San Joaquin County
Behavioral Health Services

Mental Health Services Act (MHSA)

2024-2025 Annual Update to the Three-Year Program and Expenditure Plan FY 2023-26

DRAFT - 30 Day Public Comment Period

4/5/2024

SAN JOAQUIN COUNTY

MHSA FISCAL ACCOUNTABILITY CERTIFICATION

County/City: SAN JOAQUIN COUNTY

☐ Three-Year Program and Expenditure Plan

X **Annual Update**

☐ Annual Revenue and Expenditure Report

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

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

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

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

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

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

Jeffery Woltkamp, _____ _____
County Auditor Controller Signature Date

SAN JOAQUIN COUNTY
MHSA COMPLIANCE CERTIFICATION

County/City: SAN JOAQUIN COUNTY

☐ Three-Year Program and Expenditure Plan

X **Annual Update**

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

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

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

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

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

Genevieve G. Valentine, LMFT, _____ _____

Behavioral Health Director Signature Date

Table of Contents

I. Introduction

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

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

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

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

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

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

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

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

MHSA Program Priorities

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

Mission Statement

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

Vision Statement

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

Planning Priorities

II. Community Program Planning and Stakeholder Process

Community Program Planning Process

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

Quantitative Analysis (Program period July 2022 – June 2023):

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

Community Discussions:

4. MHSA Showcase
    - October 5, 2023 – MHSA Programs - Public Showcase, Stakeholder and Community Engagement Survey

5. Behavioral Health Advisory Board (BHAB)
    - September 20, 2023
        - Announcement to BHAB of Planning Dates for the 2024-2025 MHSA Annual Update – Feed back from BHAB on areas in San Joaquin County to focus

6. Public Forums – Community Planning & Stakeholder Feedback Presentations
    - October 24, 2023 – MHSA Community Planning – Lodi, CA (Lodi Public Library)
    - October 25, 2023 – MHSA Community Planning – Tracy, CA (Tracy Community Center)
    - October 26, 2023 – MHSA Community Planning – Manteca, CA (Manteca Library)
    - October 31, 2023 – MHSA Community Planning (General Community Zoom Call)
    - November 1, 2023 – MHSA Consortium (Zoom Meeting)
    - November 2,2023 – MHSA Community Planning – Stockton, CA (Catholic Charities/Spanish Session)
    - November 7, 2023 – MHSA Community Planning (Spanish Session) – Stockton, CA - El Concilio (Zoom Meeting)
    - November 8, 2023 – MHSA Community Planning (General Community Zoom Call)
    - November 14, 2023 – MHSA Community Planning – Stockton, CA (South) – Kennedy Community Center

- November 15, 2023 – MHSA Community Planning - BHS Behavioral Health Advisory Board
- November 16, 2023 – MHSA Community Planning - Stockton, CA (East) – Garden Acres Community Center
- December 12, 2023 – Community Stakeholder Feedback Presentation - MHSA Consortium (Zoom Meeting)
- December 20, 2023 – Community Stakeholder Feedback Presentation - BHS Behavioral Health Board
- December 22, 2023 – Community Stakeholder Feedback Presentation - Consumer Advisory Council
- January 9, 2024 – Community Stakeholder Feedback Presentation - Cultural Competency Committee
- January 18, 2024 – Community Stakeholder Feedback Presentation - BHS Leadership (BHS Managers Meeting)

Targeted Discussions:

7. Consumer Focus Groups
- October 17, 2023 - Co-hosted by the Martin Gipson Socialization Center Co-hosted by the Wellness Center
- October 19, , 2023 - Co-hosted by the Wellness Center Co-hosted by the Martin Gipson Socialization Center

Consumer and Stakeholder Surveys:

8. 2023-24 MHSA Consumer and Stakeholder Surveys

Assessment of Mental Health Needs

County Demographics and County's Underserved/Unserved Populations

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

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

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

*Source: San Joaquin Council of Governments

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

Population Served

BHS provides mental health services and substance use disorder treatment to over 17,500 consumers annually. In general, program access is reflective of the diverse population of San Joaquin County, with a roughly even division of male and female clients. An analysis of services provided in 2021-22 demonstrates the program participation compared to the county population.

Mental Health Services Provided in 2022-23

Services Provided by Age	Number of Clients*	Percent of Clients
Children	3,449	20%
Transitional Age Youth	3,088	18%
Adults	9,139	52%
Older Adults	1,837	10%
Total	**17,591**	**100%**

*Source: BHS Client Services Data

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

Services Provided by Race/Ethnicity	County Population by Race/Ethnicity**	Percent of County Population	Clients Served*	Percent of Clients
White	223,036	28%	5,511	31%
Latino	337,646	43%	4,453	25%
African American	55,683	7%	2,690	15%
Asian	135,117	17%	1,297	7%
Multi-Race/Other	28,383	4%	3,050	17%
Native American	3,298	.4%	452	3%
Pacific Islander	5,116	.6%	60	0.3%
Total	**788,279**	**100%**	**17,513**	**100%**

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

The diversity of clients served is similar to the distribution in prior years. African Americans are disproportionately over-represented amongst consumers compared to their proportion of the general population (15% of participants, though comprising 7% of the population of the County). Native Americans are also over-represented within the service continuum (3% of clients are Native American). Latinos are enrolled in mental health treatment services at rates lower than expected, compared to their proportion of the general population (25% of clients versus 43% of the population). Asian clients are also underrepresented by 10%.

Services Provided by City	County Population by City**	Percent of County Population	Clients Served*	Percent of Clients
Stockton	319,731	41%	10,926	62%
Lodi	66,293	8%	1,381	8%
Tracy	95,615	12%	1,292	7%
Manteca	88,803	11%	1,114	5%
Lathrop	35,080	5%	333	2%
Ripon	15,769	2%	153	1%
Escalon	7,264	1%	126	1%
Balance of County	157590	20%	3,188	14%
Total	**786145**	**100%**	**17,513**	**100%**

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

The majority of clients are residents of the City of Stockton. Stockton is the County seat of government and the largest city in the region, accounting for 41% of the County population. The majority of services and supports for individuals receiving public benefits, including mental health, are located in Stockton.

Stakeholder Involvement:

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

Discussion Group Input and Stakeholder Feedback

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

Community Program Planning for 2023-24:

Behavioral Health Advisory Board (BHAB) Agenda Items

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

Community Stakeholder and Consumer Discussion Groups

There were 18 community discussion groups convened between October 2023 – January 2024, two of which specifically targeted adult consumers and family members. Two of the 18 community discussion groups were held in a Behavioral Health Advisory Board meeting so stakeholders could present their input directly to members of the Board.

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

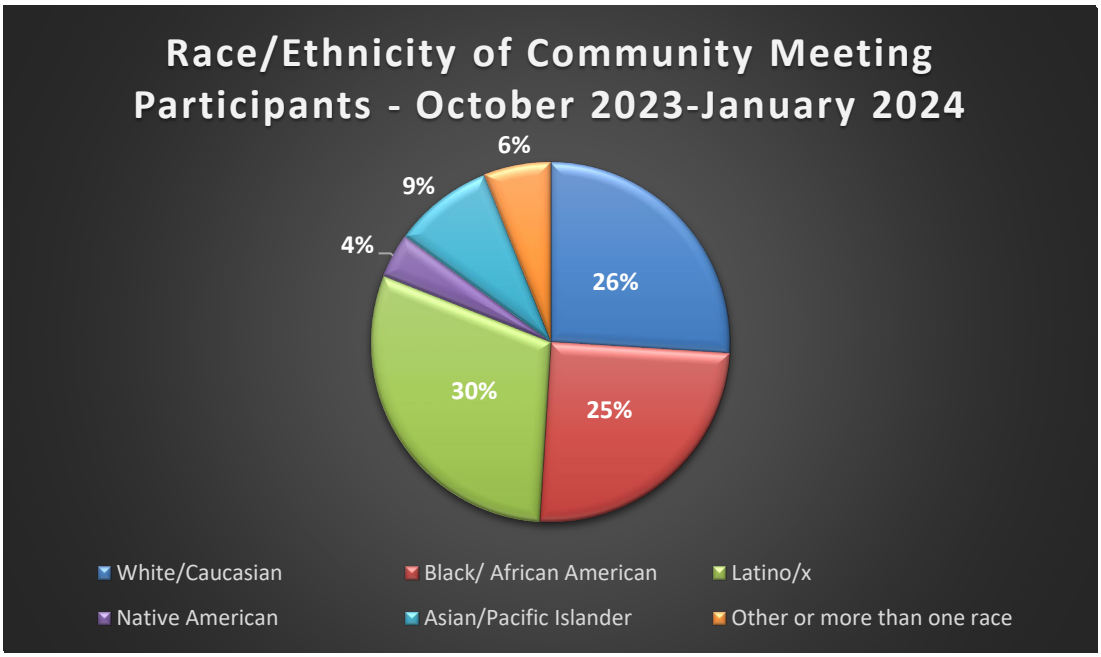
- Funding priorities
- Populations of need
- Regulations guiding the use of MHSA funding.

