED BUDGET:

Actual FY 2018/2019	Actual FY 2019/2020
$1,393,907	$268,087

CO-OCCURRING DISORDER PROJECT (INN-16)

Operated by SCBHRS

PROJECT DESCRIPTION

This innovation project is a Full-Service Partnership (FSP) focused on testing the efficacy of an FSP providing evidence-based treatment approach of Assertive Community Treatment (ACT). The uniqueness of the approach lies in the initial "lens" through which individuals are viewed and the services that are offered as the "lens" informs what is needed for the individuals'' recovery needs and strengths to be developed.

TARGETED POPULATION:

- Adults with both serious mental illness and co-occurring substance use disorder.

STRATEGY:

This Innovation Project explores making a change to an existing mental health practice/approach, including adaptation for a new setting or community/treatment options for people struggling with both substance abuse and mental illness.

Specific strategies and activities with individuals served include integrated primary care access, a "housing first" approach, and co-location on an SUD/Co-occurring treatment site under a state based co-occurring treatment philosophy and practice. Team-based, client-centered, stage-based treatment, low case load ration, 24-7 availability, in vivo services, and access to supportive services funds are strategies to be employed.

PRIMARY PURPOSE:

Increase the quality of mental health services, including measurable outcomes.

LEARNING PROPOSED:

1) Will clients be successfully engaged by receiving a combination of services through this new FSP?
2) Will using stage-based treatments for both mental health and SUD concurrently lead to improved outcomes for clients participating in the FSP Project?
3) What engagement strategies and interventions will emerge from this concurrent stage-based approach that is most effective for this population?
4) While utilizing the concurrent stage-based approach, what practices/processes are most effective from staff perspective?
5) Will access to integrated primary care positively affect outcomes?
6) Will employing an integrated "Housing First" approach positively affect outcomes?
7) Will co-locating this FSP on a SUD/Co-Occurring treatment site lead to increased peer support, SUD treatment follow through and linkages to mental health and SUD resources?

PROJECT UPDATES

The Project ended in June 2019 as an Innovation Project and was presented to the Representative Stakeholder Steering Committee (RSSC). Both consumers and stakeholders wanted COD to continue and remain a BHRS program. As of June 2019, COD became funded under MHSA as a Full-Service Partnership Program under the Community Services and Supports. The final report was completed and published in February 2020. The Final Report can be accessed at: www.stanislausmhsa.com.

SUICIDE PREVENTION INNOVATION PROJECT (INN-17)
Operated by SCBHRS

PRIMARY PURPOSE:

Increase the quality of mental health services, including measurable outcomes.

CONTRIBUTION TO LEARNING:

Introduce a new application to the mental health system of a practice or approach that has been successful in a non-mental health context or setting.

PROJECT DESCRIPTION:

Over the three-year project period, the Suicide Prevention Innovation Project will use and evaluate the Collective Impact Model as a new best practice or approach to the mental health system.

The project will form and regularly convene stakeholders and partners from various sectors of the community to establish the Suicide Prevention Advisory Board (project collaborative). The Advisory Board will use the Collective Impact Model as its framework to learn about and address suicides in Stanislaus County. The primary purpose is to increase the quality of mental health services, including measurable outcomes. In addition to the primary purpose, the project will also evaluate the Collective Impact Model as a new practice and the impact it has on our community's ability to collaboratively work together on a large-scale issue like suicide.

STRATEGY:

To introduce the application of the Collective Impact Model to the mental health system as a promising practice or approach that has been successful in a non-mental health setting. The Collective Impact Model was adopted as the innovative approach for the project because it allows for cross-sector perspectives, collaboration and the ability to address complex root causes.

The Collective Impact Model is a framework used to tackle deeply rooted and complex social problems.

It is the commitment of a group of stakeholders from different sectors of the community, with a shared vision for solving a specific-complex social problem. The model is based on 5 core principles:

- Common Agenda – various stakeholders come together, collectively define the problem and create a shared vision to solve it
- Shared Measurement – stakeholders agree to collect data and track progress and success in the same way over time, to ensure efforts remain aligned and support shared accountability

- Mutually Reinforcing Activities – diverse actions among stakeholders that coordinate through an agreed upon plan, to maximize results;
- Continuous Communication - building trust and relationships among all stakeholders through consistent open communication;
- Backbone Organization – a dedicated team to convene and coordinate the participation and work among the stakeholders.

LEARNING PROPOSED:

1. Through collective efforts, will the group develop a shared understanding of suicide data in our county? If so, how will the shared understanding impact suicide prevention planning?
2. Can a collaborative use data and combined information from multiple sources to develop a suicide prevention strategic plan that the community will support and embrace?
3. What methods are most effective in increasing suicide prevention awareness in Stanislaus County?
4. Will the collaborative impact the rate of suicide in Stanislaus County? Will specific demographic groups be impacted?

PROJECT UPDATES

FY 18-19 and FY 19-20

Outreach and Engagement

- The SPIP as a collaborative sponsored several suicide prevention and awareness events throughout the community. The following events were sponsored in 2018-2019:
    - "Send Silence Packing" – Active Minds national backpack display brought to California State University, Stanislaus and Modesto Junior College in partnership with the Student Mental Health Wellness Partnership.
    - "Strike Out Suicide" community bowling event in partnership with AFSP.
    - 10th Annual American Foundation of Suicide Prevention (AFSP) Out of the Darkness Walk held at Graceada Park in Modesto.

Strategic Planning

- The Project contracted with Clear Impact, a firm specializing in Results Based Accountability (RBA) and the Collective Impact framework, to help build RBA capacity within the Advisory Board and facilitate a strategic planning process.
- The Advisory Board used RBA to develop suicide prevention strategic recommendations across various community sectors.
- The Project purchased a three-year user license for the Clear Impact Scorecard which served as a mechanism to capture the strategic planning recommendations of the Project, and as a tool to be leveraged for future strategic planning efforts.

CHALLENGES

FY 18-19 and FY 19-20

- The advisory board membership remained small with lower engagement on activities outside of the advisory board meetings.
- The strategic planning activities were initiated on a very aggressive timeframe as the Project was ending. It did not seem there was ample time to really undertake a community strategic planning process.
- Additionally, the group was surveyed to see if any other Advisory Board member organization wanted to continue the strategic planning work of the collaborative by providing back bone support, and at that time none expressed the desire/ability to do that.
- There is need for continued community strategic planning and collaboration around suicide prevention however, leadership is needed to initiate and sustain that collaborative work.

CONCLUSION

The Project ended in September 2019 and the final report was completed and published in July 2020. The Final Report can be accessed at: www.stanislausmhsa.com.

Though the Project did not continue as a funded Program, BHRS will explore ways to support a future suicide prevention strategic planning community effort as it evaluates the need, opportunity and support for a collaborative in the future as well as leverage the learning and the strategic recommendation that came forth from this Project.

NAMI on CAMPUS HIGH SCHOOL MODEL (NAMI on CAMPUS)
(INN-19) (Effective FY 2019/2020)
Operated by Stanislaus County Office of Education

PRIMARY PURPOSE:

Increases access to mental health services.

CONTRIBUTION TO LEARNING:

This project introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

PROJECT DESCRIPTION:

NAMI on Campus High School Innovation Project seeks to increase access to mental health services by applying a proven effective model for youth leadership, development and organization to advance the mental health outreach efforts in high schools throughout Stanislaus County.

The project will integrate the framework of Protecting Health and Slamming Tobacco (PHAST), a program incorporating a strong county-wide coordination of student clubs in Stanislaus County, with NAMI on Campus High School (NCHS) to raise mental health awareness and reduce stigma. This collaboration is expected to propel and sustain the local growth of student organizations in high schools, creating a culture shift to train and equip students to improve mental health awareness, conduct outreach, increase advocacy and destigmatize mental illness.

STRATEGY:

To introduce NAMI on Campus High School through this innovative framework of county-wide collaboration to high schools in Stanislaus County.

- Develop and sustain dedicated leadership of administrators and faculty club advisors which recruit student members and leaders, provide support and guidance for youth-led operations of Club activities, meetings and events.
- Cultivate student leaders to communicate and educate peers on how to access available mental health services in the County, increase knowledge of the signs and symptoms of mental health challenges and end the stigma preventing many individuals from seeking help.
- Embrace a culture of youth who are hungry to lead, passionate about building up and improving their community, and genuinely care about helping their peers by providing opportunities for researching, communicating and advocating for others.
- Conduct annual outreach campaigns addressing topics such as suicide prevention, mental health awareness and advocacy.

- Through monthly NCHS Club advisor meetings, build a county-wide collaborative to help strengthen the combined efforts and leverage resources for up to 15 high schools in Stanislaus County.
- Strengthen the collaboration between NAMI Stanislaus, NAMI California and Stanislaus County School Districts by providing a centralized hub for communication, resources and training.

This work will improve access to mental health services, reduce stigma related to mental health challenges and increase knowledge on the signs and symptoms of mental health challenges.

LEARNING PROPOSED:

- Can adopting new and expanded outreach strategies improve overall access for people in need of services?
- Can adopting new and expanded outreach strategies decrease stigma of mental health problems among high school students?
- Will coordinated cross-collaboration among SCOE, NAMI and school districts increase and sustain mental health outreach and education at high school campuses?
- Will student participation in mental health outreach increase protective factors and improve well-being among high school students?
- Through coordinated peer outreach strategies, we anticipate youth will have increased knowledge of the signs and symptoms of mental health problems and how to seek services. We also anticipate a positive change in attitudes towards seeking mental health services and encouraging others who may need services to seek support.

PROJECT UPDATES

- Secured Memorandum of Understanding (MOU) with Ceres Unified School District, Hughson Unified School District, Modesto City Schools, Oakdale Unified School District, Patterson Unified School District, Turlock Unified School District, establishing NAMI on Campus Clubs at ten High Schools.
- NCHS Clubs have flourished at most of the schools despite challenges triggered by the world-wide COVID-19 pandemic. Clubs are meeting virtually, and county-wide Club membership is 236 students.
- Established communication strategies with NAMI Stanislaus and local Clubs, through virtual monthly NCHS Advisor meetings, monthly NCHS Advisor Newsletter, NCHS Website, which serve to increase resource awareness, engage student learning and maintain Club fidelity while striving to engage the innovative
- PHAST framework. Developed a strong cooperative and reciprocal relationship with NAMI California and NAMI Stanislaus to provide resources, trainings and support for Stanislaus County NCHS Clubs.

- Collaborated with Behavioral Health and Recovery Services (BHRS) to provide a county-wide advocacy training, “Add Your Voice” with the objective to increase awareness and engage youth in the Community Planning Process.

CHALLENGES

- Virtual engagement with students has restricted planned county-wide mental health trainings and resource mapping.
- Some schools continue to struggle with Club member recruitment, while others flourish in the virtual environment. The monthly Club Advisor meetings provide encouragement and creative ideas for staying the course.
- Development of evaluation tools has been limited due to restraints on the Project Evaluator because of COVID-19.

Stanislaus Behavioral Health and Recovery Services

Mental Health Services Act

INNOVATION PROJECT PLAN PROPOSALS FY 2021-22

June 2021

WELLNESS • RECOVERY • RESILIENCE

Stanislaus County Behavioral Health and Recovery Services 800 Scenic Drive, Modesto, 95350, 209.525.6247

INNOVATION OVERVIEW

Innovation is one of five components of Proposition 63, the Mental Health Services Act (MHSA), passed by California voters in 2004. It provides funds to evaluate new approaches in mental health. The projects are intended to contribute to learning and address unmet needs, rather than having a primary focus on providing services.

As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Innovation funding is uniquely focused and intended for projects that demonstrate one of the following primary purposes:

a) Increase access to mental health services to underserved groups.

b) Increase the quality of mental health services, including measurable outcomes.

c) Promote interagency and community collaboration related to mental health services, supports, or outcomes.

d) Increase access to mental health services.

In addition, Innovation projects are expected to contribute to learning in the following ways:

a) Introduce a new mental health practice/approach that has never been done before.

b) Make a change to an existing mental health practice/approach, including an adaptation for a new setting or community.

c) Introduce a new application to the mental health system of a promising, community driven practice/approach or a practice/approach that's been successful in a non-mental health context or setting.

An Innovative Project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solve persistent mental health challenges; including but not limited to, administrative, governance, and organizational practices, processes, or procedures; advocacy; education and training for service providers, including nontraditional mental health practitioners; outreach, capacity building, and community development; system development; public education efforts; research; services and interventions, including prevention, early intervention, and treatment. (Section 9, Part 3.2, 5830c)

As with all MHSA components, Innovation projects must be guided by the following MHSA values:

- Community collaboration - Initiates, supports and expands collaboration and linkages, especially connections with systems, organizations, and practitioners not traditionally defined as mental health entities;
- Cultural competence - Demonstrates cultural competency and capacity to reduce disparities in mental health services and outcomes;
- Client driven mental health system - Includes ongoing involvement of clients, including but not limited to implementation, staffing, evaluation and dissemination;
- Family driven mental health system - Includes ongoing involvement of family members, including but not limited to implementation, staffing, evaluation and dissemination;
- Wellness, recovery, and resiliency focus - Prevent mental health problems, increase resilience and/or promote health recovery;
- Integrated service experiences for clients and family - Encourages and provides for access to a full range of services provided by multiple agencies, programs and funding sources for clients and family members

Innovation projects are developed through input from community planning processes and are reflective of the unmet need identified by inclusive and diverse stakeholder input. Innovation funding makes it possible to try out new approaches, gather data, define and measure the success of the new approach or practice without taking funds away from other necessary services. Since January 2010, Stanislaus County has conducted community planning for Innovation funding that resulted in the development of 17 new projects to date.

Round 1 of Innovation Funding

The first round of planning in 2009 resulted in one (1), three-year project with learning goals related to stakeholder and agency partner participation in understanding public funding processes and how these community partners may contribute to decision-making.

- BHRS/Evolving a Community-Owned Behavioral Health System of Supports and Services Concluding in FY 2012-13, the final report was submitted to the MHSOAC in June 2013.

Round 2 of Innovation Funding

Stanislaus County's unique second round of Innovation planning began with the BHRS Leadership Team's intention to bring project ideas in behavioral health with the county's commitment to community capacity building, increasing protective factors, and advancing of non-stigmatizing early intervention approaches. On October 26, 2010, the Stanislaus County Board of Supervisors authorized the first Request for Proposals (RFP) process for the Innovation learning projects. It resulted in the selection and funding of nine (9) new projects operated by six (6) unique community-based organizations and one county agency. Implementation began in August 2011.

Two (2) year projects:

- Center for Human Services/Building Support Systems for Troubled Children
- Center for Human Services/Civility School Learning Project
- Center for Human Services/Revolution Project
- Stanislaus County Health Services Agency/Integration Innovations
- Sierra Vista Child and Family Services/Connecting Youth to Community Supports
- Tuolumne River Trust/Promoting Community Wellness through Nature

Three (3) year projects:

- National Alliance for Mental Illness (NAMI)/Beth and Joanna Friends in Recovery
- West Modesto King Kennedy Neighborhood Collaborative/Families in the Park
- Peer Recovery Art Project/Arts for Freedom

Final reports may be viewed on-line by going to www.stanislausmhsa.com.

Round 3 of Innovation Funding

A third round of Innovation planning was conducted in FY 2012-13 and resulted in two (2) three-year projects:

- Center for Collective Wisdom/Stanislaus County Wisdom Transformation Initiative
- Turning Point Community Programs /Garden Gate Innovative

Final reports may be viewed on-line by going to www.stanislausmhsa.com.

Round 4 of Innovation Funding

A fourth round of Innovation planning was conducted in FY 2013-14 and resulted in three (3) two-year projects:

- Center for Human Services/Father Involvement Project
- BHRS Juvenile Justice Program /Youth Peer Navigator Project
- Sierra Vista Child and Family Services/Quiet Time Project

Final reports may be viewed on-line by going to www.stanislausmhsa.com. The Quiet Time Project was terminated early due to significant implementation barriers in public schools and there is no final report posted.