Stakeholder participation was tracked through Sign-In Sheets, zoom chat and completed anonymous demographic Survey Monkey links. Stakeholder participants were demographically diverse and included representatives of unserved and underserved populations, according to the surveys. The community discussion and focus groups had participation by over 200 individuals, nearly 90% of whom self-identified as a consumer of public mental health services or as a family member of a consumer. The majority of participants identified as adults ages 26-59, 14% were older adults over 59 years of age, and 16% were transitional age youth ages 18-25.

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

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

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



Survey Input and Stakeholder Feedback

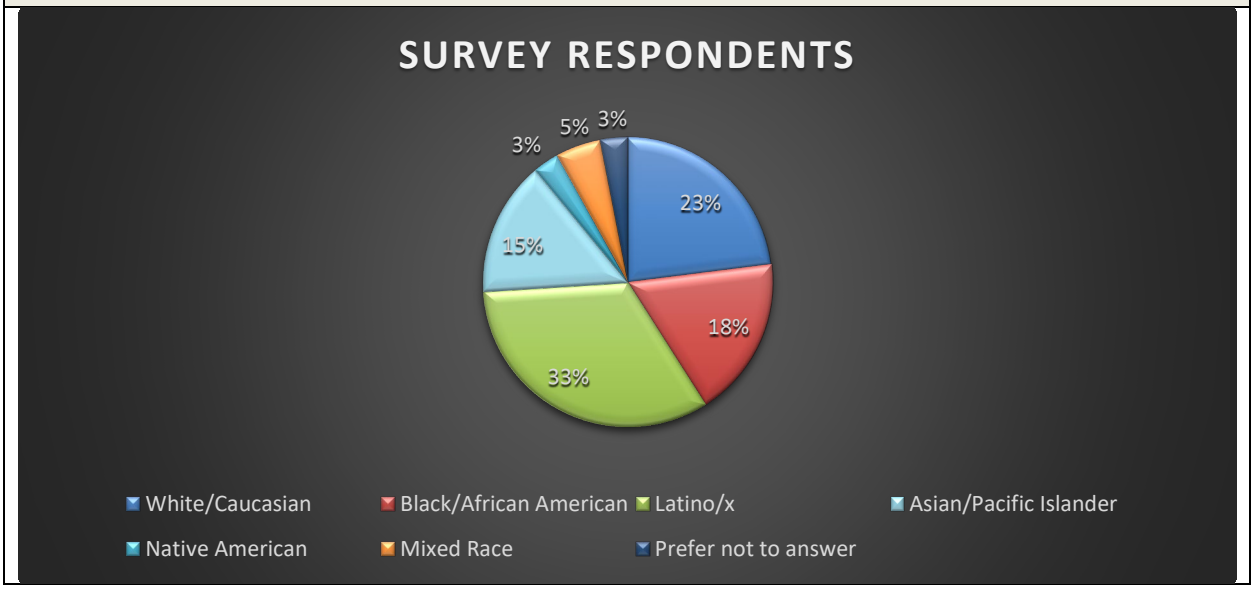
In October 2023 and January of 2024, BHS distributed electronic and paper surveys to consumers, family members, and stakeholders to learn more about the perspectives, needs, and lives of clients served through mental health programs. Surveys were completed online and in person with multiple-choice answers and responses were tallied through Survey Monkey reports. There were 300 surveys completed. Survey instruments can be reviewed in the Appendix.

BHS consumers and their family members reported mid to high levels of satisfaction with the services provided to address mental health and/or substance use disorders, with 92% of respondents reporting that they would recommend BHS services to others. According to respondents, BHS Informational materials such as flyers, brochures and website need to be updated. A large majority of respondents reported that the BHS Lobby and reception areas are friendly and welcoming from a cultural and linguistic perspective. Respondents agreed strongly with statements regarding staff courtesy and professionalism, respect for cultural heritage, and their capacity to explain things in an easily understood manner.

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

Survey respondents were diverse and identified as: White/Caucasian (23%), Latino/x (33%), African American (18%), Asian/Pacific Islander (16%), Native American (3%), and Mixed Race (4%)

Self-Reported Race and Ethnicity of Stakeholder Survey Respondents
MHSA 2023-24 Consumer and Stakeholder Surveys



Self-Reported Age/Gender of Stakeholder Survey Respondents

Age Range	Percent
Under 18	.5%
18-25	11%
26-59	76%
60 and over	10%
Prefer not to say	2.5%

Gender	Percent
Male	30%
Female	66%
Transgender	1%
Non-Binary	0%
Prefer not to say	3%

The 300 respondents surveyed represent the broad diversity of stakeholders in the community and consumers served by BHS. 32% of respondents identify as someone who is receiving, or who needs, mental health treatment services. More than half of respondents have children, with 53% describing themselves as parents. Consistent with the general population, 8% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQ). Nearly 17% of respondents identified with having a physical or developmental disability. Few are military veterans, with 5% reporting that they have served in the US Armed Forces. 10% of consumers reported experiencing homelessness more than four times or being homeless for at least a year; and 18% of respondents reported having been arrested or detained by the police.

Community Mental Health Issues

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

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

- Parental involvement – Bridge between school, caregiver capacity, family stressors, integration of home and case management
- Reduce Stigma around mental health through after school programs for parent nights – programming for MH Prevention (BEYOND THE BELL)
- Needs to address generational and cultural gap between parents and children around mental health diagnosis.
- Stakeholders expressed a need for education and training for all family/caregivers to recognize signs and symptoms of mental health concerns and possibly expanding MH Services in afterschool programs.

Recommendations to Strengthen Services for Children and Youth:

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

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

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

- Focused efforts to ensure that TAY programming includes enhancing life skills and suicide prevention education.

- TAY Workforce development and training opportunities, specifically for Peer Support Specialist within the TAY Community.
- TAY focused temporary crisis housing and permanent housing to prevent homelessness.
- TAY need community activities to enhance social skills.

Recommendations to Strengthen Services for Transition Age Youth

- Expand Mentoring for Transitional Age Youth PEI Project to include community culturally based providers to meet the needs of the underserved African American and Latino Youth in San Joaquin County
- Provide workforce development and training opportunities through community providers to build vocational opportunities for Transitional Age Youth
- Develop programming with Community Based Organizations to enhance Access and linkage efforts with focus on vulnerable communities that represent the TAY Population.
- Expand existing Mentoring for Transitional Aged Youth program with focus on trauma informed care practice and exploring the use of culturally rooted healing practices for TAY Population

Key Issues for Adults

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

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

Recommendations to Strengthen Services for Adults

- BHS should continue to strengthen the housing continuum for people with serious mental illnesses by expanding opportunities for housing options.
- BHS should promote and MH Services and Warm Line number in all public communities (libraries, city hall, county buildings) – focused on culturally appropriate and community integrated messaging.
- BHS should tap into the public libraries and local community centers throughout the County to educate community on MH Services

- BHS should utilize peer specialists to enhance treatment and support options further supporting recovery efforts for consumers and family members.
- BHS should expand group and group therapy throughout several locations outside of the main campus to provide group services readily available to the community.
- BHS should consider utilizing community centers to provide community driven/culturally appropriate education for communities of color, LGBTQIA, and Asian communities – exploring opportunities to enhance and develop support groups throughout the county.

Key Issues for Older Adults

Older adults with mild to moderate mental health concerns remain at-risk for untreated depression and suicide ideation. More articulation is needed with senior and older adult service providers to offer interventions for older adults that have escalating behavioral health challenges. More public information and education about the risk of suicide in adults and older adults is needed; particularly focusing on adult men who are at the highest risk for suicide in San Joaquin County. Finally, stakeholders identified the biggest risk among older adults living independently as social isolation, especially in light of the COVID-19 Pandemic. Stakeholders encouraged more behavioral health services co-located at county community centers that provide senior activities, services, and support throughout the County.

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

Recommendations to Strengthen Services for Older Adults:

- BHS Older Adult Services should provide meaningful alternatives such as a “day program” for daily living that combats depression and isolation including more socialization activities and more activities that prevent memory deterioration or loss of cognitive functioning.
- Strengthen newly developed Prevention & Early Intervention for Older Adults by providing presentation in the community on the vital prevention service for the older adult population.
- Broaden suicide prevention efforts to target the older adult community. Include targeted prevention information for middle age and older adult men. Address handgun and firearm safety when living with loved ones experiencing depression.

III. Public Review of the 2024-25 Annual Update to the 2023-26 MHSA Three Year Program and Expenditure Plan

Dates of the 30 day Review

The public is invited and encouraged to review and submit input to the draft MHSA Plan from April 5, 2024, to May 7, 2024.

Methods of Circulation

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

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

MHSA Coordinator
San Joaquin County Behavioral Health Services
1212 N. California Street
Stockton, CA 95202

E-mail notices were sent to the BHS MHSA e-mail list which has been continuously maintained since MHSA planning began in 2006. Contracted providers were asked to post notifications in their public program areas, indicating that the 2024-2025 MHSA draft annual update to the 2023-26 MHSA Three Year Plan was available for review.

Public Hearing

A public hearing will convene on May 7, 2024, in conjunction with a regularly scheduled Behavioral Health Board Meeting:

Meeting Date/Time/Location
Tuesday, May 7, 2024 – 5pm-7pm

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

Public Hearing will begin with a brief presentation of the 2024-25 MHSA Annual Update and the community planning process used to inform the Plan. The presentation will also include highlights of changes created throughout the plan. The presentation concluded with a comment period allowing attendees to provide direct feedback on the plan.