Round 5 of Innovation Funding

A fifth round of Innovation planning was conducted FY 2015-16 and resulted in two (2) three-year projects:

- BHRS/Full-Service Partnership (FSP) Co-Occurring Disorders Innovation Project
- BHRS/Suicide Prevention Innovation Project (SPIP)

Final reports may be viewed on-line by going to www.stanislausmhsa.com

Round 6 of Innovation Funding

A sixth round of Innovation planning was conducted in FY 2018-19 that resulted in two (2) five-year projects being selected:

- Romeo Medical Clinic/ Whole Health Approach to Improve Mental Health Outcomes
- Stanislaus County Office of Education/NAMI on High School Campus

Although the Stanislaus County Board of Supervisors approved the Stanislaus County Office of Education (SCOE) NAMI on Campus and the Romeo Clinic Whole Person Health Innovation Proposals on October 22, 2019, the Stanislaus County Behavioral Health and Recovery Services Department (SCBHRS) withdrew the Romeo Clinic Whole Person Health Innovation Proposal from final submission with the Mental Health Services Oversight and Accountability Commission (MHSOAC). The SCOE NAMI on Campus was formally approved by the MHSOAC in April 2020 and began implementation in May 2020. The RSSC was informed of this action in FY 2020-21 which resulted in a broader strategic community planning process for new Innovation proposals. Further particulars are listed below.

Round 7 of Innovation Funding

A seventh round of Innovation planning was conducted in FY 2020-21 that has resulted in two (2) multi-year, multi-county collaborative projects being selected:

- Early Psychosis Learning Healthcare Network Collaborative (LHNC)
- Full-Service Partnership (FSP) Multi-County Collaborative

This document describes the community planning process and each of the two project proposals in detail.

Community Program Planning Background in Stanislaus:

Over the years, planning by BHRS for MHSA funds has included collaborative partnerships with local community members and agencies. Several key elements are central to the mission of BHRS to be successful in these processes strive to present information as transparently as possible, manage expectations in public planning processes related to what can reasonably and legally be done within a government organization, follow the guidelines given by the State, honor community input, ensure that when plans are posted for public review and comment, stakeholders can recognize community input in the plan, post documents and conduct meetings in understandable language that avoids use of excessive technical jargon and provides appropriately fluent speakers for diverse populations when needed.

Compelling community input obtained at the original launch of MHSA community planning in 2005 developed core guiding principles that serve to inform all subsequent planning processes. Whenever feasible, MHSA plans, processes, and programs should address inclusion and service to all age groups and all geographic areas of the county, be based on existing community assets, not exceed the community's or BHRS' capacity to organizationally or fiscally sustain programs and be compatible with the statutory responsibility BHRS holds to administer MHSA funds.

The Representative Stakeholder Steering Committee (RSSC) is actively engaged in identifying needs, priorities, and guiding principles during planning processes. The RSSC is comprised of approximately 40 individuals representing a diverse spectrum of community interests in accordance with MHSA guidelines. In Stanislaus County, diverse participants have included, but are not limited to, consumers and family members, social services, education, underserved communities, providers of health care, contract providers of public mental health services, representatives from diverse communities, law enforcement, courts, probation, faith-based community, disability serving organizations, labor organizations, Stanislaus County Chief Executive Office, Behavioral Health Department staff, Area Agency on Aging, and regional geographical areas of Stanislaus County including South and Westside of the county. The primary language spoken in these meetings is English unless other languages or methods of communication are requested.

Representative Stakeholder's role includes giving input on all plans and updates to be submitted, reviewing outcome data in the annual update, and sharing information about MHSA plan processes and results with the constituency/community they represent.

Community Program Planning for Innovation in 2020-2021:

Stanislaus County Behavioral Health and Recovery Services (BHRS) had been actively engaging in the Community Planning Process specifically with the intent to inform engaged stakeholders on updates facing MHSA, with the focus of strengthening stakeholder engagement. Traditionally stakeholder meetings were convened twice a year, in some years quarterly. However, with the onset of the COVID-19 crisis that began in March of 2020 and policy effects on MHSA, BHRS identified the opportunity to create a more robust stakeholder process. In this effort stakeholders were informed formally of MHSA regulations and their specific role as it relates to the community planning process for the MHSA Three-Year Plan and Annual Update.

Formal Representative Stakeholder Steering Committee (RSSC) meetings for MHSA were held on June 12th, June 26th, September 18th, and December 11th of 2020. Each meeting averaged 62-80 participants; the information session had 44 attendees. The meeting held on December 11, 2020, was also offered in person at the new Granger Community Center to gain additional participation from peers and consumers. During the December 11th meeting RSSC members were informed of the reversion issue facing BHRS; related to unspent Innovation funds from previous fiscal periods. Stanislaus and other counties facing this issue, were encouraged by the MHSOAC to explore alignment with Innovation projects already approved. BHRS quickly observed that two multi-county collaborative Innovation projects provided by the MHSOAC aligned very well with insights from stakeholder input on the BHRS system as whole, and one aligned well with BHRS efforts to create a more robust stakeholder process for future Innovations.

To explore this further and to ensure stakeholder support on these Innovation projects, BHRS conducted an informational session that detailed each project proposed as well as allowed time for discussion and questions surrounding these projects. The informational session for proposed Innovations Projects was a dedicated meeting on December 29th. Following the December 29th Innovation informational session, stakeholders were invited to the RSSC meeting on January 15, 2021, to formally measure the level of support to move forward and pursue the proposed Innovation Projects. After engaging in small group discussion and large group feedback discussion, RSSC members were surveyed utilizing the gradients of agreement scale; a scale utilized to measure the level of agreement and support towards a proposal. BHRS provided a one through five scale, with one being non acceptance of the proposed project and five being complete and full acceptance. RSSC members identified fours and fives as their measurement during this meeting. The meeting concluded with agreement to move forward with both proposed Innovations Projects.

Proposed Innovations Projects were posted for 30-day Public Review April 21, 2021 in which no public comment was received. Additionally, the Innovation Projects were presented to the Local Mental Health Board on April 22, 2021, and the public hearing to the Local Mental Health Board occurred on May 27, 2021. No public comments were received.

Innovation Project Proposed:
Early Psychosis Learning Healthcare Network Statewide Collaborative

Primary Purpose and Qualification as an Innovation Project

The proposed Innovation Project will make a change to an existing practice in the field of mental health by introducing a collaborative Learning Health Care Network (LHCN) to support quality improvements, consumer engagement and provider use of measurement-based care in early psychosis (EP) programs. This LHCN will collect and visualize real-time data at the individual, clinic, county and state levels to inform consumer and program-level decisions and develop learning opportunities for individuals, staff, programs and administrators, in order to improve consumer outcomes. In addition, this project will include training and technical assistance to EP program providers to help them fully utilize the data in routine clinical care. The associated evaluation will examine the impact of the LHCN on the EP programs, and will quantify the cost of implementation and utilization, in order to support statewide efforts for early identification and treatment of psychosis. This project proposes an innovative approach to state-level learning and real-time outcomes monitoring for consumers, their families, and EP programs. Aligning with a primary purpose for an Innovation project as identified by the MHSOAC, this project seeks to increase the quality of services, including measurable outcomes.

The proposed project meets a variety of unmet needs across the state:

1. Collects and visualizes consumer-level data across a variety of recovery-oriented measures to directly inform day-to-day service provision. Training and technical assistance will be provided to support the ability for EP program providers to use the LHCN data in practice, transforming these services to measurement-based care.
2. Provides immediate access to relevant outcome data for program leadership that can be quickly shared with stakeholders, the county, or the state. Rapid dissemination of program outcomes has historically been a challenge for county-based programs.
3. Provides infrastructure for an EP Learning Collaborative across counties, in which common challenges can be identified and "lessons learned" can be quickly disseminated, creating a network of programs that rapidly learn from and respond to the changing needs of their consumers and communities.
4. Evaluation of the LHCN will provide information on how to incorporate measurement-based care into mental health services and demonstrate impact of the LHCN on the recipients and providers of EP care.

Primary Problem

A number of interventions are effective in reducing psychotic symptoms and promoting functional recovery in first-episode psychosis, including low doses of antipsychotic medication (Sanger et al., 1999), cognitive behaviorally-based psychotherapy (Lecomte et al., 2008; Wang et al., 2003), family education and support (Leavey et al., 2004) and educational and vocational rehabilitation (Nuechterlein et al., 2008). These elements are typically delivered together in a team-based approach in specialized early psychosis (EP) programs (Goldstein & Azrin, 2014). This contrasts with standard care delivered within non-

specialized community mental health teams where fewer of these treatment components are typically available, and the components that are available are often delivered across multiple services in a less coordinated approach.

The Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA), coupled with a legislative focus on early psychosis (AB 1315, SB 1004), has led to an expansion of specialized EP programs across California. These programs target individuals early in the course of mental illness, with a goal of preventing mental disorders from becoming severe and disabling. As of 2017, 30 EP programs exist serving consumers across 24 of the 58 Counties of California. However, these programs were started county by county with little collaboration in training or implementation. As a result, there is significant variation in the EP programs delivered across counties (Niendam et al., 2017), and many programs feel isolated and struggle to get the training and technical assistance needed to keep their EP program flourishing. While there is evidence that EP programs are effective (Kane et al., 2015), it is not clear which components of the EP service model are key to improving particular outcomes. As a result, it is currently unclear to what degree this variation is impacting outcomes and overall program effectiveness. In addition, the impact of these programs on the individuals and communities they serve in CA remains largely unknown.

Proposed Project:

The proposed Innovation project seeks to:

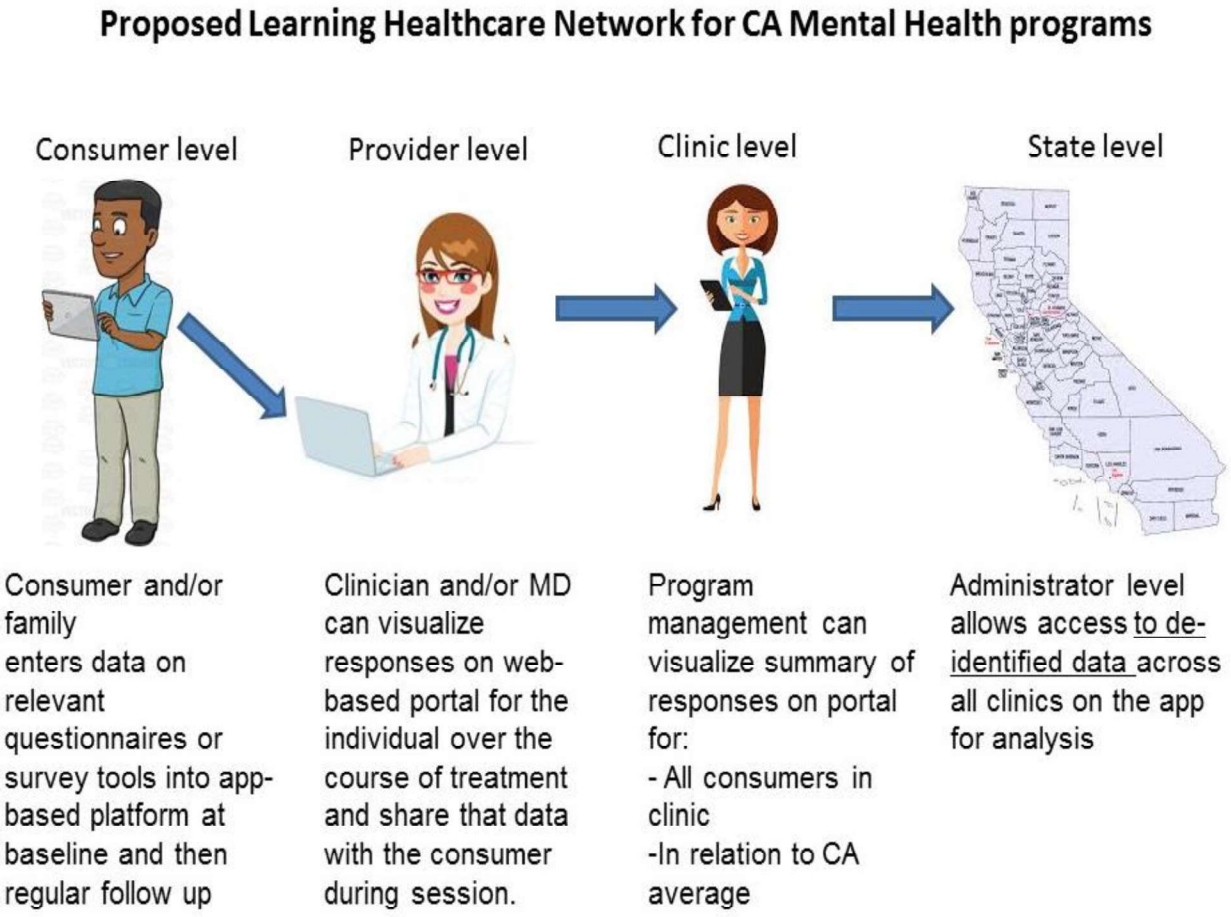
1) Develop an EP learning health care network (LHCN) software application (app) to support ongoing data-driven learning and program development across the state.
2) Utilize a collaborative statewide evaluation to:
    a. Examine the impact of the LHCN on the EP care network
    b. Evaluate the effect of EP programs on the consumer- and program-level outcomes.

Six counties (Los Angeles, Orange, San Diego, Solano, Napa, Sonoma), in collaboration with the UC Davis Behavioral Health Center of Excellence and One Mind, have been approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) to use Innovation Funds to develop the infrastructure for a sustainable LHCN for EP programs, the utility of which will be tested through a robust statewide evaluation. Stanislaus County is now seeking approval from the MHSOAC to join the Collaborative as the seventh county. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary and a number of California counties, will bring consumer-level data to the clinician's fingertips, allow programs to learn from each other, and position the state to participate in the development of a national network to inform and improve care for individuals with early psychosis across the United States. The evaluation would assess the impact of the LHCN on consumer and program-level metrics, as well as utilization and cost rates of EP programs. This will allow counties to adjust their programs based on lessons learned through multiple research approaches. One Mind, a foundation focused on improving brain health outcomes, has partnered in this project to enhance available resource to support achievement of project goals in a timely fashion.

Background Research on Innovation Component

The foundation for the proposed California EP LHCN and associated evaluation was developed through a prior MHSOAC-funded project (14MHSOAC010), which sought to develop a method for evaluating publicly funded EP programs statewide. Based on the current research literature, cumulative findings of the previous project, and stakeholder input, it became clear that EP program consumers, providers and county supports wanted to have immediate access to their data in real time at various levels (see Figure 1 below).

Figure 1. Proposed LHCN for CA Mental Health Programs



Through a collaborative county-led development process, several advantages of collecting such data in this manner were identified. For example:

- Consumers and their families and EP providers could review individual-level data while in session together to help identify needs, support the delivery of consumer-centered care, and help understand what factors may be contributing to treatment progress.
- Clinic managers or county administrators could visualize data across the program and compare program averages to a statewide benchmark to help identify possible areas for program-level improvement.
- At the highest level, this data could be de-identified and combined across counties to support large-scale analysis to identify system-wide strengths or areas of need.

While this project was initially conceived as an evaluation, stakeholder input shifted the focus to development of a LHCN where the system rapidly accumulates data from routine clinical practice and makes it immediately available to improve clinical care. EP programs and their associated counties recognized the unique opportunity to have longitudinal consumer- and service-level clinical data available to providers and their consumers in real-time that can be used as part of the consultation. In addition, they also recognized that this network would allow them the opportunity for improved outcome recording and reporting, which can be used for service planning and improving standards of care via comparison to a statewide benchmark. These stakeholders proposed that this could serve as the basis for an EP learning collaborative, through which programs or counties could use the data to identify areas of unmet clinical or training needs, identify which service components drive outcomes in a particular area, collaborate to hold trainings, and learn from each other's successes and struggles. Through the network, these otherwise disparate programs could come together to learn, grow and improve.

In addition, this Innovation project would leverage the California LHCN to support our potential participation in a national early psychosis LHCN, which will be funded by the National Institute of Mental Health (NIMH). The NIMH is interested in developing a national network of EP programs –named EPINET – but involvement in this national network requires the participating states to have established infrastructure for large scale data collection and reporting. California has the largest dissemination of EP services in the US. However, at present we lack the infrastructure to participate in this network. By systematically designing outcome reporting for counties across the state, the LHCN moves beyond simple program level evaluation and lays the groundwork for linking data on both a state and national level, to address more complex questions about best practices.