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

Public Comments: TBD

IV. MHSA Component Funding for FY 2024-25

MHSA Component Worksheets describe the total planned expenditures for Fiscal Years 2024-25

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

FY 2024-2025 Mental Health Services Act Annual Update
Funding Summary

County: San Joaquin Date: 3/27/24

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
C. Estimated FY2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	29,182,555	18,045,074	9,791,196	1,151,128	17,649,858	
2. Estimated New FY2024/25 Funding	66,309,500	15,671,176	4,123,994			
3. Transfer in FY2024/25	(2,000,000)			500,000	1,500,000	
4. Access Local Prudent Reserve in FY2024/25						0
5. Estimated Available Funding for FY2024/25	93,492,055	33,716,250	13,915,190	1,651,128	19,149,858	
D. Estimated FY2024/25 Expenditures	86,737,996	15,611,403	1,547,947	967,730	11,788,455	

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

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

FY 2024-2025 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Component Worksheet

County: San Joaquin Date: 3/27/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children and Youth FSP	12,954,876	8,266,102	4,659,974			28,800
2. Transitional Age Youth FSP	1,361,570	942,544	400,426			18,600
3. TAY Intensive Care Coordination and Intensive Home Based Services FSP	6,500,000	6,500,000				
4. Adult FSP	14,170,025	9,560,826	4,341,399			267,800
5. Older Adult FSP	1,584,415	1,123,990	428,375			32,050
6. Community Corrections FSP	2,410,100	1,947,429	403,231			59,440
7. InSPIRE FSP	1,006,169	738,581	260,588			7,000
8. Intensive Adult FSP	2,729,010	1,614,162	1,089,248			25,600
9. Intensive Justice Response FSP	2,671,788	1,287,260	1,324,328			60,200
10. High-Risk Transition Team	979,200	497,200	429,000			53,000
11. Adult Residential Treatment Services	5,119,936	3,726,034	1,393,902			
12. Housing Stabilization FSP Services	1,650,000	1,650,000				
Non-FSP Programs						
13. Mental Health Outreach and Engagement	684,889	684,889				
14. Mobile Crisis Support Team	2,471,998	2,334,498	125,000			12,500
15. Peer Navigation	585,000	555,000	25,000			5,000
16. Wellness Center	1,750,052	1,750,052				
17. Project Based Housing	5,700,000	5,700,000				
18. Employment Recovery Services	537,602	537,602				
19. Community Behavioral intervention Services	918,000	630,462	251,438			36,100
20. Housing Coordination Services	13,040,167	12,910,810	108,757			20,600
21. Crisis Services Expansion	7,866,788	3,757,958	3,793,891			314,939
22. Co-Occuring Disorder Program	700,000	509,425	190,575			
23. TAY Outpatient Care	750,001	545,813	204,188			
24. JCID Restart Program	984,609	822,109	162,500			
25. System Development Expansion	5,065,062	4,864,062	201,000			
CSS Administration	13,281,188	13,281,188				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	107,472,445	86,737,996	19,792,820	0	0	941,629
FSP Programs as Percent of Total	56.4%					

FY 2024-2025 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Component Worksheet

County: San Joaquin Date: 3/27/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention Programs for Children, Youth & Families						
1. Skill Building for Parents and Guardians	1,662,502	1,662,502				
2. Prevention for Children 0-5	600,000	600,000				
3. Mentoring for Transitional Age Youth	846,223	846,223				
4. Coping and Resiliency Education Services	2,441,940	1,953,552	488,388			
Early Intervention Programs for Children and Youth						
5. Early Interventions to Treat Psychosis	1,672,952	831,072	831,780			10,100
Early intervention Programs for Adults and Older Adults						
6. Community Trauma Services for Adults	2,700,000	2,160,000	540,000			
7 Prevention and Early Intervention for Older Adults	500,000	500,000	0			
Access and Linkage to Treatment Program						
8. Whole Person Care	1,164,191	1,164,191	0			
9. Cultural Brokers Program	1,000,000	1,000,000	0			
Outreach for Increasing Recognition of the Early Signs of Mental Illness						
10. Increasing Recognition of Mental Illnesses	75,000	75,000				
Stigma and Discrimination Reduction Program						
11. Information and Education Campaign	750,000	750,000				
Suicide Prevention Program						
12. Suicide Prevention with Schools	832,320	832,320				
13. Suicide Prevention and Education in the Community	750,000	750,000				
PEI Administration	2,249,269	2,249,269				
PEI Assigned Funds	0					
Funds assigned to CalMHSA	237,274	237,274				
Total PEI Program Estimated Expenditures	17,481,671	15,611,403	1,860,168	0	0	10,100

FY 2024-2025 Mental Health Services Act Annual Update
Innovations (INN) Component Worksheet

County: San Joaquin Date: 3/27/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. CalMHSA Semi-Statewide EHR Innovation Project	1,346,041	1,346,041				
INN Administration	201,906	201,906				
Total INN Program Estimated Expenditures	1,547,947	1,547,947	0	0	0	0

FY 2024-2025 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Component Worksheet

County: San Joaquin Date: 3/27/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	682,904	682,904				
2. Internship and Financial Assistance	158,600	158,600				
WET Administration	126,226	126,226				
Total WET Program Estimated Expenditures	967,730	967,730	0	0	0	0

FY 2024-2025 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Joaquin Date: 3/27/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Residential Treatment Facilities for COD	0					
2. Facility Renovations	1,500,000	1,500,000				
3. Facility Repair and Upgrades	8,511,700	8,511,700				
CFTN Programs - Technolgical Needs Projects						
4. Technology Equipment and Software	500,000	500,000				
CFTN Administration	1,276,755	1,276,755				
Total CFTN Program Estimated Expenditures	11,788,455	11,788,455	0	0	0	0

V. Community Services and Supports

Essential Purpose of Community Services and Supports Component Funds

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

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

In San Joaquin County CSS funding will support:

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

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

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

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

Full Service Partnership Program Regulations

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

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

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

FSP Eligibility Criteria

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

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

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

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

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

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

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

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

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

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

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

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

Criteria 4: San Joaquin County Priority Service Needs

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

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

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

Full Service Partnership Program Implementation in San Joaquin County

FSP Component Services

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

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

<u>Standard FSP Programs</u>

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

<u>Enhanced FSP Programs</u>

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

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

Accessibility and Cultural Competence

Equal Access:

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

Linguistic Competence:

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

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

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

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

Full Service Partnership Program Services

FSP Engagement:

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

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

FSP Assessment and Referral Process:

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

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

FSP Enrollment into a Treatment Team

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

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

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

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

FSP Treatment and Recovery Plan

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

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

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

Clinical and Service Interventions:

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

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

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

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

    - Aggression Replacement Training

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

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

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

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

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

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

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

Monitoring Treatment Progress

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

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

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

Transition to Community or Specialty Mental Health Services

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

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

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

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

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

Community Services and Supports Funded Programs

Full Service Partnerships

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

Outreach & Engagement

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

General System Development

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

21. Crisis Services Expansion

22. Co-Occuring Disorder Program

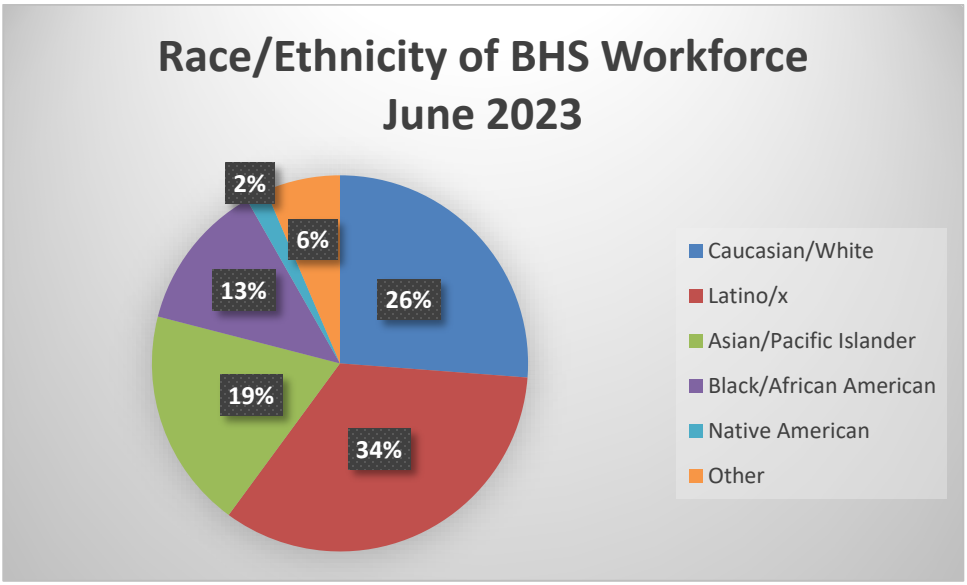
23. TAY Outpatient Care

24. System Development Expansion

Capacity to Implement CSS Programs

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

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



BHS works hard to recruit and retain a diverse workforce. Compared to the general population the BHS workforce is relatively diverse, and somewhat reflective of the residents of San Joaquin County. Data shows that Hispanic/Latino individuals are under-represented in the workforce, comprising 34% of the workforce, compared to 41% of the county population and 46% of Medi-Cal Beneficiaries, however in the recent year, Hispanic/Latino individuals have become slightly higher in representation than their Caucasian/White counterparts.

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

CSS FSP Program Work Plans

Funding is allocated towards nine FSP programs that are implemented by 22 different clinical teams comprised of psychiatrists, clinicians, case managers, peer partners, nurses, psychiatric technicians and others. Annually, over 1,900 individuals receive services within San Joaquin's FSP programs. FSP program participants may also participate in one or more specialty programs to receive additional services and supports beyond those usually provided by an FSP team.

	Unique Count of Clients Served in FY 22-23
Full Service Partnership Programs	
1. Children and Youth FSP (5 Teams)	968
2. Transitional Age Youth (TAY) FSP (2 Teams)	75
3. Adult FSP (7 Teams)	659
4. Older Adult FSP (1 Team)	74
5. Community Corrections FSP (1 Team)	164
6. InSPIRE FSP (1 Team)	38
7. Intensive Adult FSP (2 Teams)	131
8. Intensive Justice Response FSP (2 Teams)	133
9. High Risk Transition Team FSP (1 Team)	81
TOTAL CLIENTS ENROLLED IN FSP PROGRAMS	**2,323**

CSS Project 1: Children and Youth FSP

Project Description

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

Target Populations

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

Project Components

There are four FSP teams working with children and youth.

FSPs for Children and Youth in the Dependency System

1. Dependency FSP Team

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

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

2. MHSA Pathways FSP Team

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

3. Therapeutic Foster Care (TFC) Team

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

4. Short Term Residential Therapeutic Programs (STRTP)

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

FSPs for non-dependent Children and Youth

5. BHS Child and Youth (CYS) FSP Team

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

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

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

Documentation of Achievement in performance outcomes:

SJCBHS completed a Performance Improvement Project (PIP) regarding increasing Intensive Home-Based Services (IHBS). The PIP was successful and deemed to have "high confidence" during our External Quality Review process. The AIM of this PIP was to increase the number of children/youths who receive IHBS and the IHBS services provided per beneficiary. There was a 102% increase in the number of children/youths who received IHBS, significantly raising the percentage of CYS clients who receive IHBS services from 8:2% to 14.1%. There was a 97% increase in the number of services provided. While hiring staff continues to be a barrier, the CYS FSP programs have been able to meet the need of the community by hiring clinicians through our contract with Maxim Staffing. We have hired three Locum Clinicians for the CYS FSP program. We have also met the need by adding practicum students to the CYS FSP programs.

Challenges or barriers:

One challenge experienced in the CYS FSP is the change in Electronic Health Record (EHR). In our past EHR we were able to work with the vendor to create an ICC/IHBS screener and referral form within the EHR. Because this form was in the EHR we were able to pull data such as number of referrals, outcome of referrals, and timeliness of referral follow ups. We were also able to track staff compliance with completion of the screening form at required times such as at intake, every 6 months and after a crisis visit or psychiatric hospital stay. We were able to use this information to create dashboards. The managers having this data at their fingertips assisted in following up with staff to ensure clients are being screened and offered the appropriate services. Our EHR also auto-populated the screener/referral form to the clinicians que when the 6 month screener was due. This resulted in more children getting more IHBS services. However, our new EHR does not have these features. Our new EHR does not have an ICC/IHBS screener/referral form. We have asked the vendor to create one and they refuse stating that it is not a regulatory requirement to have an ICC/IHBS screener even thought we are obligated to screen children and youth for these services. They want us to document screening for ICC/IHBS in the body of a note which makes pulling data impossible. We have resorted back to hand tracking and paper forms. Our ability to ensure every youth is getting screened when they should get screened is now limited.

Clients Served within the Children and Youth FSP Program

Client Demographics

Children and Youth FSP Program 2022-2023 N=968		
	Number	**Percent**
Total by Age Group Served		
▪ Children and Youth	656	68%
▪ Transitional Age Youth	312	32%
Gender Identity		
▪ Female	519	54%
▪ Male	447	46%
Race/Ethnicity		
▪ African American	161	17%
▪ Asian / Pacific Islander	34	3%
▪ Hispanic/Latino	154	16%
▪ Native American	14	1 %
▪ White/Caucasian	333	34%
▪ Other / Not-Identified	272	28%
Linguistic Group		
▪ English	908	94%
▪ Spanish	33	3%
▪ Asian/Pacific Islander	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	27	3%

Cost per Client

Number Served	**Total Expenditures**
968	$7,704,597
Average Annual Cost	**Average Monthly Cost**
$6,966	$580

Client Projections

Clients Served/Projected				
2022-23	**2023-24**	**2024-25**	**2025-26**	**Age Group**
968	970	1000	1200	Combined
656	660	650	700	Children & Youth
312	310	350	500	TAY

CSS Project 2: Transitional Age Youth (TAY) FSP

Project Description

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

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

Target Population 1: Exiting or Former Foster Care Youth

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

Target Population 2: Transitional Age Youth

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

Documentation of Achievement in performance outcomes:

The TAY FSP program in the Adult System of Care currently serves 46 consumers, providing case management, linkage, rehabilitative, and therapy services. The TAY FSP program re-established the TAY Coping Skills Group, the TAY Woman's Support Group, and are continuing to look at additional groups to add. The TAY FSP team participated in the Family WRAP Training, the Annual Child Abuse Prevention Symposium, Trauma Informed CBT for Children & Adolescents, and the LGBTQ Youth Clinical Strategies to Support Sexual Orientation and Gender Identify to assist TAY FSP program staff with increasing their knowledge and skills to utilize with the consumers.

Challenges or barriers:

The TAY FSP team continued to experience challenges related to limited housing resources and the lack of financial resources for this age group. The team continues to utilize CHOICE funding, the Homeless and Transitional Housing program, and other community housing programs until more stable placement

can be secured. Many of the TAY FSP youth do not have reliable transportation to participate in additional MH services such as group.

Strategies: The TAY FSP team will assist with transportation needs and have designated staff provide transportation to groups, therapy, and other services. CBIS services are also utilized for youth interested in learning to utilize the public transportation system.

Project Components:

There are two FSP teams working with Transitional Age Youth.

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

Client Demographics

Transitional Age Youth FSP Program 2022-2023 N=75		
	Number	**Percent**
Total by Age Group Served		
▪ Adult	14	19%
▪ Transitional Age Youth	61	81%
Gender Identity		
▪ Female	33	44%
▪ Male	42	56%
Race/Ethnicity		
▪ African American	20	27%
▪ Asian / Pacific Islander		0%
▪ Hispanic/Latino	23	31%
▪ Other	9	12%
▪ White/Caucasian	23	31%
Linguistic Group		
▪ English	64	85%
▪ Spanish	5	7%
▪ Other, Asian	0	0%
▪ Other non-English	6	8%

Cost per Client

Number Served	**Total Expenditures**
75	$628,013
Average Annual Cost	**Average Monthly Cost**
$8,374	$698

Client Projections

Clients Served/Projected				
2022-23	**2023-24**	**2024-25**	**2025-26**	**Age Group**
75	85	100	120	Combined
14	19	24	34	Adult
61	66	76	86	TAY

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

Project Description

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

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

Target Population

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

Project Components

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

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

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

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

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

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

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

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

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

Documentation of Achievement in performance outcomes:

Services to begin FY 2024-2025

Challenges or barriers:

Services to begin FY 2024-2025

CSS Project 4: Adult FSP

Project Description

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

Target Population

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

Project Components

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

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

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

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

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

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

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

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

Documentation of Achievement in performance outcomes:

We have been able to effectively use treatment planning tools that have decreased the reciprocation of hospitalizations for our consumers. We have increased their connections to community resources where they are able to learn and practice independent living skills so that they can work towards their goals of living independently. We continue transition consumers into Mental Health Apartments as they become available. We have also been able to link our consumers to an employment specialist who has worked with our consumers to complete resumes, find volunteer opportunities or employment.

Challenges or barriers:

Our main challenges continue to be housing especially emergency placements and proper facilities able to take serious medical conditions. Board and Care facilities have continued to close further decreasing the number of placements for consumers at this level of care.

Strategies – Continue efforts to collaborate on housing programs and availability in the community.

Clients Served within the Adult FSP Program

Client Demographics

Adult FSP Program 2022-2023 N=461		
	Number	**Percent**
Total by Age Group Served		
▪ Transitional Age Youth	18	4%
▪ Adults	400	87%
▪ Older Adults	43	9%
Gender Identity		
▪ Female	197	43%
▪ Male	264	57%
Race/Ethnicity		
▪ African American	114	25%
▪ Asian / Pacific Islander	50	11%
▪ Hispanic/Latino	78	17%
▪ Native American	32	7%
▪ White/Caucasian	154	33%
▪ Other / Not-Identified	33	7%
Linguistic Group		
▪ English	405	88%
▪ Spanish	17	4%
▪ Asian/Pacific Islander	7	2%
▪ Indo European	2	.5%
▪ Other non-English	30	6.5%

Cost per Client

Number Served	**Total Expenditures**
4,461	$4,467,318
Average Annual Cost	**Average Monthly Cost**
$9,649	$804

Client Projections

Clients Served/Projected				
2022-23	**2023-24**	**2024-25**	**2025-26**	**Age Group**
461	581	601	721	Combined
18	28	38	48	TAY
400	500	550	600	Adults
43	53	63	73	Older Adults

CSS Project 5: Older Adult FSP

Project Description

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

Target Population

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

Project Components

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

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

Documentation of Achievement in performance outcomes:

Older adult services currently serve 73 Full-Service Partnership consumers. Older adult services has successfully maintained minimal client hospitalizations.