The participation of the counties and programs co-authoring this proposal, in addition to support from One Mind, demonstrates the anticipated value of the LHCN and statewide evaluation. We have a unique opportunity to build a coalition of counties, their partnered programs, and leading researchers in EP services to share lessons about what works for consumers and their families across the state using qualitative and quantitative methods. With this innovative proposal, the state will have data input from consumers, family members and providers as well as quantitative impacts such as service utilization, hospitalizations, and crisis utilization. The LHCN and the statewide evaluation dovetail to inform early psychosis care across the state. It is our aim to use the LHCN as a resource and a tool for the counties before, during and after a formal evaluation, and to sustain the network beyond the 5-year project for ongoing benefit to the counties involved and the state of California.

Stakeholder Input in Project Development

In addition to stakeholder input as part of the prior MHSOAC funded project, priorities for implementation of this LHCN and statewide evaluation were identified in a series of stakeholder meetings conducted in 2017 and 2018 with relevant county and program leaders, individuals with lived experience of psychosis, and family members of those with lived experience. Three common themes were prevalent in all conversations – utility, relevance to real-world outcomes, and sustainability.

Stakeholders reported immediate value in the utility of electronic tablet data collection and the ability to display outcomes data at the individual level for use during clinical visits, at the program level for internal quality improvement, and at the state level for system level learning. Stakeholders representing consumers and family members felt that this access to data was exciting and would likely increase engagement in care. Because of this, the evaluation team has prioritized the utility of the data collected in real-time.

All stakeholders, especially individuals and family members, wanted to prioritize measures relevant to their experience and real-world outcomes. Stakeholders were presented with options for self-report measures that have been previously selected for use in community-based early psychosis programs by a national workgroup, based on validity, ease of data collection and clinical utility (www.phenxtoolkit.org), as well as additional measures for domains not represented in the toolkit. Starting from this working list, the final set of outcome measures will be selected in Year 1 of the proposed project based on the outcomes of a series of focus groups with EP providers, county and state representatives, consumers and family members, across all participating EP programs. Mental Health America has agreed to support recruitment for these focus groups. We will develop a list of core measures that will be collected across all programs, and a supplementary list which will include outcome measures that can be added to an individual program's battery to address any program or county-specific needs.

For county- and state-level stakeholders, data on costs and utilization in the EP programs, crisis/ED services and hospitals, and homelessness for the seriously mentally ill (SMI) were highlighted as key areas of interest. The ability to understand how EP programs yield differential utilization of high-cost services versus standard outpatient care is essential to clarify the impact of these programs on the communities that they serve and support ongoing funding. Stakeholders felt that combining the EP program level data collected directly from consumers and family members with the cost and utilization data will help counties and programs to understand the consumer and program-level factors that contribute to increased utilization of high-cost services, thereby enabling targeted decisions around program level changes to mitigate those costs.

Finally, the program and county stakeholders reported that plans for sustainability after the project end date are important for their ongoing interest. As part of the project, we will calculate true costs to programs for implementation of the LHCN tablets within daily clinic

operations, including costs to sustain the LHCN app, staff time to support data collection, and ongoing training needs, to inform future decisions around sustainability. Additional California counties and EP programs have expressed an interest in the LHCN (Kern, Santa Barbara, Marin, Ventura, San Mateo), highlighting growing interest in the potential of the LHCN for California.

The counties affiliated with this current proposal and their respective program partners have all agreed to participate in the development of the LHCN, and its evaluation, in collaboration with project partners at UC Davis, UC San Francisco, UC San Diego, University of Calgary and One Mind.

Overall Goals

1. Implement a LHCN app for early psychosis programs across multiple California counties.
2. Develop a LHCN implementation strategy that could be adopted by EP programs statewide.
3. Evaluate the impact of the LHCN on consumer satisfaction with care, insight into treatment needs, and alliance with the treatment team, as well as consumer and provider experience implementing the LHCN.
4. Demonstrate the utility of the LHCN through a multilevel evaluation of: a) the EP program components associated with improved consumer level outcomes, b) the potential differences in service utilization and costs (EP program, ED/crisis, hospital) between EP programs and standard care for EP consumers from de-identified county level data, and c) the consumer, family and EP provider experiences related to participation in the LHCN.

Consumer/Target Population

The target population or intended beneficiaries/users of this LHCN are:

- Individuals at increased risk or in the early stages of a psychotic disorder
- Family members, caregivers, or other support persons
- EP program providers
- County and EP program leadership
- State leadership and policy makers

Learning Goals and Project Aims

Through the development of the LHCN and the associated evaluation, we will answer the following questions:

1. Do consumer and/or provider skills, beliefs and attitudes about technology or measurement-based care impact completion of LHCN outcome measures or use of data in care?
2. Does engagement in the LHCN impact consumer satisfaction with care, insight into treatment needs, and alliance with the treatment team?
3. Are there differences in utilization and costs between EP programs and standard

care?

4. How does utilization and cost relate to consumer-level outcomes within EP programs?
5. What are the EP program components associated with consumer-level short-and long-term outcomes in particular domains?
6. Within EP programs, what program components lead to more or less utilization (e.g. hospitalization)?
7. To what extent do California EP programs deliver high fidelity to evidence-based care, and is fidelity related to consumer-level outcomes?
8. What are the barriers and facilitators to implementing a LHCN app across EP services?
9. What are the consumer, family and provider experiences of submitting and utilizing data obtained through the LHCN during routine clinical care?
10. Does a technology-based LHCN increase use of consumer-level data in care planning relative to a program's prior practice?
11. Does use of consumer-level data increase consumer insight into treatment needs, promote alliance with the treatment team, or improve satisfaction with care?
12. What will be a viable strategy to implement a statewide LHCN for EP programs?

Evaluation Plan

1. Utility of the Learning Health Care Network for Early Psychosis Programs

To examine the utility of the LHCN for EP consumers and providers, the evaluation will examine the impact of the LHCN on the counties and their services. We predict that the easy-to-access, on-demand data collected via the LHCN, in addition to provider training in how to fully utilize and share information with consumers and family members will increase the use of data in treatment planning and care decisions, moving the system toward measurement-based care. Further, our previous experience implementing mobile health technology in community-based EP programs (Kumar et al., 2018; Niendam et al., 2018) suggests that this project will improve consumer satisfaction with care, increase insight into their treatment needs, and enhance their alliance with the treatment team.

To address this question, the evaluation will gather information from a sample of EP consumers and providers prior to LHCN implementation, and from another sample of EP consumers and their providers after LHCN implementation. Consumers in the pre-implementation period (Year 1) will be asked to complete self-report questionnaires about Insight into illness, Perceived Effect of Use for the LHCN, Treatment Satisfaction, Treatment Alliance, and Comfort with Technology. Providers will complete questionnaires on Treatment Alliance, Use of Data in Care Planning, Perceived Effect of Use for the LHCN, and Comfort with Technology. After LHCN implementation (Year 4), a new group of consumers and their providers will complete the same self-report questionnaires. In both phases, consumers and providers will complete the questionnaires approximately 6 months after consumers' entry into the EP programs. This data will be compared and then combined with stakeholder

feedback and qualitative results to understand the impact of the LHCN on the consumer and provider experience.

2. Evaluation of Early Psychosis Program Fidelity

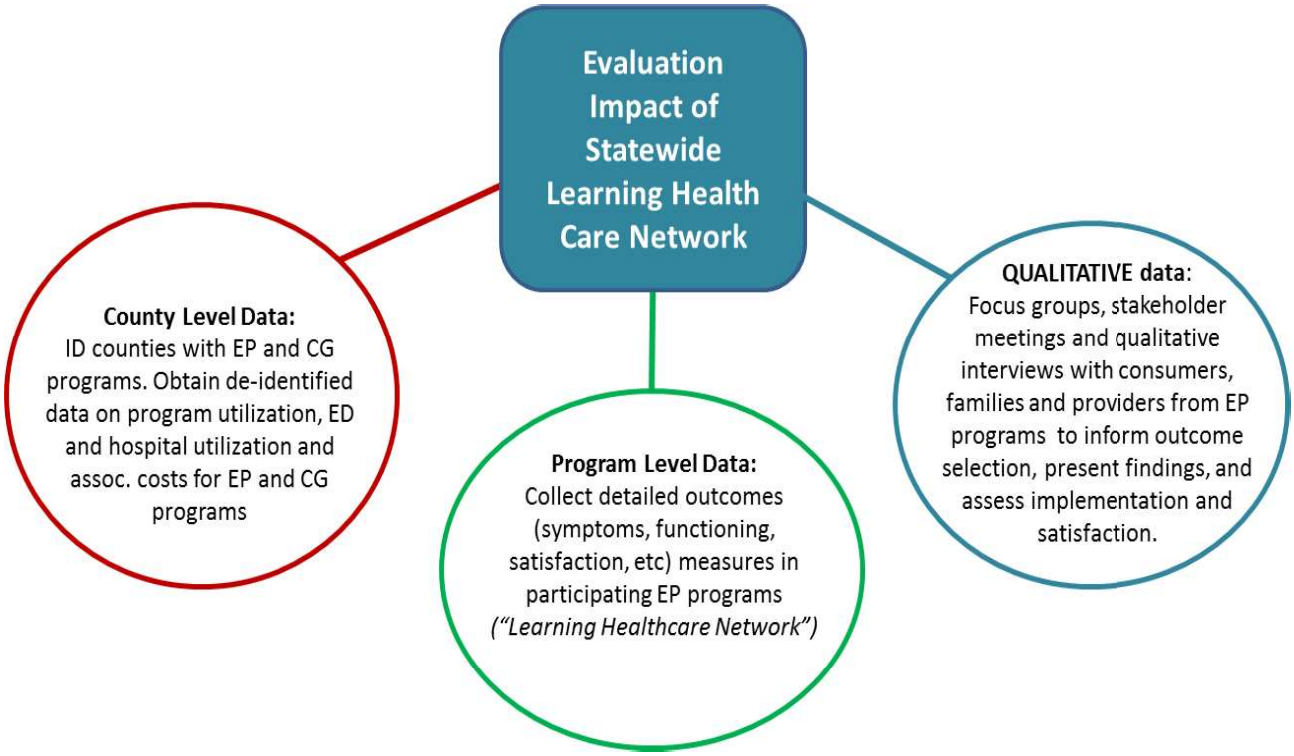
Each participating clinic will undergo a fidelity assessment to determine their adherence to evidence-based practices for first-episode services using a revised version of the First Episode Psychosis Services Fidelity Scale (FEPS-FS). The FEPS-FS represents a standardized measure of fidelity to EP program best practices (Addington et al., 2016; First Episode Psychosis Services Fidelity Scale: (FEPS-FS 1.0), 2015). The FEPS-FS was developed using an international expert consensus method, focused on six domains: (1) population-level interventions and access, (2) comprehensive assessment and care plan, (3) individual-level intervention, (4) group-level interventions, (5) service system and models of intervention, and (6) evaluation and quality improvement. This scale was tested for reliability in six EP programs in the United States and Canada, and an accompanying FEPS-FS 1.0 Fidelity Review Manual was developed for future program review. The FEPS-FS has been recently revised to meet the agreed upon standards of EP care in the United States and allow large-scale fidelity evaluation. In the proposed statewide evaluation, each EP program will participate in an assessment of EP program components using the revised FEPS-FS, which will be completed on-site or via web-based teleconference. The resulting score will be used as part of the statewide analysis. These assessments will be conducted in consultation with Don Addington, M.D. from the University of Calgary, author of the FEPS-FS scale. Dr. Addington will serve as a Co-Investigator on this project and provide oversight and support for the fidelity evaluations and interpretation of other outcomes data related to components of care. The ability to evaluate the impact of service-level factors on consumer-level outcomes collected by tablets is a key component of adopting features of a LHCN. This will provide us with important new insights into what components of the EP program of care are associated with improved outcomes in different domains. These findings can then be disseminated across the network (and beyond), further informing care and shaping service delivery.

3. Impact of Early Psychosis Programs on Costs and Outcomes

This portion of the evaluation is divided into three data components: program-level, county-level, and qualitative (see Figure 2 below). The first component (program-level), which serves as the foundation for the LHCN, utilizes a prospective, longitudinal approach to gather consumer level data elements for EP programs on core outcomes in six-month intervals across 24 months, starting at the intake assessment. The second component (county-level), modeled after a pilot analysis in Sacramento County, will focus on county-level administrative data related to consumer's program service utilization, crisis/ED utilization (if available), psychiatric hospitalization, and costs associated with these utilization domains. Service utilization and costs will be compared between EP and comparator outpatient programs in that county who serve similar consumers with EP diagnoses (Niendam et al., 2016). These comparator programs will be identified by input from county representatives, and an evaluation of county level data to identify where first-episode

psychosis consumers are typically treated in their county outside of the EP program. The third component (qualitative) incorporates qualitative interviews, stakeholder meetings and focus groups with EP providers, consumers, family members, county representatives and regulators to determine which outcomes should be incorporated into the program-level evaluation, inform the design of the program-level data collection system, identify challenges and solutions to implementing the LCHN, and to provide their experiences of delivering or receiving services under this model of care. Taken together, we believe these 3 components will provide a rich, comprehensive summary of the impact of EP programming in California where counties and programs across the state can learn from each other about what works and what can be improved. Each evaluation component is explained in detail below.

Figure 2. Three components of the evaluation associated with the Statewide LHCN.



Program-level Data Component

This component of the statewide evaluation will focus on a longitudinal, prospective study of core data elements for EP, which will serve as the foundation for the statewide LHCN. This component includes final identification of core data elements, which are considered appropriate and useful by EP programs via stakeholder engagement discussions, and determination of appropriate methods for data collection. Recovery-oriented data elements will be included to understand program impact across domains that are important to stakeholders and may not be reflected in more traditional outcome measures. As noted in stakeholder feedback, consumers and families will directly provide data via questionnaires, which would reduce the data entry burden on clinic staff. If data elements are useful metrics of program goals, the collection of outcomes data in this method could increase motivation for participation by EP programs and address stakeholder's desire to participate in the LHCN.

In this component, EP program providers and leadership, consumers and family members will be engaged to identify measures of potential outcomes selected from the PhenX Early Psychosis Toolkit (https://www.phenxtoolkit.org/index.php) and those currently in use by the national Mental Health Block Grant 10% set-aside evaluation of EP programming (see Table 3 on Outcomes below), as well as additional relevant domains. Consistent with other approaches to evaluation (Full-Service Partnership Toolkit, 2012), short and long-term outcomes as well as outcomes prioritized by cultural minority groups will be considered. Once measures are selected by the stakeholders, a prioritization process will be used to identify core outcome domains and measures that can be collected across EP programs. A method of data collection will be developed that aligns with EP program workflows, to reduce burden on EP providers, consumers and families. EP programs will complete the outcomes evaluation at baseline, and every 6 months thereafter (24 months total). Programs will also provide information on each participating consumer's diagnosis and demographics. All information will be de-identified at the program level before being submitted to the UC evaluation team.

A primary incentive for county participation is the technologically innovative component of the program-level analysis, which will serve as the foundation for the LHCN. Consumers will self-report outcomes on tablets, with access to discuss the results directly with their providers, supporting a consumer-centered approach to care while reducing provider burden. That data will be visualized in real-time on a web-based provider-facing dashboard. EP providers will receive support in how to utilize this data during consumer sessions to illustrate their progress toward recovery and inform collaborative treatment planning. The dashboard will also provide summaries at the program level to aid in program decision-making based on patterns or trends. A core set of outcome measures will be collected uniformly across the five counties, so that a program's data can also be compared to a statewide average, to provide guidance on where training or technical assistance could be helpful to improve program outcomes.

Based on estimated numbers from our previous descriptive summary of programs in California, we will expect to enroll and obtain 12-month outcome data on approximately 2000-2500 individuals, with a subset of individuals providing outcome data at 18 and 24 months (Niendam et al., 2017). Outcome on each domain will be modeled longitudinally, controlling for any demographic differences between counties (e.g. age, gender, race/ethnicity). Similarly, scores on the program fidelity assessment will be tested to determine its impact on consumer-level outcomes.