We have Improved relationships and comradery among OAS staff and better communication with other teams including increased access with linkages to other treatment programs. We continue to outreach for increased recognition of Older Adult Services.

Challenges or barriers:

There continues to be a lack of availability of appropriate housing for older adults on all levels (independent/ residential care facilities/ long term care (SNF's). Our community continues to have

closures of Board and Care homes housing Older Adult consumers which results in relocation of consumers out of County.

Strategies - Increase availability for appropriate housing. Continue to create cohesiveness and communication between teams for continuity of client care and services. Encourage Outreach and Engagement and promote the need for Older adults services.

Clients Served within the Older Adult FSP Program

Client Demographics

Older Adult FSP Program 2022-2023 N=74		
	Number	**Percent**
Total by Age Group Served		
▪ Older Adults	74	100%
Gender Identity		
▪ Female	42	57%
▪ Male	32	43%
Race/Ethnicity		
▪ African American	23	31%
▪ Asian / Pacific Islander	3	4%
▪ Hispanic/Latino	7	9%
▪ Native American	5	7%
▪ White/Caucasian	35	47%
▪ Other / Not-Identified	1	1%
Linguistic Group		
▪ English	59	80%
▪ Spanish	7	11%
▪ Other non-English	7	9%

Cost per Client

Number Served	**Total Expenditures**
74	$687,253
Average Annual Cost	**Average Monthly Cost**
$9,287	$774

Client Projections

Clients Served/Projected				
2022-23	**2023-24**	**2024-25**	**2026-27**	**Age Group**
74	84	94	104	Older Adults

CSS Project 6: Community Corrections Forensic FSP

Project Description

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

Target Population 1: Re-entry Population

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

Target Population 2: Forensic or Court Diversion Population

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

Project Components

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

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

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

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

Documentation of Achievement in performance outcomes: for CSS and INN programs/services:

Last year the Forensics FSP Teams served 164 clients and we expect this number to increase significantly in 2024-2025 and are estimated to serve 300 clients. During this time period, 3435 services were provided to our clients- 568 psychiatric services, 1189 case management, 178 comprehensive assessments and screeners, 290 group and individual rehabilitation, 89 plan development, 618 collateral and 643 non billable services.

Challenges or barriers:

During this reported time 7/1/22- 6/30/23, one of the challenges experienced in our Forensics FSP program is staff turnover. Exit interviews were implemented and conducted to gather information and feedback to help middle management and SR. leadership help with staff retention.

Another challenge experienced by our Forensics FSP program is reestablishing group rehabilitative services. As a result of the covid epidemic, group services were paused. During this time reestablishing was difficult with our specific mental health court clients/needs. By the end of this reported fiscal year staff were being trained on various topics to implement new groups.

During this reported time, a new judge was placed in mental health. In an effort to support the new transition, regular collaborative meetings were held to establish communication with the new judge.

Lastly, assisting clients in obtaining adjunct benefits/services- SSI/CalFresh/payeeship/ birth certificate/ Social Security card etc. is challenging as the process requires follow up that is difficult for intensive clients, especially homeless and those who have no phones. Also, keeping track of appointments is difficult for our symptomatic clients to remember. As a strategy to help with accessing adjunct services, clients were placed in temporary housing through CHOICE to be able to be located. Rapport building interventions were administered to help clients stay engaged in services. “Out of the box” interventions such as community food boxes were also given to clients upon placement, followed by next day contact.

A continued issue has been communication and collaboration between our various justice partners due to challenges with data collection and sharing. Efforts are currently being made to improve communication and collaboration with our judicial partners, including probation and parole, to better collaborate and coordinate care, and the sharing of data, by obtaining consents to release information sooner in the client engagement process. Another continued barrier that continues to present itself is the level of intensity of clients experiencing MH symptoms; the severity of symptoms continues to be a barrier to the warm handoff to the intensive contracts. Communication and referrals are established as soon as clients are in a “captive setting,” (jail/hospital/ inpatient hospital). Our last continued barrier has been stable housing with our acute/symptomatic population. We continue to utilize CHOICE funding and communicate and help support placement management until stable placement can be secured.

Clients Served within the Community Corrections FSP Program

Client Demographics

Community Corrections FSP Program 2022-2023 N=164		
	Number	**Percent**
Total by Age Group Served		
▪ Transitional Age Youth	13	8%
▪ Adults	144	88%
▪ Older Adults	7	4%
Gender Identity		
▪ Female	47	29%
▪ Male	117	71%
Race/Ethnicity		
▪ African American	47	29%
▪ Asian / Pacific Islander	9	5%
▪ Hispanic/Latino	40	25%
▪ Native American	3	2%
▪ White/Caucasian	47	29%
▪ Other / Not-Identified	16	10%
Linguistic Group		
▪ English	140	85%
▪ Spanish	4	2%
▪ Other non-English	19	12%
▪ Asian/Pacific Island	1	1%

Cost per Client

Number Served	**Total Expenditures**
164	$803,667
Average Annual Cost	**Average Monthly Cost**
$4,900	$408

Client Projections

Clients Served/Projected				
2022-23	**2023-24**	**2024-25**	**2025-226**	**Age Group**
164	180	190	200	Combined
13	15	15	15	TAY
144	155	165	175	Adults
7	10	10	10	Older Adults

CSS Project 7: InSPIRE FSP

Project Description

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

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

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

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

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

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

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

Target Population

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

Project Components

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

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

Documentation of Achievement in performance outcomes:

Inspire has served 40 consumers since 7/1/22 through 6/30/23. Inspire team continues to use enthusiastic engagement and "whatever it takes" models to help stabilize some of our most severe consumers.

Challenges or barriers:

Assisting InSpire clients with obtaining SSI benefits with a rep payeeship is still challenging as the process requires follow up that is difficult for intensive clients especially those who are homeless and without access to their own phone. Appointments can be difficult to track and attend for those who are symptomatic and without resources.

On that same note, we are asking the most severely mentally ill people to somehow manage to be available and attend an appt (phone usually) with SSI with very little notice (sometimes a day or two). When we should be able to just have a doctor or clinician sign off them requiring a Rep Payee. This is essential sometimes to pay for housing. This is mainly an issue with Social Security Administration and how they operate which makes it really hard to resolve. Trying to develop some good relationships and rapport but that is what the Public Guardian's office had and we still have this issue. I think the Private Payee (Service First) somehow gets around this but they can be challenging to try and work with day to day. The other solution would be to conserve them all, because most should be by the nature of their illness. However, no matter how much advocating, we rarely are successful with getting hospital to admit and maintain a consumer long enough to conserve. It's a timely process so most hospitals, including our own PHF, don't want to monopolize a bed that long.

The Adult FSP programs continued to experience staff shortages due to vacant positions. Housing and placement present challenges as more Board and Care homes have closed.

We need more "middle level" housing. There's a big jump from client's paying their SSI rate ($1398.07/mo) and BHS paying approx. $200/day for Enhanced beds to a Regular B&C beds where the client pays their SSI rate and BHS pays zero. The regular homes don't make enough to support good staff and allow for some structured activities. So when someone does well at Enhanced, there's really not much available to step them down. It's a big jump to our HAT (progressive housing) and Apartment programs. Increasing our SRP program to include all of our Regular B&C beds, and increasing the monthly amount they receive, could definitely be a solution for this problem. We could even see more

people open new B&C homes if it was profitable. (there's a lot pending on Prop 1 to see how funding for housing may change).

Clients Served within the InSPIRE FSP Program

Client Demographics

InSPIRE FSP Program 2022-2023 N=38		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	35	92%
▪ Older Adults	3	8%
Gender Identity		
▪ Female	18	47%
▪ Male	20	53%
Race/Ethnicity		
▪ African American	9	24%
▪ Asian / Pacific Islander	3	8%
▪ Hispanic/Latino	8	21%
▪ Native American	0	0%
▪ White/Caucasian	17	45%
▪ Other / Not-Identified	1	3%
Linguistic Group		
▪ English	37	97%
▪ Spanish	0	0%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	1	3%

Cost per Client

Number Served	**Total Expenditures**
38	$621,479
Average Annual Cost	**Average Monthly Cost**
$16,354	$1,363

Client Projections

Clients Served/Projected				
2022-23	**2023-24**	**2024-25**	**2025-26**	**Age Group**
38	31	72	75	Combined
35	30	70	70	Adult
3	1	2	5	Older Adults

CSS Project 8: Intensive Adult FSP

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

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

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

Target population

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

Project Components

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

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

Documentation of Achievement in performance outcomes:

Twenty one consumers received housing supports in the first quarter, and an additional 15 located Board and Care housing. Telecare is working with private landlords to place our members in room and boards, in which they have been providing support in a normalizing home environment where the members share in household chores and often cook meals together. One member was quoted to say "This is the nicest place that I have ever lived in my life."

Esperanza saw a Quarter 1 decrease in incarcerations with a 96.2% reduction, and an 87.5% reduction in the incidence of incarceration across the program.