Table 1. Possible Outcomes, Sources of Outcome Data, and Methods to Determine Costs Associated with Outcomes

Potential Outcomes of Interest	Sources of Data on Relevant Outcomes	Levels of Analysis	Sources of Cost Data associated with Outcomes
COUNTY LEVEL DATA VARIABLES			
Inpatient hospitalization for mental health concerns	• County hospitalization records	• Number/proportion of individuals hospitalized per group • Number of hospitalizations per group • Number of hospitalizations per individual • Duration of each hospitalization (days) • Total duration of hospitalizations (days) per individual	• Daily rate paid by County • Daily rate Medi-Cal reimbursement
Emergency Department or Crisis stabilization	• County crisis stabilization unit records	• Number/proportion of individuals with crisis visits per group • Number of visits per group • Duration of each visit (hours)	• Hourly rate paid by County
Outpatient service utilization	• Service unit records by outpatient program from County	• Service type • Number of service units (minutes)	• Contract service unit rates

Potential Outcomes of Interest	Sources of Data on Relevant Outcomes	Levels of Analysis	Sources of Cost Data associated with Outcomes
PROGRAM-LEVEL DATA VARIABLES			
Psychiatric Symptoms	Modified Colorado Symptom Index (CSI)* (Ciarlo & Reihman, 1977; Shern et al., 1994)	Frequency of positive, mood, and cognitive symptoms	*Self-report designed for adults 18+*
	Brief Psychiatric Rating Scale (BPRS)* (Overall, 1961)	Comprehensive evaluation of positive, negative, and affective symptoms	*Providers-administered*
Psychosis Recovery	The Questionnaire about the Process of Recovery (QPR) (Neil et al., 2009)	Consumer perception of recovery from psychosis	*Self-report designed for adults 18+*

Social and Role Functioning	Global Functioning: Social and Global Functioning (Cornblatt et al., 2007)	Current social functioning, and highest and lowest functioning in the year prior to assessment	*Providers-administered for adolescents and adults 12+*
	MIRECC Global Assessment of Functioning (GAF)* (Niv, Cohen, Sullivan, & Young, 2007)	Occupational functioning, social functioning, and symptom severity	*Providers-administered*
Personal Well-being	Personal Well-being Index (Cummins, Eckersley, Pallant, Van Vugt, & Misajon, 2003; Tomyn, Tyszkiewicz, & Cummins, 2013)	Satisfaction with standard of living, health, life achievement, personal relationships, personal safety, community connectedness, and future security	*Self-report with both adult and child forms*
	Lehman Quality of Life Scale* (Lehman, 1988)	Quality of life in chronic mental illness	*Providers-administered*
Antipsychotic Medication Side Effects	Glasgow Antipsychotic Side-effect Scale (GASS) (Waddell & Taylor, 2008)	Consumer's viewpoint about suffering due to excessive side effects from antipsychotic medication	*Self-report designed for adults 18+*
	Extrapyramidal Symptom Rating Scale (ESRS) (Chouinard & Margolese, 2005)	Drug-induced movement, balance, and muscle tone related side effects	*Providers-administered for adults 18+*
Antipsychotic Medication Adherence	Brief Adherence Scale (BARS) (Byerly, Nakonezny, & Rush, 2008)	Consumer's medication taking behaviors	*Providers-administered for adults 18+*
Family Functioning	Systematic Clinical Outcome Routine Evaluation (SCORE-15) (Stratton, Bland, Janes, & Lask, 2010)	Family difficulties, strengths, and communication	*Self-report*
Family Burden of Mental Illness	Burden Assessment Scale (BAS) (Reinhard, Gubman, Horwitz, & Minsky, 1994)	Burden on families with family members that are experiencing severe mental illness	*Self-report designed for adults 18+*
Incarceration	The National Survey on Drug Use and Health (NSDUH) 2014 Questionnaire (1997)	Arrests, legal contact, and probation information for the year prior to assessment	*Self-report with both adult and child forms*
Risk for Homelessness	Homelessness Screening Clinical Reminder (Montgomery, Fargo, Kane, & Culhane, 2014)	Risk of future homelessness in adults	*Provider administered screening tool for adults*
	At-Risk of Homelessness Indicator (Chamberlain & MacKenzie, 1996)	Risk of future homelessness in young people	*Self-report designed for school aged youth*

Physical Activity	The International Physical Activity Questionnaire (IPAQ) (Lee, Macfarlane, Lam, & Stewart, 2011)	Physical activity in the week prior to assessment	*Providers-administered for adolescents and adults 15+*
Mental Health Services Satisfaction	MHSIP Youth Services Survey (YSS) (Brunk, Koch, & McCall, 2000)	Consumer's viewpoint on service satisfaction	*Self-report for adolescents ages 13-18*
	Recovery Self-Assessment (RSA) (O'Connell, Tondora, Croog, Evans, & Davidson, 2005)	Perceptions of recovery, quality of services, and staff helpfulness and responsiveness	*Self-report for adults 18+, with family member and provider variants*

**These measures are currently used by the MHBG 10% Study*

Qualitative Data Component

The main focus of this component is the collection, interpretation and integration of county and state representative, EP program providers and leadership, consumer, and family stakeholder input across all aspects of the project. Prior to data collection, an Advisory Committee consisting of consumers and family members of service users, EP providers, researchers and county and state representatives will be recruited with the aim of providing input at each stage of the project. This Advisory Committee will convene every 6 months, and when needed, to provide input at the initiation and submission of the major project deliverables detailed below.

In the first year, focus groups with providers, consumers, family members, and state and county representatives will be conducted to identify which measures represent outcomes that are both meaningful and are feasible to implement in routine clinical practice, as described earlier. Following outcome selection, further focus groups will be held to inform the application development and dashboard design at different stages of the process to ensure that the system will be appropriate for use in a clinical setting.

Following the initial rollout of the tablets to the pilot EP program sites, a qualitative evaluation of the implementation strategy for the LHCN will be conducted in order assess its feasibility, and to identify any barriers which may need to be addressed prior to full rollout across all programs. In-depth, semi-structured interviews with consumers, family members, and providers will be conducted. Interview guides will be developed in collaboration with service users, family members, providers and county representatives to ensure that all areas deemed relevant to stakeholders are considered. Input from stakeholders in the analysis and interpretation of the data will be sought to support the validity of the findings. The aim of this investigation will be to identify any facilitators that have been found to improve the implementation of the LHCN at a site level, and identify any significant barriers to successful implementation, with a proposal of strategies to address such barriers.

MHSA programs strive to provide services to consumers with a patient-centered focus to consumers' treatment goals (MHSA, 2005). With this in mind, consumer, family and provider

experiences of delivering or receiving care within a LHCN will also be explored once the data collection systems are in full operation. This investigation will focus on the acceptability of the LHCN procedures to consumers, providers, and families; the impact of the LHCN on treatment engagement and satisfaction with care; and experiences of the data being used in routine clinical practice. At project end, a stakeholder meeting with consumers, family members, providers, county representatives and sponsors will be held to present the project findings and receive further feedback to help shape future EP LHCN implementation efforts both across the state and nationwide. Mental Health America has agreed to support recruitment for these focus groups.

County-level Data Component

The proposed analysis is based on the pilot work conducted in Sacramento County, scaled to multiple counties (Niendam et al., 2016). It focuses on consumer level data related to program service utilization, crisis/ED utilization, and psychiatric hospitalization and costs associated with these utilization domains. First, EP individuals entering the EP programs during a specified period will be identified. To compare the utilization and costs of the EP program to what they would be without the program, an appropriate comparison group is an essential component of this evaluation. Therefore, the proposed analysis of utilization and costs includes data collected as part of regular operations standard outpatient (comparator) programs during the same timeframe in the same community. Individuals with EP diagnoses, within the same age group, who enter standard care outpatient programs during that same time period will be identified as part of the comparator group (CG). Comparator group programs will be identified by input from county representatives, and an evaluation of county level data to identify where first-episode psychosis mental health consumers are typically treated in their county when not receiving specialty EP program services. Categories of service utilization will include, at a minimum, outpatient, inpatient and emergency services. It may also include justice system mental health use, if those data are available. Next, costs per unit of service will be assigned to each type of service, per provider, based on cost reports submitted to the counties from the provider clinics. All information will be de-identified at the program level before being submitted to the evaluation team.

Analyses of service utilization for both groups (EP and CG) will focus on two time periods: 1) the three years prior to the start of this project (e.g. July 2015 – June 2018) to harmonize data across counties and 2) for the 3.5-year period contemporaneous with the prospective EP program level data collection to account for potential historical trends during the evaluation period. Mean service utilization, by service type, will be modeled longitudinally between EP and CG groups, controlling for any demographic differences between groups (e.g. age, gender, race/ethnicity, socioeconomic status). Similarly, costs associated with service use would also be modeled longitudinally between groups. Scores on the FEPS survey will be tested as a moderator of both service use and costs, within the EP clinics.

The evaluation team will establish a shared database with harmonized data from multiple counties. This requires partnering closely with county representatives, EP and CG

programs. This process will be linked closely to the qualitative component of the evaluation to identify barriers and problem-solve solutions to those barriers, such as how to make the data export most efficient for counties. The collection of county-level data would overlap with the program-level data component described above. We anticipate that each county formats their utilization and cost data somewhat differently, so that each individual county's data would require analysis to clean the data and create a common format for all data elements across participating counties. This would enable the final analysis to combine data across counties, using a modeling approach that adjusts for the clustering of data within counties. Multiple stakeholders will be involved in all stages of the analysis, regarding study design, analysis and obtaining feedback on results of both the pilot and full study phases.

County Participation in Each Component of the LHCN

The initial group of counties that established the LHCN will participate in all components of the LHCN, described above. Those initial counties include Los Angeles, Napa, Orange, San Diego, and Solano Counties. As additional counties join the collaborative, they will have the option of selecting which component of the project they would like to participate in. Sonoma County will only be participating in the program-level component and fidelity assessment.

Protecting Privacy and Confidentiality

Counties will provide de-identified information on consumer-level utilization and associated costs for the fiscal years specified in the proposal. This will be for individuals in the EP program as well as individuals identified in comparator programs within the county. EP programs will enroll individuals in the online data collection system ("learning healthcare network app") that will collect data on a variety of self-report questionnaires as well as basic demographic data (sex, race/ethnicity, year born – see PHI note below) that is tied to their participant ID. Consumers will complete these surveys at baseline and every 6 months thereafter until the end of 24 month follow up. This data will be available to the consumers and EP program providers on the dashboard (via visualizations and data sheets) at an individually identifiable level, but only de-identified data will be available at the UC Davis level. Stakeholders (consumers, families, providers, county representatives) will be asked to provide feedback throughout the project, including participation in focus groups and qualitative interviews, that will ask their opinion and experiences as part of the project. Participants' responses will be recorded via handheld digital recorders or via secure conference lines (via ReadyTalk). All response audio files will be de-identified, removed of all 18 PHI identifiers, and then transcribed to document responses prior to analysis. Individuals participating in interviews are notified of this process at time of scheduling and prior to starting the interview.

Any data that is shared with UC Davis will have all PHI (protected health Information) identifiers removed except for zip code. We will work to ensure that we have enough demographic information to do meaningful analysis but avoid combinations of PHI that could identify the individual. For example, we would ask for consumer age and their year of birth, but not their DOB (please see https://research.ucdavis.edu/policiescompliance/irb-admin/researchers/hipaa/ for more information). We will work with each county to develop a

unique participant ID that will be tied to each consumer in the data. UC Davis will be provided with the participant IDs only, but the county and EP program will be able to link that to the specific person. We tend to call this the “participant ID list.”

Data will be stored at UC Davis; some data will also be stored at UCSF and UCSD with similar protections outlined below. The study investigators and primary research team are the only ones who will have access to the data. It will not be released to others. For the electronic files and data sets, copies of each file will be maintained on the Project Manager’s password-protected computer, and backup copies, will be kept on a password-protected removable computer drive. All copies of these electronic files will also be encrypted. All Windows-based computers are locally protected by Windows Firewall, and by the use of IPSec security policies that block external access to the computers. The UCDHS Sacramento campus uses a border firewall to block incoming access to their subnets. The hard drives of all computers at UC Davis are protected by Private Key Full-Disk Encryption, rendering all data unreadable in the event the computer is accessed without permission or removed from the Center. Data will be stored for 48 months after the end of the project to allow ongoing data analysis and publication.

Data will not contain PHI related to consumers, family members or EP providers who completed surveys. Any identifying information from individuals who completed qualitative interviews will be removed during the interview transcription process to de-identify the qualitative data. These individuals will not be identified by name in any reporting of results – only summary themes will be reported. In addition, we will utilize all standard protections to safeguard all this data. Investigators will follow applicable University policies (UC Davis Hospital Policy 1313, UCDHS P&P 2300-2499, and UC Business and Finance Bulletin on Information Security (IS-3)). For the electronic files and data sets, copies of each file will be maintained on the Project Manager’s password-protected computer, and backup copies will be kept on a password-protected removable computer drive. All copies of these electronic files will also be encrypted. Beyond data coding in the study electronic data files, additional steps will be taken to further ensure study data security. One will be to ensure that only authorized staff will have access to the data files, as determined by the PI. Another will be to ensure that all authorized staff have undergone appropriate briefing from the PI and project manager on techniques for maintaining electronic data security and confidentiality before they can access and use the data files. The third step will be that only the study project manager, Dr. Tara Niendam, and Dr. Joy Melnikow will be allowed to provide data files to other individuals. The fourth will be to minimize e-mailing of electronic study data files by any personnel. E-mailing of files will only be allowed if data is de-identified and can be sent via encrypted, password protected messaging. All Windows-based computers are locally protected by Windows Firewall, and by the use of IPSec security policies that block external access to the computers. The UCDHS Sacramento campus and UCSF Department of Psychiatry use a border firewall to block incoming access to their subnets. The CHPR computers are thus “doubly-secured,” falling under the protection of both the UCDHS physical firewall and machine-based security policies. The hard drives of all computers at the Center are protected by Private Key Full-Disk Encryption, rendering all data unreadable in the event the computer is accessed without permission or removed from the Center.

Contracting for County Collaborative
UC Davis will be working with Office of Research to develop contracts with each participating county. Some counties may choose to directly contract with UC Davis for this project, while other counties may choose to contract through the JPA with CalMHSA.

A grant, totaling $1.5 million over 5 years, will be provided by One Mind to support the development and implementation of the LHCN project. The contract for this grant will be established separately between UC Davis and One Mind.

Contracting for Application and Dashboard Development
The program level data will be acquired on a software application and dashboard (MOBI) built specifically for the program and county needs. To date, we have worked with Quorum and its affiliate, x-cube Labs, to develop the current MOBI platform, which will be modified for the purpose of this project. In Year 1, UC Davis will execute a service contract with Quorum/xcube labs for the modifications required by this project. We will get feedback from providers, stakeholders, and focus groups during each step of the development process. Our team has previous experience in implementing this type of technology in the UC Davis Early Psychosis Programs and has found that health software applications are useful to both consumers and providers to assess and monitor consumer outcomes of interest. The software application and web-based dashboard will be developed with all appropriate protections for consumer information according to HIPAA. Additional protections for data privacy are described below.

Ongoing Community Program Planning
Community involvement from various stakeholders is considered a central piece to the development and implementation of the project. From the outset, the focus of this project has shifted from an evaluation of the effectiveness and cost effectiveness of EP programs developed in a previous MHSOAC funded project (grant ID: 14MHSOAC010) to the current proposal based on the input from consumers, families, providers and county staff. This input has been received via Advisory Committees held under the previous project, feedback from consumer and family advocacy groups such as the National Alliance on Mental Illness (NAMI) and Mental Health America (MHA), and from a series of consultations with EP providers and county staff across six California counties.

The proposed project follows a policy of ‘nothing about us without us’, including community stakeholder involvement at all levels of the project. One feature of this will include consumer and family member representation on our Advisory Committee, which will meet regularly to oversee the implementation of all aspects of the project and propose changes where necessary. Another is the strong emphasis on the qualitative component of the investigation that will conduct focus groups and qualitative interviews with consumers, family members, providers and county representatives to ensure their views are considered at each stage of project implementation. This will include outcome selection, usability testing of the data collection and visualization software, exploring potential challenges and solutions to early implementation efforts in view to improving procedures, exploring experiences of delivering

and receiving services in this new system of care following full implementation, and finally conducting feedback sessions at the end of the project to further the sustainability of the LHCN. Community involvement will be sought in the analysis and interpretation of these qualitative findings to support the validity of these findings, and to further improve community representation.

Proposed Implementation Timeline and Dissemination Strategies

A full implementation timeline of the different components of the LHCN development, implementation and evaluation, in addition to the activities to be undertaken by the EP and county-level representatives, is presented in Table 1. We estimate that this project will start January 1, 2019 and end on December 31, 2023 (5-year project). Implementation activities over the 5-year timeline will include:

Year 1: Contracting, IRB submissions, initiating advisory group meetings, focus groups to identify outcomes for the program-level evaluation, and preliminary development of wire frame[1] and data visualization for the LHCN application and web-based dashboard. Consumers and their providers will complete surveys prior to LHCN implementation.

Year 2: Qualitative evaluation activities will include conducting fidelity assessments of EP programs and running focus groups to inform the development of the program-level data collection and visualization software. Program-level evaluation activities will include finalizing the outcome selection, beta testing the data collection and visualization software, training providers in data collection methods, and the initiation of pilot testing of program level-data collection practices. County-level evaluation activities include finalizing the methods for the county evaluation and obtaining county-level data covering a three-year prior timeframe.

Year 3: Qualitative evaluation activities will include conducting interviews to determine barriers/facilitators to implementation, and consumer and provider experiences of receiving or delivering care with the new LHCN. Program-level evaluation activities include extending the training and implementation of the data collection across all five counties. County-level evaluation activities include running the analysis from the three-year prior data pull and amending procedures in preparation for the county-level analysis of data.

Year 4: Qualitative evaluation activities include interviews of consumers, families and providers relating to their experiences receiving or delivering care within the LHCN across all six counties. Program-level evaluation activities include ongoing data collection across all sites. Consumers and their providers will complete surveys after LHCN implementation. County-level evaluation activities obtaining and analyzing the second round of county-level data.

Year 5: Qualitative evaluation activities will focus primarily on the dissemination of findings and focus groups to solicit feedback for future improvements. Program- and County-level evaluation activities will include continued data collection, and the final analysis.

[1] Wireframe: an image or set of images, which displays the functional elements of the app, used for planning our app's structure and functionality from a user perspective.

Please see below the Stanislaus County-specific Appendix that is being submitted for approval with the Approved Early Psychosis Learning Healthcare Network Statewide Collaborative Innovation Project Plan referenced above.

Appendix X: Stanislaus County

County Contact and Specific Dates

- Martha Cisneros Campos, mcisneros@stanbhrs.org, 209-525-5324
  Kirsten Jasek-Rysdahl, KJasek-Rysdahl@stanbhrs.org, 209-525-6085
- Date Proposal posted for 30-day Public Review: April 21, 2021
- Date of Local MH Board hearing: May 27, 2021
- Date of BOS approval or calendared date to appear before BOS: June 15, 2021

Description of the Local Need

The incidence of schizophrenia in the world population is approximately 1% with an estimated 75% of those individuals having experienced a prodromal or clinically high-risk period before converting to schizophrenia. It is estimated that anywhere from 20-40% of individuals classified as clinically high risk will convert to schizophrenia without treatment interventions. Few studies have been done on the prevalence of prodromal or clinically high-risk states. One study found that 8% of adolescents were able to be classified as clinically high risk utilizing the evidence-based Structured Interview for Psychosis-Risk Syndromes (SIPS) screener (Kelleher et al, 2012).

Stanislaus County has an approximate population of 550,000, which equates to an estimated 5,500 people experiencing schizophrenia within the county. Considering estimates of the cost to a community for a person with schizophrenia throughout their lifetime is up to $1,000,000, this equates to around $5 billion dollars at current population numbers. In addition, Stanislaus County has an approximate adolescent population of 35,000. At current estimates, anywhere from 560-1,120 of these adolescents may convert to schizophrenia without treatment interventions.

Stanislaus County currently has an early psychosis intervention program, LIFE Path, serving ages 14-25 and their families who have either qualified as clinically high risk (prodromal) or have experienced a first break within the past year. The program is modeled after the EASA (Early Assessment Support Alliance) program of the state of Oregon, an evidenced-based Coordinated Specialty Care (CSC) program. LIFE Path utilizes evidence-based practices such as Multi-Family Group, Cognitive Behavioral Therapy for Psychosis, and Individualized Resiliency Treatment. The LIFE Path program is designed to provide intensive therapeutic services, family psychoeducation, educational/vocational support, case management, and optional medication services. In addition, the LIFE Path program includes a Parent Advocate to assist family members in negotiating educational and mental health systems.

Although operating since 2011, LIFE Path has predominantly operated independently in the early psychosis field outside its mentorship with EASA due to the limited first episode psychosis (FEP) programs at the time, variance between FEP programs, and lack of a shared network for FEP programs. LIFE Path has provided early psychosis services to 162 unduplicated clients and additional family members since its inception but has struggled in attempting to adapt the various measurement tools utilized by the County that gauge a program's growth and efficacy. This has been due to the lack of tools designed and developed specifically for CSC/FEP programs.

Over the last few years, with various legislation and funding streams opened for FEP programs, there has been a dramatic increase in program availability across the nation and throughout California. There has also been an increase in the availability of learning collectives regarding FEP. As the nation and California build capacity and knowledge in the area of early psychosis, Stanislaus County and the LIFE Path program can benefit from those strides through the Early Psychosis Learning HealthCare Network (LHCN). Stanislaus County, through LIFE Path, and its participants strive to learn more, apply the knowledge gained, and improve our ability to positively impact clients experiencing early psychosis.

Description of the Response to the Local Need

The LHCN Project aligns with the current challenges of the LIFE Path program and will improve the program's ability to:

- Increase fidelity to current evidenced-based practices including effective and efficient service delivery
- Improve data collection, tracking, analysis, and reporting
- Provide participants, counselors, and administrators access to data in real-time
- Engage participants and family members in treatment and recovery

As part of the Early Psychosis Learning Healthcare Network Collaborative, Stanislaus County and LIFE Path will benefit from sharing and learning with the multiple and diverse participating counties. LIFE Path will gain technical assistance; an effective early psychosis-specific data collection methodology; innovative treatment approaches; and a learning collaborative that will enhance the program's access to new research, clinical support, and solution-oriented ideas for programmatic challenges. By receiving this assistance and support, LIFE Path will be able to use the evidence-based practices to be more effective and efficient and will also improve engagement of participants and family members in treatment and recovery. The expectation is that LIFE Path will increase the number of referred individuals who move forward with the assessment process as well as those who are retained in treatment and recovery. LIFE Path anticipates an increase of 20% in the number of clients served by the end of the Innovation Project. It is important to note that LIFE Path has identified that their existing internal resources and capacity is sufficient to improve and expand their services to support this Project with the additional support of BHRS and the Program Assistant identified in this Proposal.

Cultural & Linguistic Competency

Based on the Department of Finance January 2020 population estimates, Stanislaus County has 557,709 residents, of which 45.6% reported Hispanic/Latino; 42.6% reported White; 5.3% reported Asian; 2.6% reported Black; 2.5% reported two or more races (not Hispanic/Latino); .7% Native Hawaiian or Pacific Islander; .5% reported American Indian and Alaska Native; and .2% reported Other Race (not Hispanic/Latino).

Although diverse, Stanislaus County currently has one threshold language of Spanish. BHRS county staff consist of approximately 25% Spanish speaking staff. In addition, we have staff that speak other languages such as; Cambodian, Assyrian, Hindi, and many other languages. The LIFE Path program maintains a Spanish bilingual case manager and Spanish bilingual clinician. In addition, LIFE Path is a collaborative program between Sierra Vista Child & Family Services and Center for Human Services and is able to use the various language services of the two organizations. Sierra Vista Child & Family Services employs staff fluent in several languages including Cambodian, Laotian, Farsi and Punjabi. Both Sierra Vista Child & Family Services and Center for Human Services have numerous interpreters on contract if needed and Sierra Vista Child & Family Services also maintains a contract with a language line service if an interpreter is not available.

BHRS is committed to strategies that embrace diversity and to provide welcoming behavioral health and compassionate recovery services that are effective, equitable, and responsive to individuals' cultural health beliefs and practices. To ensure we continue to improve the quality of services and eliminate inequities and barriers to care for marginalized cultural and ethnic communities, BHRS supports the Cultural Competence, Equity, and Social Justice Committee (CCESJC). The committee consists of program providers, consumers, family members, and communities representing all cultures and meets monthly to discuss cultural and linguistic needs of our county. Our Cultural Competence and Ethnic Services Manager chairs the committee and ensures the county behavioral health systems are culturally and linguistically competent and responsive in the delivery of behavioral health services. This innovation project will support the cultural and linguistic needs of the County through a better understanding of the client needs.

Description of the Local Community Planning Process

Stanislaus County Behavioral Health and Recovery Services (BHRS) had been actively engaging in the Community Planning Process specifically with the intent to inform engaged stakeholders on updates facing MHSA, with the focus of strengthening stakeholder engagement. Traditionally stakeholder meetings were convened twice a year, in some years quarterly. However, with the onset of the Covid-19 crisis that began in March of 2020 and policy effects on MHSA, BHRS identified the opportunity to create a more robust stakeholder process. In this effort stakeholders were informed formally of MHSA regulations and their specific role as it relates to the community planning process for the three-year plan and annual update.

Formal Representative Stakeholder Steering Committee (RSSC) meetings for MHSA were held on June 12th, June 26th, September 18th, and December 11th of 2020. Each meeting

averaged 62-80 participants; the information session had 44 attendees. The meeting held on December 11, 2020 was also offered in person at the new Granger Community Center to gain additional participation from peers and consumers. During the December 11th meeting RSSC members were informed of the reversion issue facing BHRS; related to unspent innovation funds from previous fiscal periods. Stanislaus and other counties facing this issue, were encouraged by the MHSOAC to explore alignment with innovation projects already approved. BHRS quickly observed that two multicounty collaborative innovation projects provided by the MHSOAC aligned very well with insights from stakeholder input on the BHRS system as whole and one aligned well with BHRS efforts to create a more robust stakeholder process for future innovations.

To explore this further and to ensure stakeholder support on these innovation projects, BHRS conducted an information session that detailed each project proposed as well as allowed time for discussion and questions surrounding these projects. The information session for proposed innovations was a dedicated meeting for proposed innovations on December 29th. Following the December 29th innovation information session stakeholders were invited to the RSSC meeting on January 15, 2021 to formally measure the level of support to move forward and pursue the proposed innovation projects. After engaging in small group discussion and large group feedback discussion, RSSC members were surveyed utilizing the gradients of agreement scale; a scale utilized to measure the level of agreement and support towards a proposal. BHRS provided a one through five scale, with one being non acceptance of the proposed project and five being complete and full acceptance. RSSC members identified fours and fives as their measurement during this meeting. The meeting concluded with agreement to move forward with all three proposed innovations.

Proposed projects will go formally to the Stanislaus County Board of Supervisors (BOS) on June 15, 2021. Following formal approval by the BOS the projects will go through the review period with the MHSOAC as well be posted for the 30-Day local review period for the public.

TOTAL BUDGET REQUEST BY FISCAL YEAR:

Total budget by fiscal year for the county collaborative portion of the costs.

	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	TOTAL
Total County Contribution to Collaborative	*340,777*	*318,091*	*327,881*	*338,765*	*239,119*	*1,564,633*

BUDGET NARRATIVE FOR LHCN AND EVALUATION:

Stanislaus County will adopt and maintain the successful practices identified during this project into its Early Psychosis programs. After the completion of this project, the County's intention is to continue to fund the Early Psychosis Program and the improvements gained through this Innovation Project with Prevention and Early Intervention funding.

A detailed budget narrative for the entire multi-county collaborative is described previously.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR LHCN AND EVALUATION

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR LHCN AND EVALUATION							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Salaries	18,477	19,030	19,600	20,188		77,295
2.	Direct Costs	7,928	8,409	8,922	9,462		34,721
3.	Indirect Costs	4,660	4,842	5,033	5,232		19,767
4.	Total Personnel Costs	31,065	32,281	33,555	34,882		131,783
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5a.	Direct Costs (Supplies)	7,490	1,190	1,190	1,340		11,210
5b.	Direct Costs (Travel)	1,650	1,650	1,650	1,650		6,600
5c.	Direct Costs (Other Directs)	100	350	350	100		900
6.	Indirect Costs	1,631	563	563	545		3,302
7.	Total Operating Costs	10,871	3,753	3,753	3,635		22,012
NONRECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
8							
9.							
10.	Total Non-recurring Costs						
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
11a.	Direct Costs (Subawards)	50,244	49,914	52,034	55,120		207,312

11b.	Direct Costs (Consultants & App)	20,875	10,875	10,875	10,875		53,500
12.	Indirect Costs	3,684	1,919	1,919	1,919		9,441
13.	Total Consultant Costs	74,803	62,708	64,828	67,914		270,253
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS:							
Personnel (line 1)		26,405	27,439	28,522	29,650		112,016
Direct Costs (add lines 2, 5 and 11 from above)		80,359	63,979	66,099	69,085		279,522
Indirect Costs (add lines 3, 6 and 12 from above)		9,974	7,324	7,515	7,697		32,510
Non-Recurring costs (line 10)							
Other expenditures (line 16)							
TOTAL INNOVATION BUDGET		**116,738**	**98,742**	**102,136**	**106,432**		**424,048**

BUDGET NARRATIVE FOR COUNTY SPECIFIC NEEDS:

Personnel

The total personnel cost for the county portion is $822,374 over five years. This includes $490,573 for salaries and $311,801 for fringe benefits.

Personnel will include a 0.5 FTE Software Developer/Analyst III and a 0.5 FTE Staff Services Coordinator for five years. After reviewing the overall goals and objectives for all participating counties we consulted with UC Davis to assess our internal capacity with what is required to support this project successfully. UC Davis consulted with the current participating counties to develop a recommendation with what the ideal internal support structure or team would consist of. The current participating counties shared lessons learned and stated where they may have underestimated the internal staffing need in addition to the workflow needed from the internal staff to carry the project goals throughout the various stages. BHRS and LIFE Path will be working together to expand data collection, analysis, and sharing/reporting that is detailed in the proposal above. The .5 FTE positions are designed to support this expansion and learning, as well as the coordination of these efforts. The positions are not exclusive to an administrative and oversight role but are designed to support and coordinate the project based on the recommendations from UC Davis and the current participating counties, and to meet resource capacity need for the program and

project to be successful. It should also be noted that with these County support positions along with the Program Assistant described below, the program structure and resources will meet the capacity requirements as specified in the description of responsibilities for this project.

Staff Services Coordinator will:

- Oversee and act as liaison to the Innovation Project contractors;
- Coordinate and facilitate meetings and discussions amongst Innovation Project contractors, partners, and other stakeholders;
- Coordinate internal staff and project partners to ensure the necessary assignments are completed to meet project requirements, timelines, and quality expectations;
- Develop and monitor project timelines; provide updates/status of projects to stakeholders as appropriate;
- Oversee, coordinate, and provide technical assistance for the data collection, analysis and reporting of the performance measures for this Innovation Project;
- Provide training and technical assistance related to project data and results to staff and stakeholders;

Software Developer/Analyst III will:

- Help identify the appropriate county-level data and data transfer methods;
- Extract county-level data from the electronic health record and other program databases and sources; de-identify data before transferring to contracted staff;
- Identify problems and possible solutions in the county-level and program-level data (e.g., issues with available data or methods);
- Participate in all relevant meetings regarding data for this Innovation Project.

The personnel costs include a 3% annual increase to include cost-of-living salary increases and the associated retirement, and FICA increases based on the increased salaries as well as increases for health care costs.

Operating Costs

The ongoing operating costs total $30,700 over five years. This includes cell phones, office supplies, copier costs, computer licenses, MiFi service for laptops, utilities, alarm and security costs, zoom subscriptions, telephone and data processing services, and janitorial costs.

Nonrecurring Costs

Nonrecurring costs total $10,900 for equipment for the set-up of the office for the two staff members. This includes, desks, chairs, computers, laptops, and software.

Contracts

Contracts total $276,611 over five years to provide program assistance to the LIFE Path contractor for coordination and facilitation between the contractor, clients and family members, UC Davis, and BHRS. Assistance will also be provided for data collection and scheduling. A 3% annual increase is included to support cost of living increases.