Challenges or barriers:

The program's reported two biggest challenges, as they have been for some time, continue to be the proliferation of fentanyl that has increased the likelihood of fatal overdoses and has taken the life of one of Telecare's members, and the amount of available permanent housing.

Clients Served within the Intensive Adult FSP Program

Client Demographics

Intensive Adult FSP Program 2022-2023 N=131		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	116	89%
▪ Older Adults	11	8%
▪ Transitional Aged Youth	4	3%
Gender Identity		
▪ Female	44	34%
▪ Male	87	66%
Race/Ethnicity		
▪ African American	30	23%
▪ Asian / Pacific Islander	11	8%
▪ Hispanic/Latino	22	17%
▪ Native American	6	5%
▪ White/Caucasian	60	46%
▪ Other / Not-Identified	2	2%
Linguistic Group		
▪ English	129	98%
▪ Spanish	0	0%
▪ Other, Asian	1	1%
▪ Arabic or Farsi	0	0%
▪ Other non-English	1	1%

Cost per Client

Number Served	**Total Expenditures**
131	$2,005,513
Average Annual Cost	**Average Monthly Cost**
$15,189	$1,266

Client Projections

Clients Served/Projected				
2022-23	**2023-24**	**2024-25**	**2025-26**	**Age Group**
131	131	131	131	Combined
116	116	116	116	Adult
11	11	11	11	Older Adults
4	4	4	4	TAY

CSS Project 9: Intensive Justice Response FSP

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

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

Additional information regarding Assertive Community Treatment can be found through:

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

Target population

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

Project Components

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

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

Documentation of Achievement in performance outcomes:

Telecare: 46 members had zero homeless days.

Justicia: saw a decrease in incarcerations with a 85.9% reduction, and an 92.2% reduction in the incidence of incarceration across the program.

Challenges or barriers:

The program's reported two biggest challenges, as they have been for some time, continue to be the proliferation of fentanyl that has increased the likelihood of fatal overdoses and has taken the life of one of Telecare's members, and the amount of available permanent housing.

Clients Served within the Intensive Justice Response FSP Program

Client Demographics

Intensive Justice Response FSP Program 2022-2023 N=133		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	122	92%
▪ Older Adults	6	4%
▪ Transitional Aged Youth	5	4%
Gender Identity		
▪ Female	41	31%
▪ Male	92	69%
Race/Ethnicity		
▪ African American	40	30%
▪ Asian / Pacific Islander	9	86%
▪ Hispanic/Latino	23	17%
▪ Native American	5	4%
▪ White/Caucasian	54	41%
▪ Other / Not-Identified	2	2%
Linguistic Group		
▪ English	132	99%
▪ Spanish	0	0%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	1	1%

Cost per Client

Number Served	**Total Expenditures**
133	$1,237,380
Average Annual Cost	**Average Monthly Cost**
$9,304	$775

Client Projections

Clients Served/Projected				
2022-23	**2023-24**	**2024-25**	**2025-26**	**Age Group**
133	140	140	140	Combined
122	127	127	127	Adult
6	7	7	7	Older Adults
5	6	6	6	TAY

CSS Project 10: High-Risk Transition Team FSP

Project Description

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

Target Population

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

Program Components

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

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

- Intensive Case Management: Assist clients in accessing primary and behavioral health care services, peer-based services, financial, educational, prevocational, rehabilitative or other community based services and supports needed by clients to meet their personal goals.
- Provide 24/7 “on-call” services for clients in crisis.

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

Documentation of Achievement in performance outcomes:

High Risk Transition Team continues to engage and provide services for the most vulnerable clients to provide intensive wrap-around FSP services. During this FY reporting period – 16 clients were able to secure employment, three clients went back to school, nine clients found permanent housing, and 30 clients were able to reconnect with their families.

Challenges or barriers:

The program's reported two biggest challenges, as they have been for some time, continue to be the proliferation of fentanyl that has increased the likelihood of fatal overdoses and has taken the life of one of Telecare's members, and the amount of available permanent housing.

Client Demographics

High Risk Transition FSP 2022-2023 N=81		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	62	77%
▪ Older Adults	6	7%
▪ Transitional Aged Youth	13	16%
Gender Identity		
▪ Female	33	41%
▪ Male	48	59%
Race/Ethnicity		
▪ African American	27	33%
▪ Asian / Pacific Islander	9	11%
▪ Hispanic/Latino	18	22%
▪ Native American	1	1%
▪ White/Caucasian	20	25%
▪ Other / Not-Identified		7%
Linguistic Group		
▪ English	72	89%
▪ Spanish	3	4%
▪ Other, Asian	1	1%
▪ Arabic or Farsi	0	0%
▪ Other non-English	5	6%

Cost per Client

Number Served	**Total Expenditures**
81	$694,062
Average Annual Cost	**Average Monthly Cost**
$8,569	$70

Client Projections

Clients Served/Projected				
2022-23	**2023-24**	**2024-25**	**2025-26**	**Age Group**
81	81	81	81	Combined
62	62	62	62	Adult
6	6	6	6	Older Adults
13	13	13	13	TAY

CSS Project 11: FSP Adult Residential Treatment Services

Project Description

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

Target Population

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

Program Requirements

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

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

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

Per state licensing requirements, services will include:

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

Program Components

ARTS shall provide the appropriate level of therapeutic support, staffing and programming for program participants to avoid transitioning to a higher level of care. It is anticipated that residents

will move toward a more independent living setting within six months from the date of their admission.
Crisis intervention, treatment plans, and collateral services shall be provided for program participants as follows:

A. Crisis Interventions

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

B. Treatment

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

C. Collateral

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

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

CSS Project 12: Housing Stabilization FSP Services

Community need and project description:

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

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

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

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

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

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

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

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

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

General System Development Programs

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

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

Outreach and Engagement

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

General System Development

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

CSS Project 13: Mental Health Outreach & Engagement

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

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

Target populations

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

Mental Health System Outreach and Engagement

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

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

Documentation of Achievement in performance outcomes

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

Challenges or barriers:

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

CSS Project 14: Mobile Crisis Support Team

Project Description

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

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

Target Population

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

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

Project Components

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

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

Documentation of Achievement in performance outcomes:

MCST has completed several hours of M-TAC training to become better trained at providing Mobile Crisis treatment. All of the outreach workers have trained and passed the California state certification to become Peer Support Specialist. For the fiscal year MCST received 1249 referrals, with over 500 from family members and 400+ from law enforcement. MCST detained a total of 162 people in the fiscal year of 22-23. MCST is project to serve over 1,300 clients in the next year.

Challenges or barriers:

MCST has faced the challenge of creating a new program, MCRT, which is a 24/7/365, program. The process of hiring new staff that is willing and able to work extended hours, or are willing to work in

the environment of MCRT. The decrease in LE staffing has created a challenge/barrier for MCST, there are longer response times due to less LE available to answer or assist MCST.

CSS Project 15: Peer Navigation

Project Description

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

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

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

Project Components

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

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

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

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

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

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

Skills and Competencies:

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

Documentation of Achievement in performance outcomes:

Connect III continues to work with clients to provide warm hand approach in connecting clients from high level of care to provide navigation services to those in need. Peer Navigators are the key staff that provide this service and create opportunities to engage clients into outpatient clinic services and additional education and information related to their care. The Peer Navigation Team provided a total of 1,440 services for FY 2022-23 and served 48 unduplicated clients.

Challenges or barriers:

Peer Navigators will receive County 211 System training to enhance their knowledge for resources for the additional navigation to resources in the community.

CSS Project 16: Wellness Center

Project Description

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

Project Goal

The primary objectives for this program will be to:

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

Target Population

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

Project Components

The Wellness Center will provide the following services:

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

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

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

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

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

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

Documentation of Achievement in performance outcomes:

There has been a significant amount of time devoted to planning for, and hiring of, new staff for the expansion into North and South County. Our new Program Director has been very helpful in many ways, including recruiting and interviewing for the additional positions. The Lodi Wellness Center is taking shape and will begin offering groups and classes at the SJCBHS Lodi Clinic Tuesday November 1st. We recently hired an Assistant Lead Recovery Coach for the Lodi area. We are still searching for a permanent site; however, we have made great connections with service providers and leaders within

the city. We are continuing to lease space for the Manteca Wellness Center, although we recognize the need to find a larger space and are searching for that as well. Due to the pandemic, we continue to see a reluctance among many consumers to go to places where there are gatherings of people. Because of this, we are finding creative ways to do outreach and connecting with consumers in ways that don't require them to meet us at the wellness center sites in person. The Wellness Center interacted with 1,123 unduplicated consumers in FY 22/23; surpassing initial estimates of 950 consumers.

Challenges or barriers:

We have had consistent success with outreach efforts in the county, and especially in the Lodi community making contact with many consumers. Attendance at the LWC has been growing steadily. In the south county we have developed a good relationship with the BHS Tracy Clinic staff and hope to begin offering groups there soon. We are still exploring options for the south county, including whether the greatest need is to expand our Manteca Wellness Center (MWC) location, or possibly make it a p/t Wellness Center with our 'main' south county Wellness Center to be located in Tracy. Both the MWC and LWC's received City Proclamations honoring the centers and proclaiming May as Mental Health Awareness month. We held a successful "Walk for Wellness" during Mental Health Awareness month.