The Program Assistant will:

- Instruct and support clients and family members in the use of technology for data collection
- Educate new clients and families on Innovations project and gather consents for projects
- Monitor timeliness of data collection from clients and family members
- Scheduling client and families to complete core battery on tablet at each follow up
- Assist in coordination with UCD and BHRS

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY SPECIFIC NEEDS

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY SPECIFIC NEEDS							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Salaries	154,898	159,545	164,331	169,261	174,339	822,374
2.	Direct Costs						
3.	Indirect Costs						
4.	Total Personnel Costs	154,898	159,545	164,331	169,261	174,339	822,374
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5.	Direct Costs	6,140	6,140	6,140	6,140	6,140	30,700
6.	Indirect Costs						
7.	Total Operating Costs	6,140	6,140	6,140	6,140	6,140	30,700
NONRECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
8	Desk, Chair, Computer, Laptop	9,900					9,900
9.	Software	1,000					1,000
10.	Total Non-recurring Costs	10,900					10,900

CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	TOTAL
11a.	Direct Costs	52,101	53,664	55,274	56,932	58,640	276,611
12.	Indirect Costs						
13.	Total Consultant Costs	52,101	53,664	55,274	56,932	58,640	276,611
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS:							
Personnel (line 1)		154,898	159,545	164,331	169,261	174,339	822,374
Direct Costs (add lines 2, 5 and 11 from above)		6,140	6,140	6,140	6,140	6,140	30,700
Indirect Costs (add lines 3, 6 and 12 from above)							
Non-Recurring costs (line 10)		10,900					10,900
Other expenditures (line 16)							
TOTAL INNOVATION BUDGET		224,039	219,349	225,745	232,333	239,119	1,140,585

BUDGET NARRATIVE FOR TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR:

Funding for the project will come from MHSA Innovation funds.

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY):

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for <u>ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	224,039	219,349	225,745	232,333	239,119	1,140,585
2.	Federal Financial Participation						
3.	1991 Realignment						

4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Administration**	**224,039**	**219,349**	**225,745**	**232,333**	**239,119**	**1,140,585**
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	116,738	98,742	102,136	106,432		424,048
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Evaluation**	**116,738**	**98,742**	**102,136**	**106,432**		**424,048**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total for funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	340,777	318,091	327,881	338,765	239,119	1,564,633
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Expenditures**	**340,777**	**318,091**	**327,881**	**338,765**	**239,119**	**1,564,633**

Innovation Project Proposed:
Full-Service Partnership Multi-County Collaborative

Introduction:

Primary Purpose of INN Project:	
☒	Increases the quality of mental health services, including measured outcomes
☒	Promotes interagency and community collaboration related to Mental Health Services, supports or outcomes
This Proposed Project meets one of the following criteria:	
☒	Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention

Review History: Current Counties Participating in Collaborative to Which Stanislaus Is Applying.

COUNTY	Fresno	Sacramento	San Bernardino	Siskiyou	Ventura
Total INN Funding Requested	$950,000 **Approved June 2019**	$500,000	$979,634	$700,001	$979,634
Duration of INN Project	4 Years	4.5 Years	4.5 Years	4.5 Years	4.5 Years
County Submitted INN Project	5/30/2019	2/7/2020	2/7/2020	2/7/2020	2/7/2020
Date Posted for 30-Day Public Comment	6/18/2019	11/18/2019	11/27/2019	12/10/2019	12/17/2019
Approved by BOS	6/18/2019	1/14/2020	June 9, 2020	2/4/2020	3/10/2020

A total of six Counties are currently participating in the Full-Service Partnership (FSP) Multi-County Collaborative. The Counties of Sacramento, San Bernardino, Siskiyou, and Ventura sought innovation spending authority to develop standardization practices for FSP service programs by utilizing data driven strategies and evaluation to better coordinate, improve, and implement FSP services statewide and were approved. Fresno County received Commission approval to participate in this Full Service (FSP) Multi-County Collaborative on June 24, 2019. San Mateo is utilizing unspent CSS funds and - additional CSS funding to participate in the goals and activities of this Multi-County Collaborative alongside the other counties. Stanislaus County is seeking MHSOAC approval to join the Collaborative beginning FY 21-22.

Third Sector (the Contractor) will work collaboratively with the above Counties by administratively guiding counties through development and implementation of sharing data driven strategies and providing critical technical assistance. This project is aimed at improving service delivery, operations, data collection, and FSP service evaluation. There will NOT be a disruption in FSP services; each contractor—Third Sector and the California Mental Health Services Authority (CalMHSA), and selected evaluators—will act in an administrative advisory capacity only. Participating counties will continue to provide FSP services throughout the duration of this project.

The value of the project will be examined through a statewide evaluation that will enhance meaningful outcomes and improve client experiences. The data-driven project goals will help with consistent implementation of FSP programs service eligibility, enrichment of client experiences and service delivery; moreover, providing structure to share newly created data-driven opportunities and learning to promote ongoing program improvements. The project will allow shared data-driven criteria to be evaluated, standardized, and implemented to provide consistency of FSP services for all counties in California.

Identified Need:

Full-Service Partnerships are designed to support individuals requiring services with the most severe mental health needs and co-occurring disorders. The FSP model serves this most severe population, for all age groups, and mandates a doing “whatever it takes” approach to provide services to those in need to help individuals on their path to recovery and wellness.

According to The National Institute of Mental Health, Serious Mental Illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI. Nearly one in five U.S. adults live with a mental illness (46.6 million, in 2017).

The FSP’s are designed to serve those who have been diagnosed with a severe mental illness and would benefit from an intensive service program.

FSP programs have encountered two significant barriers in the facilitation and delivery of the "whatever it takes" model, interfering with the delivery of the FSP promise. (1) Specific FSP programs are difficult to establish, support and treat underserved populations, (2) data collection coordination has not been established and/or consistently implemented. Delivering on the promise requires defining what components are essential and establish standardization for statewide FSP services. Service coordination to evaluate essential components of FSP service programs is limited by the lack of data collection, sharing and evaluation for establishing best practice service deliverables from the results.

The participating counties expressed that they would like to further improve, standardize, and implement FSP best practices while also utilizing ongoing data sharing strategies for continuous service improvements and implementation. This includes clearly defined eligibility criteria, referrals, and graduation. San Bernardino County stated, "consumers have expressed interest in a standardized format for eligibility criteria and (seek) consistency in services that are offered and/or provided." This Multi-County Collaborative will evaluate data across counties and better define FSP best practices. As a result of the learning and evaluation, standardization for FSP programs will improve client services and outcomes, ultimately, delivering on the FSP promise.

Discussion:

The proposed project is county-driven and seeks to address two main barriers to meeting the "whatever it takes" model through FSP programs: (1) a lack of information about FSP programs and their components that are found to deliver the greatest impact; and (2) inconsistent FSP implementation. Counties report that while there have been attempts to overcome these barriers, there is still a need for further innovation.

While all counties participating in this collaborative provide FSP services, the program implementation and components of this project are specific to each counties' identified needs (see pages 31-52 for individual county plans). This Innovation projects seeks to define, and measure county identified FSP outcomes, and consistent methods of data collection, data sharing, and data usage. Additionally, this project seeks to standardize essential components of FSP programs, service guidelines, as well as ongoing FSP performance management and improvement processes.

This project is informed by two FSP projects. The first is a multi-county collaboration of four counties that are taking part in a classification study sponsored by the Commission. One limitation of this study, however, is the scope of the study. This project does not evaluate the full range of FSP programs, such as its exclusion of FSP programs that serve children. A second project is being conducted by the Los Angeles Department of Mental Health with support from Third Sector Capital Partners and UCLA. This study examines

components of FSP programs that are associated with outcomes—namely early exits. While this study has led to the development of strategies that will help to overcome the identified barriers, this project does not propose ways in which these strategies may be applied to FSP programs. Additionally, the changes implemented in Los Angeles County may not be appropriate in meeting the needs of smaller, more rural counties, and the general makeup of other counties overall.

The proposed multi-county project seeks to build on lessons learned from the above-mentioned projects. This project takes on the multi-county approach that the FSP classification pilot study has taken, and the development of learning collaboratives that has been taken by the FSP project being headed by Los Angeles County. Doing so will allow for county-specific needs to be addressed, but also contribute to statewide learning that non-participating counties can also benefit from.

The FSP Multi-County Collaboration project will have five distinct areas of focus:

1. Defining and Tracking Priority Outcomes: there is a strong need for FSP service program improvement through data collection and evaluation to help define and track past and current performance measures as well as outcomes. The data will assist in establishing a *best practice* approach to track, standardize, and apply measures consistently between counties and across programs for statewide consistency.
2. Develop and/or Strengthen Processes: establish new processes including supporting shared learning collaborations, accountability, develop and strengthen existing processes for continuous improvements, support meaningful comparisons, and utilize data to provide continuous improvements of FSP services for clients statewide.
3. Strategy to Track and Streamline Performance Measures: evaluate state-level and county-specific reporting tools to develop strategies for best tracking performance measures and outcomes.
4. Develop a Consistent FSP Framework: develop a *best practice* FSP framework and consistent interpretation of core components that allow adaptations for county specific needs.
5. Define Program Criteria: define clear and consistent eligibility, enrollment, referral and graduation criteria. Develop county and provider guidelines for dissemination of information and implementation protocols.

The Commission has supported the development of this proposal through a contract with Third Sector to lead this project through administration and technical assistance. Third Sector has also assisted in identifying the counties that will take part in this project—both through their partnership in this Innovation project as well as through the learning community that will be developed.

The approach that is being proposed by this project is justified and supported by current research, legislation, and local need. Commission staff were unable to identify any other existing multi-county projects that (1) are county-driven, (2) provide technical assistance to help providers improve both system-level and consumer-level outcomes, and (3) seek to develop a best practice for FSP program implementation.

Learning Objectives and Evaluation:

Participating counties are seeking to implement a project that will help to develop new data-informed strategies to improve and coordinate FSP service delivery, operations, data collection, and evaluation. The proposed project will increase the quality of mental health services, including measured outcomes as well as promote interagency collaboration. Though not service-oriented, this project's main goal is to improve FSP client outcomes through its attempt at transforming the delivery and management of FSP programs—or its systems-level impact.

To guide their project, the counties have identified several learning questions that are centered on both systems-level and client-level outcomes. These learning questions include:

1. What was the process that each participating county and Third Sector took to identify and refine FSP program practices?
2. What changes to counties' original FSP program practices were made and piloted?
3. Compared to current FSP program practices, do practices developed by this project streamline, simplify, and/or improve the overall usefulness of data collections and reporting for FSP programs?
4. Has this project improved how data is shared and used to inform discussions within each county on FSP program performance and strategies for continuous improvement?
5. How have staff learnings through participation in this FSP-focused project led to shared learning across other programs and services within each participating county?
6. What was the process that participating counties and Third Sector took to create and sustain a collaborative, multi-county approach?
7. What concrete, transferrable learnings, tools, and/or recommendations for state-level change have resulted from the outcomes-driven FSP learning community and collective group of participating counties?
8. Which types of collaborative forums and topics have yielded the greatest value for county participants?
9. What impacts has this project and related changes created for clients' outcomes and clients' experiences in FSP?

With the assistance of Third Sector and CalMHSA, the counties will work to procure an outside evaluator to finalize the overall evaluation for the project within the first year of implementation. The Counties have identified the RAND Corporation as a potential evaluator for the FSP project. In addition to finalizing the overall goals and learning questions for the project, counties will also finalize the measures, data sources, and baseline data that will be used to evaluate system- and client-level impacts. The counties propose utilizing both quantitative and qualitative data to evaluate the project.

System-Level Impacts

Data that will be used to evaluate system-level impacts will be gathered from surveys and qualitative interviews that will be completed by participating counties and state agencies. Some system-level measures may include:

- Number of policy changes made by DHCS or the Commission
- Number of counties implementing a new FSP services approach
- Number of counties adopting improvements or changes to FSP practices
- Overall staff and clinician satisfaction with outcomes measures selected
- Increased stakeholder engagement and representation in decision-making and FSP program discussions

Outcome-Level Impacts

Data that will be used to evaluate client-level impacts will gathered from local data collection systems, such as those from local housing agencies, local jails, billing records from local hospitals, as well as FSP provider data, among others. Some client-level measures may include:

- Percentage of "housing insecure" FSP clients connected with housing support
- Changes in recidivism levels for "justice involved" FSP clients
- Changes in utilization of emergency psychiatric facilities
- Percentage of clients graduating FSP successfully
- Percentage of FSP clients reporting trust and satisfaction with their FSP provider

Because the counties have identified accessing individual data as part of the evaluation plan, the counties have stated that steps will be taken by the outside evaluator to ensure data protections are in place when accessing Personally Identifiable Information (PII) or Protected Health Information (PHI).

Overall, the evaluation plan proposed by the counties meets the learning objectives and primary purposes of the project. At the conclusion of the project, Third Sector will assist counties in developing a communication plan to share lessons learned and accomplishments gained through this project. Additionally, any recommendations that result from this project may be used to make recommendations to state-level data collection and reporting requirements.

The Community Program Planning Process

Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou and Ventura Counties each demonstrated that this project was reviewed and supported by their communities through a local community planning process.

This project was shared initially on the Commission's listserv and with its six stakeholder contractors on December 17, 2019 and the final proposal was shared on February 18, 2020. During this period, **one letter of support** from a member of the Commission's Client and Family Leadership Committee was received (see comments below) and **no letters of opposition** were received.

"*I think this is an excellent Innovation Project opportunity to use a multi-county approach to solve the FSP challenge. The two barriers presented, 'lack of information' and 'inconsistent FSP implementation' are in my opinion the main reasons for skewed data. It appears that the six counties selected for the study shall present the MHSOAC with enough diversity to take this matter to the next level."*

- CFLC Member

Fresno

Fresno County leadership discussed the possibility of developing this plan to evaluate FSP programs and contract with Third Sector and other counties in January 2019. Fresno County submitted a letter of support advising the Commission of its interest in joining the FSP Multi-County collaborative on March 8, 2019.

On April 30, 2019, this project was included in a Summary of Changes to the Annual Update, which had originally been posted for public comment on April 15, 2019. The County then held a public hearing of its Behavioral Health Board on the Annual Update, including the FSP Multi-County Collaborative project, on May 15, 2019. There were no public comments or objections to the intent to use Innovation funds on this project. The Fresno County Board of Supervisors final approval and adoption was completed on June 18, 2019. The Commission approved the project in the amount of $950,000 on June 24, 2019.

This project was shared with the Commission list serve for public comment and stakeholder contractors on June 3, 2019. There were no letters of support or opposition received.

Sacramento

On May 16, 2019, the FSP Innovation Project was introduced to stakeholders at the Mental Health Services Steering Committee. The FSP Project was presented and discussed at the MHSA Steering Committee on October 17, 2019. The Steering Committee meeting held on October 17, 2019, included 24 committee members and 17 members of the public. The Sacramento County Division of Behavioral Health Services received full support of the Steering Committee in favor of participating in the FSP Project

utilizing Innovation funding. Members of the committee volunteered to represent other multiple stakeholder interests including Veterans and Faith-based/Spirituality communities.

Sacramento County's Multi-County FSP Innovation Project was posted as an attachment in the Annual Update (FY 2019-2020) from November 18, 2019 through December 18, 2020. No public comments were received regarding this project. The Board of Supervisors approved the project on January 14, 2020.

Sacramento will be using funds subject to reversion in the amount of $500,000.

San Bernardino

The FSP Multi-County Collaborative was shared with stakeholders at several local meetings between July 2019 and October 2019. Some of the meetings included: Community Advisory Policy Committee (CPAC), July 18, 2019; Asian Pacific Islander Awareness Subcommittee, September 13, 2019; Santa Fe Social Club, September 16, 2019; African American Awareness Subcommittee, September 16, 2019; Yucca Valley One Stop TAY Center, September 16, 2019; Native American Awareness Subcommittee, September 17, 2019; Transitional Age Youth (TAY) Subcommittee, September 18, 2019.

Most of the stakeholder feedback was in favor of San Bernardino County Department of Behavioral Health participating in the Multi-County FSP Innovation project with 96% of the stakeholders in support of the project, 4% neutral, and 0% opposed. On November 27, 2019, a draft of the plan was posted for 30-day public comment. No feedback was received. On January 2, 2020, the plan was presented before the San Bernardino County Behavioral Health Commission and is set to be reviewed and submitted for approval by the Board of Supervisors in February or March 2020.

San Bernardino requests to contribute $979,634 in MHSA Innovation funds. A portion of the funds ($386,222) will cover specific expenditures for San Bernardino and the remainder ($593,412) towards shared pool of resources the county will utilize to cover shared projects costs (i.e. Third Sector TA; CalMHSA; third=party evaluation).

San Bernardino reported that they are not using funds subject to reversion for this project.

San Mateo

The county of San Mateo is utilizing unspent CSS funding for this project. San Mateo will be utilizing $750,000 in unspent CSS funds. The designated and approved one-time funds are to be utilized to meet a similar purpose and set of objectives such as The Multi-County FSP Innovation Project, and ongoing efforts to improve FSP programs.

Siskiyou

The Multi-County FSP Innovation Project was shared with stakeholder groups in March 2019 and the proposed use of Innovation funds was well-received. On December 10, 2019, a draft of the plan was posted for public comment. No comments were received. The plan was also presented at a public hearing with the Local Mental Health Board on January 21, 2020. The Board of Supervisors reviewed and approved the plan on February 4, 2020.

Siskiyou is not using funds subject to reversion.

Ventura

The Multi-County Collaborative FSP Project was shared at the Behavioral Health Advisory Board subcommittee meetings including the Adult Committee, November 7, 2019; Executive Meeting, November 12, 2019; Prevention Committee, November 12, 2019; Youth & Family Committee, November 13, 2019; TAY committee, November 21, 2019; and the General Meeting, November 18, 2019.

Ventura County is using funds subject to reversion in the amount of $979,634.

County	Total INN Funding Requested	Third Sector (Direct Costs)	CalMHSA (Direct Costs)	Evaluator (Direct Costs)	Personnel Costs	Operating Costs
Sacramento	$500,000	$409,718 (82 %)	$48,614 (10%)	$41,668 (12%)	$0	$0
San Bernardino	$979,634	$498,494 (51%)	$53,250 (5%)	$41,668 (12%)	$349,272 (36%)	$36,950 (4%)
Siskiyou	$700,001	$220,336 (31%)	$53,252 (8%)	$231,668 (64%)	$178,745 (26%)	$16,000 (2%)
Ventura	$979,634	$498,494 (51%)	$53,250 (5%)	$41,668 (12%)	$246,264 (25%)	$139,958 (14%)
Total	**$3,159,269**	**$1,627,042**	**$208,336**	**$356,672**	**$953,375**	**$192,908**

County	Total INN Funding APPROVED	Total Other Expenditures	Personnel Costs	Operating Costs
Fresno	$950,000	$840,037 (89%)	$69,963 (7%)	$40,000 (4%)
Total INN Funding	**$4,109,269**	**$840,037**	**$69,963**	**$40,000**

County		Third Sector (Direct Costs)	CalMHSA (Direct Costs)	Evaluator
	Utilization of Unspent CSS Funds			**(Direct Costs)**
San Mateo	*$750,000*	$498,494 (66%)	$53,250 (7%)	$198,256 (26%)
Total	**$750,000**	**$498,494**	**$53,250**	**$198,256**
Total INN Funding for Multi-County FSP Project (including CSS & PEI funding components):				**$4,859,269**

The Budget

Fresno, Sacramento, San Bernardino, Siskiyou, and Ventura counties are collectively contributing $4,109,269 of innovation dollars to fund the FSP Multi-County Collaborative for the next 4.5 years. San Mateo is contributing $750,000 dollars of CSS unspent funding. for a project total of $4,859,269.

Evaluation Costs

The current budget projects a total of $596,596 for evaluation costs for all six counties, with Fresno County also contributing $41,668. Third Sector and CalMHSA will assist counties in procuring an outside evaluator. Counties have identified the RAND Corporation as a potential evaluator for the project.

Personnel Costs

For all six counties total personnel cost including county staff salaries and benefits, are approximately $1,023,338 for the duration of the project.

Operating Costs

Total operating expenses for all counties, including travel costs for site visits and administrative assistance, participating in this project are $232,000 for the duration of the project. The budget table identifies specific operating costs for each participating county.

Non-Recurring Costs

No recurring costs are required or identified.

Additional Contractor Costs

Both Fresno County and San Bernardino County are contributing additional "in kind" funding to support the project.

Sustainability Plan

While most of the sustainability planning will take place during the final two months of the project, Third Sector will provide sustainability guidance throughout each stage of the project. It is important to note that Third Sector will **not** provide FSP services to clients from participating counties, they are providing administrative services only. FSP services **will** continue to be provided by each participating county throughout the duration of the project.

Third Sector will work with each county to develop a sustainability plan and make corrections and adjustments from learnings throughout each project stage, which will be amended and refined accordingly.

All individual counties seeking to join this project appear to have met the minimum regulatory requirements listed under MHSA Innovation regulations, and once the Innovation Project is approved, the County must receive and inform the MHSOAC of their certification of approval from the San Bernardino County Board of Supervisors before any Innovation Funds can be spent.

Comments:

Given the evaluation plan for this multi-county project may change when an evaluator is procured, the counties should provide an update to the Commission once the evaluation plan is finalized.

References:

Mental Illness: Serious Mental Illness Definition and prevalence of SMI (2017). National Institute of Mental Health (NIMH). Retrieved from: http://www.nimh.nih.gov/health/statistics/mental-illness.shtml

Please see below the Stanislaus County-specific Appendix that is being submitted for approval with the Approved Full-Service Partnership Multi- County Collaborative Innovation Project Plan referenced above.

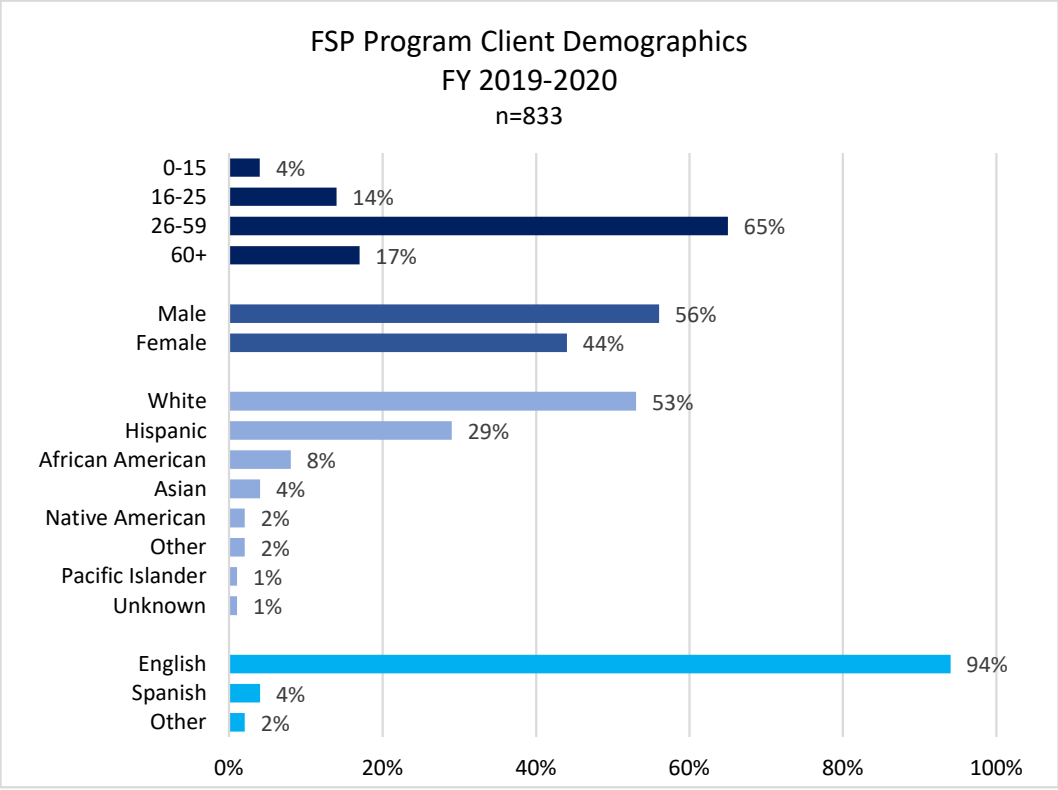
Appendix X: Stanislaus

County Contact and Specific Dates

- Martha Cisneros Campos, mcisneros@stanbhrs.org, 209-525-5324
  Kirsten Jasek-Rysdahl, KJasek-Rysdahl@stanbhrs.org, 209-525-6085
- Date Proposal posted for 30-day Public Review: April 21, 2021
- Date of Local MH Board hearing: May 27, 2021
- Date of BOS approval or calendared date to appear before BOS: June 15, 2021

Description of the Local Need

Stanislaus County Behavioral Health and Recovery Services (BHRS) currently has eight Full-Service Partnership (FSP) programs, and during FY 2019-2020 these programs served a total of 833 clients. The client demographics illustrate the populations that are receiving the majority of FSP program services, but it is not clear if this reflects the current needs of Stanislaus County.



Although these clients represent some of the most underserved or unserved community members, it has been over a decade since BHRS implemented FSP programs by utilizing a comprehensive and thorough approach to explore the demographic and individual needs of Stanislaus County's FSP population. Since we are dedicated to continuously evaluate what is working well and what could be improved in our FSP programs, BHRS has recently engaged the community to update and further understand and address the unique challenges and needs of our FSP clients. We plan to leverage this engagement and apply a human-centered design (HCD) approach through this Innovation Project. In addition, BHRS recognizes the need to share outcomes with our stakeholders to both inform and elicit feedback from the community. Stakeholders have expressed strong interest in improving FSP program data and better understand program outcomes.

BHRS has identified the need and desire to use and share meaningful data in a clear and engaging way to better understand if our FSP programs are truly resulting in positive recovery outcomes for the clients served. This also includes reviewing ways to improve where we are less successful, e.g., exploring ways that BHRS can be more responsive to individuals' needs, and to better coordinate with other community partners. BHRS overarching goals for this project are reflected below:

- More clearly identify priority outcomes for FSP clients
- Develop effective data collection and tracking mechanisms to increase the accuracy and meaning of FSP data for transforming into performance measures and outcomes
- Create an FSP framework and practices that foster continuous improvement of outcomes for FSP clients
- Develop sustainable ways to continuously evaluate how BHRS FSP programs are effectively meeting the community needs

In recent years, BHRS staff have explored ways to improve data collection, analysis, presentation, and use of data to be more outcome oriented and data-driven, but there are multiple issues and challenges that affect our ability to meet our overarching goals:

- Consistent and accurate data collection by staff is challenging.
    - Staff are focused on quality care and it is often difficult to elicit buy-in for the importance of entering and utilizing client data regularly when using the DCR and other databases is time consuming.
    - Data collection tools can be confusing or frustrating for staff.

- Extracting, analyzing, presenting, and interpreting/creating meaning from data requires skilled staff and time.
- Utilizing data consistently for improvement requires monitoring and resources committed to that practice.
- Stakeholders have multiple perspectives about what data and outcomes are meaningful, and how to use this information.
- Data-driven decisions regarding program design/revisions can be difficult to implement and sustain.

Since BHRS internal resources are limited as described above, this Innovation Project will provide the support and shared learning necessary to fulfill the goals outlined above.

Description of the Response to the Local Need

The proposed Innovation Project will address Stanislaus County BHRS' FSP program challenges and needs through a thorough and inclusive approach. The project will support BHRS in implementing improvements in how we design, provide, and continuously improve FSP programs in the following ways:

- Create shared understanding of current FSP programs – who the programs are serving, how they are serving them, and what data is being collected to yield outcome measurement
- Include stakeholders in the identification of FSP program strengths and areas of improvement
- Identify problem statements that can be used to create FSP programs that are data and outcome oriented
- Develop and support data collection, analysis, and presentation processes that allow BHRS to identify disparities through demographics and outcomes data, as well as ensure individual clients are connected to appropriate and customized services to increase positive outcomes
- Identify and define FSP program outcome goals, and develop meaningful performance measures to track progress towards goals; concurrently develop sustainable processes for using the data for continuous tracking and improvement
- Clarify, streamline, and improve design and practices within FSP programs to better serve our County's FSP population and subpopulations
- Leverage other counties' processes, learning, and best practices while participating in the Multi-County FSP Innovation Project

Ultimately, this project will help BHRS meet the overarching goals of identifying priority outcomes for FSP clients, developing effective data collection techniques and ongoing measurement, creating an effective FSP framework to improve FSP client outcomes, and developing a structure for continuous evaluation of how well BHRS FSP programs are meeting community needs.

Cultural & Linguistic Competency

Based on the Department of Finance January 2020 population estimates, Stanislaus County has 557,709 residents, of which 45.6% reported Hispanic/Latino; 42.6% reported White; 5.3% reported Asian; 2.6% reported Black; 2.5% reported Two or more races (not Hispanic/Latino); .7% Native Hawaiian or Pacific Islander; .5% reported American Indian and Alaska Native; and .2% reported Other Race (not Hispanic/Latino).

Although diverse, Stanislaus County currently has one threshold language of Spanish. BHRS county staff consist of approximately 25% Spanish speaking staff. In addition, we have staff that speak other languages such as; Cambodian, Assyrian, Hindi, and many other languages. When programs are unable to have a staff person assist in translation, programs utilize our contracted translators (including American Sign Language) or connect with Language Line.

BHRS is committed to strategies that embrace diversity and to provide welcoming behavioral health and compassionate recovery services that are effective, equitable, and responsive to individuals' cultural health beliefs and practices. To ensure we continue to improve the quality of services and eliminate inequities and barriers to care for marginalized cultural and ethnic communities, BHRS supports the Cultural Competence, Equity, and Social Justice Committee (CCESJC). The committee consists of program providers, consumers, family members, and communities representing all cultures and meets monthly to discuss cultural and linguistic needs of our county. Our Cultural Competence and Ethnic Services Manager chairs the committee and ensures the county behavioral health systems are culturally and linguistically competent and responsive in the delivery of behavioral health services. This innovation project will support the cultural and linguistic needs of the county through a better understanding of the client needs.

Description of the Local Community Planning Process

Stanislaus County Behavioral Health and Recovery Services (BHRS) had been actively engaging in the Community Planning Process specifically with the intent to inform engaged stakeholders on updates facing MHSA, with the focus of strengthening stakeholder engagement. Traditionally stakeholder meetings were convened twice a year, in some years quarterly. However, with the onset of the Covid-19 crisis that began in March of 2020 and policy effects on MHSA, BHRS identified the opportunity to create a more robust stakeholder process. In this effort stakeholders were informed formally of

MHSA regulations and their specific role as it relates to the community planning process for the three-year plan and annual update.

Formal Representative Stakeholder Steering Committee (RSSC) meetings for MHSA were held on June 12th, June 26th, September 18th, and December 11th of 2020. Each meeting averaged 62-80 participants; the information session had 44 attendees. The meeting held on December 11, 2020 was also offered in person at the new Granger Community Center to gain additional participation from peers and consumers. During the December 11th meeting RSSC members were informed of the reversion issue facing BHRS; related to unspent innovation funds from previous fiscal periods. Stanislaus and other counties facing this issue, were encouraged by the MHSOAC to explore alignment with innovation projects already approved. BHRS quickly observed that two multicounty collaborative innovation projects provided by the MHSOAC aligned very well with insights from stakeholder input on the BHRS system as whole and one aligned well with BHRS efforts to create a more robust stakeholder process for future innovations.

To explore this further and to ensure stakeholder support on these innovation projects, BHRS conducted an information session that detailed each project proposed as well as allowed time for discussion and questions surrounding these projects. The information session for proposed innovations was a dedicated meeting for proposed innovations on December 29th. Following the December 29th innovation information session stakeholders were invited to the RSSC meeting on January 15, 2021 to formally measure the level of support to move forward and pursue the proposed innovation projects. After engaging in small group discussion and large group feedback discussion, RSSC members were surveyed utilizing the gradients of agreement scale; a scale utilized to measure the level of agreement and support towards a proposal. BHRS provided a one through five scale, with one being non acceptance of the proposed project and five being complete and full acceptance. RSSC members identified fours and fives as their measurement during this meeting. The meeting concluded with agreement to move forward with all three proposed innovations.

Proposed projects will go formally to the Stanislaus County Board of Supervisors (BOS) on June 15, 2021. Following formal approval by the BOS the projects will go through the review period with the MHSOAC as well be posted for the 30-Day local review period for the public.

TOTAL BUDGET REQUEST BY FISCAL YEAR:

Total budget by fiscal year for the county collaborative portion of the costs.

	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	TOTAL

Total County Contribution to Collaborative	*412,729*	*838,017*	*330,999*	*175,401*		*1,757,146*

BUDGET NARRATIVE FOR COUNTY SPECIFIC NEEDS:

Personnel

The total personnel cost for the county portion is $648,035 over four years. This includes $386,574 for salaries and $261,461 for fringe benefits.

Personnel will include a 0.5 FTE Software Developer/Analyst III and a 0.5 FTE Staff Services Coordinator for four years.