CSS Project 17: Project Based Housing

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

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

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

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

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

Project Components

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

1) Establish a Project Based Housing Fund:
   $5.7 million will be transferred to the Housing Fund for the purpose of acquisition, construction or renovation of Project Based Housing Units.

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

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

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

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

In addition to the above projects, BHS will partner with the Housing Authority of San Joaquin to construct Satellite II Project Based Housing to increase the permanent supportive housing continuum for clients that are justice-involved.

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

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

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

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

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

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

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

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

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

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

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

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

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

CSS Project 18: Employment Recovery Services

Project Description

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

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

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

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

Target Population

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

Project Components

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

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

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

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

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

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

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

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

Documentation of Achievement in performance outcomes:

The Employment Recovery Services program served 50 unduplicated consumers. Out of these consumers, 10% obtained competitive employment and 6% attended an education program. Twenty seven consumers demonstrated knowledge of self-sufficiency skill and/or demonstrated knowledge of how employment impacts their benefits. Seventy-five percent of the consumers had their employment skills assessed and sixty-eight percent of them had an increase in their employment skills assessment.

Challenges or barriers:

Due to the Job Developer being on leave during the 4th quarter the University of the Pacific ERS programs was unable to contact 25 discrete community based employers. However, they have developed a plan to reach this objective if the Job Developer is on leave moving forward.

CSS Project 19: Community Behavioral Intervention Services

Project Description

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

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

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

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

Target Population

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

Project Components

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

- Individualized goals developed to meet the needs of each consumer;
- Teaching skills that are broken down into manageable, easy-to-learn steps;
- Opportunities for consumers to practice each step;
- Acknowledgement of successes using a tangible reward system; and

- Continuous measurement of individual consumer progress so that treatment may be adjusted as needed.

Additional project components include:

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

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

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

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

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

Documentation of Achievement in performance outcomes:

211 consumers began their assessments this fiscal year. 186 consumers completed their annual behavioral assessment. Out of the 90 behaviors served that inhibit medication compliance, fifty five of the behaviors were reduced. One hundred eighty one out of one hundred eighty two consumers had reduced rehospitalizations. Ninety four percent of treatment goals for enrolled consumer have shown improvement per data collected and measured by University of the Pacific. Ninety six percent of consumers enrolled in the program had reduced or eliminated behaviors that would have impeded their ability to seek employment.

Challenges or barriers:

CBIS staff continue to struggle with meeting with all clients at least twice per week. CBIS staff attempts to schedule multiple appointments during the week with consumers in hopes that if they cancel one, at

least there will already be a couple more appointments already scheduled. Client's lack of appointment compliance has been one of the contributing factors of the low productivity numbers. A stricter appointment policy will be enforced in the new fiscal year in an effort to increase productivity and get clients off the waiting list. CBIS has also added a part time shuttle driver into the budget for FY24.

CSS Project 20: Housing Coordination Services

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

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

Project Components

Project 1: Housing Referral and Linkage

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

Project 2: Housing-based Case Management

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

Project 3: Housing Stabilization Resources

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

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

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

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

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

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

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

Documentation of Achievement in performance outcomes:

The housing continuum program was able to establish a housing application committee which includes members from administration, 24-hour services, and clinical staff to screen client applications to determine appropriate level of care for residential placement. This screening has been influential in determining application outcomes. Lastly, the housing continuum program has established on-site case management services for consumers to help provide wrap around services that support independent living and further reduce risk factors that impede residential stability.

Challenges or barriers:

Many consumers who are accepted into BHS supportive housing are living independently for the first time. We have found out that providing intense case management services that include daily to weekly contact is imperative to prevent decompensation and maintain a level of functioning for successful independent living. However, case management services are optional for consumers who are enrolled in BHS services. This creates challenges with treatment compliance and the maintaining of residence.

Strategies- Continuous weekly to bi-weekly meetings to address concerns and mitigate continued risks. Continue to train and educate BHS staff on how to provide clinical case management and rehabilitation interventions to increase client's self-sufficiency.

CSS Project 21: Crisis Services Expansion

Project Description

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

Project Components

Project 1: Capacity Expansion

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

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

Project 2: Warm Line

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

Project 3: Crisis Community Response Teams (CCRT)

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

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

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

Documentation of Achievement in performance outcomes:

Crisis services continue to provide triage services and screenings and dispense medication through its med room. The Crisis med room is an essential part of Crisis Services in that it provides most of the basic medical and psychiatric needs for clients, including psychiatric meds, medical supplies and serves as storage for medications of clients placed in crisis residential facilities. For FY 22/23, response times for urgent conditions meet our set goal of 98%. The Crisis Community Response Team received around **11,650** crisis visits, requests for evaluation from local hospitals, family and support members, law enforcement for immediate response and other providers or an average of 971 per month. About 20% of all calls/referrals resulted in legal holds and these individuals subsequently received psychiatric hospitalization/treatment. The Crisis program continues to function effectively through several systems, including but not limited to the use of e-fax and electronic client tracking. E-faxing enables Crisis to facilitate placement of detained persons in psychiatric hospitals throughout California. The process makes psych placement work more efficient and organized from shift to shift as it significantly reduced errors and duplication of work. The CIS Tracker is a real-time electronic display of client status. It plays a significant role in improving program performance. The CIS tracker enables Crisis staff to easily track and monitor hospital requests for psych eval, detained clients, psych placements and current Crisis walk in clients. Like e-faxing, the CIS tracker greatly simplified and streamlined many internal processes in Crisis, so that the program can focus more on client care. Since its inception in 2009, Warm-line Support program, which is a phone-based support service, continues to be open 24/7 manned by fulltime and part-time MHOWs with diverse backgrounds and lived-experiences and handles calls from individuals within the County and outside the County, and on a few occasions even from other nations. The Team has also grown from a staff of 1-2 each shift to now a range of 2-5 staff per shift. The Warm-line Support Team's roles have also expanded to providing in-person support for adults and minors during pre-hospitalization and post-hospitalization care.

Challenges or barriers:

The cascading effects of the COVID pandemic continued to impact our programs during FY 22/23. The program continues struggle covering shifts and the various unit staff had to be spread thin resulting in more need for overtime work and employee burn out. Recruitment for hard to fill positions in 24-Hour Services positions also continued to be a barrier in maintaining program outcomes. In the last few years, Crisis lost all of our Part-Time after-hours Mental Health Clinicians and about 4 other Crisis staff (Psych Techs and MH Specialists) for weekends/after-hours and to date have not been able to hire replacements. Except for two additional outpatient staff working part-time after-hours, shifts are being covered by existing Crisis staff which is unfortunately leading to signs of burnout. As a 24-hour service program, Crisis experiences computer issues that range from connectivity and server issues, program malfunctions that highly interrupt, delay and totally prevent the program from providing services and responding to immediate calls. Crisis team can use additional IT support after-hours. The transition to the new EHR which kicked off 7/1/23 is a huge challenge for all program staff.

CSS Project 22 – Co-Occuring Disorders Program

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

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

PROGRAM DESCRIPTION

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

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

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

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

TARGET POPULATION

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

SERVICES AND ACTIVITIES

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

The estimated number of individuals to be served in FY 2023-2024 is 80. Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

Documentation of Achievements in performance outcomes:

This program began in Fiscal Year 23/24

Challenges or barriers:

This program began in Fiscal Year 23/24

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

Project Description

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

Target Population

This program will serve youth ages 16 through 20 who are stepping down from Full Service Partnership Programs (FSP) but still need Specialty Mental Health Services (SMHS).

Project Components

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

Documentation of Achievements in performance outcomes:

This program will begin Fiscal Year 24/25

Challenges or barriers:

This program will begin Fiscal Year 24/25

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

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

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

Target Population

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

Project Objectives

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

Project Goals

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

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

Documentation of Achievements in performance outcomes:

This program began in Fiscal Year 23/24

Challenges or barriers:

This program began in Fiscal Year 23/24

CSS Project 25: System Development Expansion

Project Description

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

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

Areas of expansion include:

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

VI. Prevention and Early Intervention

Overview

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

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

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

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

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

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

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

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

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

San Joaquin County PEI Prevention Program – Adults and Older Adults

- Whole Person Care Project

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

San Joaquin PEI Early Intervention Programs – Children and Youth

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

San Joaquin PEI Early Intervention Programs – Adults and Older Adults

- Community Trauma Services for Adults
- Prevention and Early Intervention for Older Adults

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

- Whole Person Care Project
- Cultural Brokers Program

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

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

- Increasing Recognition of Mental Illnesses
- Cultural Brokers Program

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

- Information and Education Campaign

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

- Suicide Prevention with Schools
- Suicide Prevention for the Community

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

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

All MHSA funded prevention programs utilize evidence based and/or promising practices. PEI Evaluation findings from the 22-23 fiscal year is included in the appendix.

Significant Changes for the 2024-25 Update on PEI Projects approved in the 2023-2026 MHSA Three Year Plan –

<u>PEI Project #5 (In the 2023-26 Plan) – School Based Interventions</u>

- Implementation of the Children and Youth Behavioral Health Initiative (CYBHI) – Established as part of the Budget Act of 2021, the Children and Youth Behavioral Health Initiative

(CYBHI) was imagined as a multiyear, multi-department package of investments that seeks to reimagine our behavioral health services (BHS) for all California's children, youth, and their families. The overarching goal of the initiative is to focus on promoting social and emotional well-being, preventing behavioral health challenges, and providing equitable, appropriate, timely, and accessible services for emerging and existing behavioral health (mental health and substance use) needs for children and youth ages 0-25.