These two positions will provide the following support to contribute to the success of this Innovation Project.

Staff Services Coordinator will:

- Oversee and act as liaison to the Innovation Project contractors
- Coordinate and facilitate meetings and discussions amongst Innovation Project contractors, partners, and other stakeholders
- Coordinate internal staff and project partners to ensure the necessary assignments are completed to meet project requirements, timelines, and quality expectations
- Develop and monitor project timelines; provide updates/status of projects to stakeholders as appropriate
- Oversee, coordinate, and provide technical assistance for the data collection, analysis and reporting of the performance measures for this Innovation Project
- Provide training and technical assistance related to project data and results to staff and stakeholders

Software Developer/Analyst III will:

- Help identify the appropriate county-level data and data transfer methods
- Extract county-level data from the electronic health record, DCR, and other program databases and sources; de-identify data before transferring to contracted staff

- Identify problems and possible solutions in the county-level data (e.g., issues with available data or methods)
- Participate in all relevant meetings regarding data for this Innovation Project

The personnel costs include a 3% annual increase to include cost-of-living salary increases and the associated retirement, and FICA increases based on the increased salaries as well as increases for health care costs.

Operating Costs

The ongoing operating costs total $24,560 over four years. This includes cell phones, office supplies, copier costs, computer licenses, MiFi service for laptops, utilities, alarm and security costs, zoom subscriptions, telephone and data processing services, and janitorial costs.

Nonrecurring Costs

Nonrecurring costs total $10,900 for equipment for the set-up of the office for the two staff members. This includes, desks, chairs, computers, laptops, and software.

Consultant Costs/Contracts

The budget includes $1,073,651 for contracted services over three years. This includes $810,000 for Third Sector, $88,651 for CalMHSA, and $175,000 for RAND as the Evaluator.

The total budget over four years is $1,757,146.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY SPECIFIC NEEDS

EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Salaries	154,898	159,545	164,331	169,261		648,035
2.	Direct Costs						
3.	Indirect Costs						
4.	Total Personnel Costs	154,898	159,545	164,331	169,261		648,035
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5.	Direct Costs	6,140	6,140	6,140	6,140		24,560

6.	Indirect Costs						
7.	Total Operating Costs	6,140	6,140	6,140	6,140		24,560
NONRECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
8	Desk, Chair, Computer, Laptop	9,900					9,900
9.	Software	1,000					1,000
10.	Total Non-recurring Costs	10,900					10,900
CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
11a.	Direct Costs (Third Sector)	220,909	441,818	147,273			810,000
11b.	Direct Costs (CalMHSA)	19,882	55,514	13,255			88,651
11c.	Direct Costs (RAND)		175,000				175,000
12.	Indirect Costs						
13.	Total Consultant Costs	240,791	672,332	160,528			1,073,651
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS:							
Personnel (line 1)		154,898	159,545	164,331	169,261	-	648,035
Direct Costs (add lines 2, 5 and 11 from above)		246,931	678,472	166,668	6,140	-	1,098,211
Indirect Costs (add lines 3, 6 and 12 from above)							
Non-Recurring costs (line 10)		10,900					10,900
Other expenditures (line 16)							
TOTAL INNOVATION BUDGET		412,729	838,017	330,999	175,401		**1,757,146**

BUDGET NARRATIVE FOR TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR:

Funding for the project will come from MHSA Innovation funds.

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY):

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for <u>ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	412,729	663,017	330,999	174,401		1,582,146
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Administration**	412,729	663,017	330,999	174,401		1,581,246
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds		175,000				175,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						

5.	Other Funding						
6.	**Total Proposed Evaluation**		175,000				175,000
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total for funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	412,729	838,017	330,999	175,401		1,757,146
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Expenditures**	**412,729**	**838,017**	**330,999**	**175,401**		**1,757,146**

Stanislaus County Behavioral Health & Recovery Services
30-Day Public Comment Form

Mail completed forms to: 800 Scenic Drive, Modesto, CA 95350
Fax completed forms to: 209-558-4326
E-mail completed forms to: mbhrs@stanbhrs.org
More information: www.stanislausmhsa.com, 209-525-6247

Mental Health Services Act (MHSA)
Three Year Program and Expenditure Plan for Fiscal Years 2020-2023 And Annual Updates for Fiscal Years 2019-2020 and 2020-2021

30-Day Comment Period:
April 1, 2021 – April 30, 2021

PERSONAL INFORMATION (optional)

Name: _____ Agency/Organization: _____

Phone Number: _____ Email address:_____

Mailing address: _____

MY ROLE IN THE MENTAL HEALTH COMMUNITY (check all that apply)

__ Consumer/Service Recipient
__ Family Member
__ Education
__ Social Services
__ Service Provider
__ Law Enforcement/Criminal Justice
__ Probation
__ Other (specify) _____

WHAT DO YOU SEE AS THE STRENGTHS OF THE PROJECT?

IF YOU HAVE CONCERNS ABOUT THE PROJECT, PLEASE EXPLAIN.

Servicios de Salúd Mental, Alcohol y Drogas del Condado de Stanislaus
Formulario Para Comentarios Públicos de 30-Días

Enviar formularios completados a:	800 Scenic Drive, Modesto, CA 95350
Enviar formularios completados por fax a:	209-558-4326
Enviar formularios completados por correo electrónico a:	mbhrs@stanbhrs.org
Para mas información, visite o llame a:	www.stanislausmhsa.com, 209-525-6247

Acta de Servicios de Salúd Mental (MHSA)
Programa de Tres Años y Plan de Gastos 2020-2023 y Plan Anual de MHSA del Año Fiscal 2019-2020 y 2020-2021

Período de 30-Días Para Comentarios :
1 abril de 2021- 30 abril de 2021

INFORMACIÓN PERSONAL (opcional)

Nombre: _____
Agencia/Organización: _____
Teléfono: _____
Dirección Electrónico:_____
Domicilio: _____

MI PAPEL COMMUNITARIO EN EL SISTEMA DE SALUD MENTAL (marque todo lo que aplique)

__ Consumidor/Recipiente de Servicios
__ Miembro de Familia
__ Educación
__ Servicios Sociales
__ Proveedor de Servicios
__ Enforsar la Ley/Justicia Criminal
__ Libertad Condicional
__ Otro (especifique)
_____

¿QUE CONSIDERA USTÉD QUE SON LOS PUNTOS FUERTES DEL PROYECTO?

SI TIENE CONCIERNES ACERCA DEL PROYECTO, POR FAVOR EXPLIQUE:

BHRS Public Comment Log

Three Year Program and Expenditure Plan For Fiscal Years 2020-2023 And Annual Updates For Fiscal Years 2019-2020 and 2020-2021

- BHRS received No public comments from stakeholders or community members related to the Stanislaus County MHSA Three Year Program and Expenditure Plan for Fiscal Years 2020-2023 and Annual Updates for Fiscal Years 2019-2020 and 2020-2021.
- Additional comments/feedback were received by SCBHRS Staff.
- The following table notates the comments/feedback and any revision made.

Comment/ Feedback Provided By	Date Comment/ Feedback Received	Page Number	Added/Revised	Date Comment/ Feedback Resolved
SCBHRS Staff	April 23, 2021	Pg. 156	O&E 02 – Budget was changed to reflect additional clients served as reported by secondary data that became available. Cost of participant was also recalculated to reflect the actual number based on clients served.	May 11, 2021
SCBHRS Staff	April 23, 2021	Pgs. 157-160	O&E 02 – Data was updated to reflected additional program data that was made available.	May 11, 2021
SCBHRS Staff	April 23, 2021	Pgs. 158-159	O&E 02 – Additional narrative added to provide context to the added data presented.	May 11, 2021
SCBHRS Staff	April 23, 2021	Pg. 160	O&E 02 – Outcomes Data table was updated to reflect newly added data.	May 11, 2021
SCBHRS Staff	April 23, 2021	Pgs. 173-175	PEI: Prevention– Changes made to the Program listings to better align with how they are listed in the Revenue and Expenditure Report.	May 11, 2021
SCBHRS Staff	May 24, 2021	Pgs. 237-290	INN: Innovations – The (2) New Innovation Project	May 24, 2021

			Proposal for FY 2021-2022 were added to this Report and are featured at the end of the Innovation Annual Update. This was done to create one streamlined Annual Update and Three-Year Plan that included the proposed INN projects.	
SCBHRS Staff	May 24, 2021	Pg. 19	Innovation (INN) projects proposed for FY 2021-2022 were added to the "2021-2022 programs Added" summary of Programs scheduled for 2021-22. Please note the (2) INN projects proposed were originally reflected in the fiscal tables, and the projects underwent a Community Planning Process. Adding the (2) project descriptions here allowed for one streamlined Annual Update and Three-YR Program and Expenditure Plan with Innovations included.	May 24, 2021
SCBHRS Staff	May 24, 2021	Pg. 20	Workforce Education and Training (WET) Regional Partnership project description was added to the "2021-2022 Programs Added" as this is an initiative that is likely to occur during FY's 2021-2025.	May 24, 2021
SCBHRS Staff	May 24, 2021	Pg. 18	In the summary of "2021-2022 Programs Added," School Based Behavioral Health Services (SBBHS) program activities were	May 24, 2021

			added to provide more detail on the program scope.	
SCBHRS Staff	May 24, 2021	Pg. 78	FSP 06 – High Risk Health Program Description was amended to more accurately reflect the scope of services for that program.	May 24, 2021
SCBHRS Staff	May 24, 2021	Pgs. 116-122	GSD 02 – Mobile Community Emergency Response Team (MCERT) program activities were modified to add more detail	May 24, 2021
SCBHRS Staff	June 9, 2021	Pg. 121	GSD 02 – An MCERT Challenge was removed given that there was no viable data to substantiate the claim.	June 9, 2021
SCBHRS Staff	June 9, 2021	Pgs. 190-191	PEI – Clarification regarding CALMHSA's role in the state and added reference to the Each Mind Matters material.	June 9, 2021
SCBHRS Staff	June 9, 2021	Pgs. 80-82	FSP 06 – Program updates, program challenges/strategies to mitigate and opportunities were modified/updated to provide more clarity and reduce redundancy.	June 9, 2021

Stanislaus County
Striving to be the Best

BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act Plan, Updates and Innovations Projects

Approval to adopt the Mental Health Services Act Three Year Program and Expenditure Plan for Fiscal Years 2020-2023, Annual Updates for Fiscal Years 2019-2020 and 2020-2021, Early Psychosis Learning Health Care Network and Full Service Partnership Multi-County Collaborative Innovations Plans, and to authorize expenditure of Mental Health Services Act funds for Innovations Projects

Mental Health Services Act Funding

- Counties are responsible for ensuring compliance with Welfare and Institutions (W&I) Code Section 5892(a) and State guidance and allocate and expend funds in the following categories:
  - Innovations – 5%
  - Prevention and Early Intervention (PEI) – 19%
  - Community Services and Supports (CSS) – 76%

Background

On March 30, 2021, the Stanislaus County Board of Supervisors (BOS) accepted the Stanislaus County BHRS Strategic Plan.

The Board also and authorized the Behavioral Health Director to finalize the Mental Health Services Act Three Year Program and Expenditure Plan for Fiscal Years 2020-2021, 2021-2022, and 2022-2023 for Board consideration that aligns program services with sustainable funding (Resolution 2021-0136).

Overview

BHRS is requesting approval of the following:

- MHSA Three Year Program and Expenditure Plan ("Plan") for Fiscal Years 2020-2021, 2021-2022, and 2022-2023
- Annual Updates ("Update") for Fiscal Years 2019-2020 and 2020-2021
- Early Psychosis Learning Health Care Network and Full-Service Partnership Multi-County Collaborative Innovations Plans ("Innovations Plan") and to Allow Expenditure of MHSA Funds for Innovations Projects

COVID-19 Impacts to Community Planning

- In March of 2020, Governor Newsom implemented a mandatory Stay-At-Home Order due to the Coronavirus Disease 2019 (COVID-19).
- In June of 2020, the California Department of Health Care Services released Information Notice 20-040 which allowed counties to extend the timeframe of currently approved plans.
- Extension allowed:
  - Continued operation of programs and services from Fiscal Year 2019-2020 into Fiscal Year 2020-2021 extended the deadline for the submission of a new Plan to July 1, 2021.

Local Review Process

- Plans and Updates are developed with feedback from the MHSA Representative Stakeholder Steering Committee (RSSC).
- The development process must also include a 30-day public review/comment period and a public hearing.

Three Year Program and Expenditure Plan (2020-2023)

The Plan summarizes the progress in implementing all services and activities. New or proposed changes to services or programs are included in each reporting component section.

Annual Updates for Fiscal Years 2019-2020 and 2020-2021

The Updates summarize:

- What was new or different for each fiscal year reported
- Challenges and strategies
- Essential data and analysis

Innovation Funding

- Innovation is one of five components of MHSA
- Provides funds to evaluate new approaches in mental health
- Contribute to learning and address unmet needs

Avoid Innovation Funding Reversion

- COVID-19 impacted the normal community planning process.
- MHSOAC encouraged counties to explore already-approved Innovation projects.
- BHRS identified two Innovation Projects:
  - Early Psychosis Learning Health Care Network (LHCN) Innovations Project
  - Full Service Partnership Multi-County Collaborative Innovations Project
- $1,346,811 of Innovation funding will revert on June 30, 2021, if not approved.

Early Psychosis Learning Health Care Network (LHCN) Innovations Project

LIFE Path Early Psychosis Intervention Program– Operated by Sierra Vista Child and Family Services will benefit from sharing and learning with the multiple and diverse participating counties

- Implement a LHCN app for early psychosis programs across multiple California counties.
- Develop a LHCN implementation strategy that could be adopted by EP programs statewide.
- Evaluate the impact of the LHCN on consumer satisfaction with care, insight into treatment needs, and alliance with the treatment team, as well as consumer and provider experience implementing the LHCN.

Early Psychosis Learning Health Care Network (LHCN) Innovations Project

Demonstrate the utility of the LHCN through a multilevel evaluation of:

- The EP program components associated with improved consumer level outcomes
- The potential differences in service utilization and costs (EP program, ED/crisis, hospital) between EP programs and standard care for EP consumers from de-identified county level data
- The consumer, family and EP provider experiences related to participation in the LHCN

Full Service Partnership Multi-County Collaborative Innovations Project

Defining and Tracking Priority Outcomes: The data will assist in establishing a best practice approach to track, standardize, and apply measures consistently between counties and across programs for statewide consistency.

Develop and/or Strengthen Processes: Establish new processes including supporting shared learning collaborations, accountability, develop and strengthen existing processes for continuous improvements, support meaningful comparisons, and utilize data to provide continuous improvements of FSP services for clients statewide.

Strategy to Track and Streamline Performance Measures: Evaluate state-level and county-specific reporting tools to develop strategies for best tracking performance measures and outcomes.

Develop a Consistent FSP Framework: Develop a best practice FSP framework and consistent interpretation of core components that allow adaptations for county specific needs.

Define Program Criteria: Define clear and consistent eligibility, enrollment, referral and graduation criteria. Develop county and provider guidelines for dissemination of information and implementation protocols

Fiscal Impact

Fiscal Year 2021-2022 Mental Health Services Act Fund Proposed Budget

- $56 Million Total Appropriations
- $49.4 million Estimated Revenue
- $6.6 million Use of Fund Balance

Staff Recommendations

1. Adopt the Mental Health Services Act Three-Year Program and Expenditure Plan for Fiscal Years 2020-2023 and Annual Updates for Fiscal Years 2019-2020 and 2020-2021, reporting outcomes for Fiscal Years 2018-2019 and 2019-2020, respectively.
2. Adopt the Early Psychosis Learning Health Care Network and Full-Service Partnership Multi-County Collaborative Innovations Projects and authorize expenditure of MHSA Funds for Innovations Projects.

Staff Recommendations Continued

3. Authorize the Behavioral Health Director, or designee, to sign and submit the Mental Health Services Act Three Year Program and Expenditure Plan for Fiscal Years 2020-2023 and Annual Updates for Fiscal Years 2019-2020 and 2020-2021, and Early Psychosis Learning Health Care Network and Full-Service Partnership Multi-County Collaborative Innovations Projects to the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission.

Staff Recommendations Continued

4. Authorize the Auditor-Controller, or designee, to sign the Mental Health Services Act County Fiscal Accountability Certification certifying that the fiscal requirements have been met.

Questions?