- *What does that mean for our current Behavioral Health System in San Joaquin County for Children and Youth?*
    - All individual youth services and supports (mild to moderate) will now be funded and provided by health plans, school districts, and CBO providers and integrated into the core model of CYBHI. In 2024, BHS will embark on transitioning current MHSA- PEI (prevention and early intervention) programs to the above-aforementioned school-wide entities and provide Technical Assistance (TA) as needed.

<u>PEI Project #8 (In the 2023-26 Plan– Forensic Access & Engagement)</u>

- This PEI program will be rolled into the current CSS Project 6 – Community Corrections Forensic FSP
    - The Access & Engagement function will be made by contracted FSP Service team to enhance enthusiastic engagement to individuals reluctant to receive services. This will be primarily for clients that are justice-involved and are part of the Misdemeanor ISD Diversion program.
    - In addition, the INSPIRE FSP team will also function as an access & engagement team to work with clients that are justice-involved and that may meet criteria for Care Court.

PEI Project 1: Skill-Building for Parents and Guardians

Community Need
Research demonstrates that some of the risk factors associated with a higher than average likelihood of developing mental illnesses include adverse childhood experiences, trauma and ongoing stress, family or domestic violence, and prior self-harm or suicide attempts. Developing

ways to empower parents with the skills necessary to mitigate stress within the family unit is essential to reducing risk and building resiliency among children and youth.

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

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

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

Potential evidence-based parenting classes include:

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

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

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

Positive Parenting Program (Triple P) is an evidence-based 12-hour program, delivered in six 2-hour group meetings with between 8 and 12 parents. The goal of Triple P is to prevent behavioral, emotional and developmental problems by teaching parents skills to reduce

parental stress and increase confidence in parenting. The success of Triple P is demonstrated by increased knowledge, skills and confidence, as measured by a Parenting Task Checklist and decreased levels of stress, over-reactivity and hostility, as measured by the Parenting Scale. For more details about the Positive Parenting Program see: http://www.triplep.net/glo-en/home/

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

Community Need

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

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

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

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

Project Description

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

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

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

Project Components

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

Interventions and support could include but are not limited to:

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

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

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

Referrals sources may include but are not limited to:

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

PEI Project 3: Mentoring for Transitional Age Youth

Community Need

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

Project Description

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

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

Project Components

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

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

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

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

TIP mentoring:

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

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

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

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

PEI Project 4: Coping and Resiliency Education Services

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

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

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

Program Components

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

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

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

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

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

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

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

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

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

Early Intervention Services

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

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

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

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

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

PEI Project 5: Early Interventions to Treat Psychosis

Community Need

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

Project Description

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

Promising models include, but are not limited to:

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

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

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

Project Components

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

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

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

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

Community Need

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

Project Description

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

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

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

Additional priority populations are:

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

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

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

Project Components

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

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

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

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

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

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

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

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

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

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

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

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

PEI Project 7: Prevention and Early Intervention for Older Adults

Community Need:

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

Target Population:

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

Project Description

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

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

Project Components:

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

Program Goals

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

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

PEI Project 8: Whole Person Care

Community Need

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

Project Description

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

Project Components

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

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

BHS Linkage and Treatment Team:

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

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

PEI Project 9: Cultural Brokers

Community Need:

Community Stakeholders have expressed the need to provide culturally congruent and linguistically appropriate Outreach and Engagement to underserved and unserved communities of color in San Joaquin County. The lack of cultural brokers within the community has created a mistrust within communities of color and has increased stigma towards mental health needs of the community; driving disparities within the context of mental health and substance use disorder services.

Project Description

The Cultural Brokers program will expand outreach and engagement efforts through a cultural lens and health equity perspective. An internal outreach and engagement team will lead the charge in making impact within the community. PEI funding will also be awarded to one or more community partners with expertise in outreach and engagement for underserved communities to inform and educate community members about the causes and symptoms of mental illness and substance use disorders. Partners will provide training related to mental health and substance use disorders with emphasis on stigma reduction, education of local resources, treatment options, and referrals to appropriate behavioral health clinics in the community.

Target Population

Community Stakeholder defined underserved and unserved cultural communities: African American, Latino/a/x, and Asian and Pacific Islander.

Project Components:

- **Intensive Outreach & Engagement –** providers will utilize the Promotoras Model or similar evidenced based community cultural engagement model to conduct intensive outreach and engagement activities for underserved communities in San Joaquin County.
- **Education and Presentation –** providers will provide community presentation and education at local community events to inform community leaders and community members of the nature of mental health illnesses and substance use disorders and how to seek assistance. Presentations will be specific to stigma reduction, education on local resources, culturally and linguistically appropriate information and education.
- **Information and Education Campaign** – providers will be key informant stakeholders in the development of San Joaquin County's Information and Education Campaign (PEI Project 11) and Suicide Prevention and Education in the Community Campaign (PEI Project 13).
- **Community Events –** providers will coordinate and/or attend health related events and activities to provide mental health information to targeted underserved communities.

- **Access and Linkage to Treatment –** providers will coordinate "warm-hand" activities to promote referral pathway to behavioral health clinics that provide clinical services to mild to moderate and/or severe mental illness clients to receive appropriate level of care.

Program Goals

- Increase the receptiveness of San Joaquin County underserved populations in seeking Mental Health Services each year.
- Increase awareness of Mental Health Services by providing and attending targeted health fair events throughout San Joaquin County

PEI Project 10: Increasing Recognition of Mental Illnesses

Community Need

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

Project Description

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

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

Project Components

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

Project 1: Community Trainings for Potential Responders

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

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

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

- **Mental Health First Aid (MHFA):** Mental Health First Aid is an 8-hour course that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training teaches community members who to identify, understand, and respond to signs of addictions and mental illness. Two trainings are offered in San Joaquin County. Mental Health First Aid and Youth Mental Health First Aid (YMHFA). In 2023-24, BHS will provide Mini grants for organizations to become Trainers in MHFA and YMHFA.

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

Project 2: Community Education:

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

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

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

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

PEI Project 11: Information and Education Campaign

Community Need

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

Project Description

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

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

Project Components

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

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

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

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

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

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

PEI Project 12: Suicide Prevention with Schools

Community Need

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

Project Description

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

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

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

Project Components

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

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

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

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

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

Suicide Prevention Education and Awareness Training

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

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

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

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

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

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

Depression Screening and Referral

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

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

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

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

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

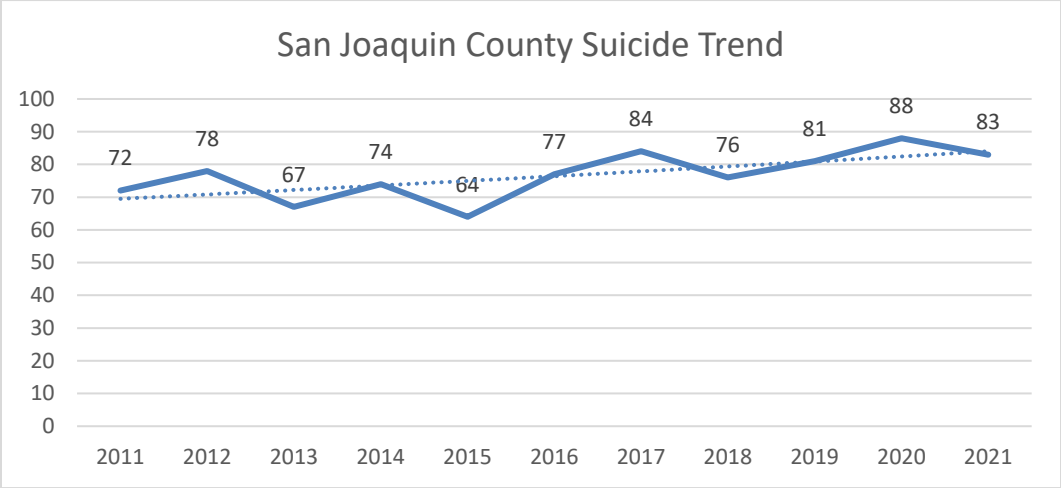
Break Free from Depression is a school-based curriculum designed to increase adolescents' awareness and knowledge about depression, enhance their ability to recognize signs and symptoms in themselves and their friends, and increase students' skills and strategies for finding help for themselves and their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

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

PEI Project 13: Suicide Prevention and Education in the Community

Community Need

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



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

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

Project Description

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

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

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

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

Project Components

Suicide Prevention for the Community

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

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

VII. Innovation

Innovation Component Funding Guidelines:

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

Innovation funding may be used for the following purposes:

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

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

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

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

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

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

Project 1: CalMHSA EHR Multi-County Innovation Project

INN Project 1: CalMHSA EHR Multi-County Innovation Project

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

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

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

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

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

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

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

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

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

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

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

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

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

Project Management and Administration

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

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

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

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

Project Objectives

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

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

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

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

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

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

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

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

Project Learning Goals

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

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

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

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

VIII. Workforce Education and Training

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

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

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

Significant Considerations in Workforce, Education and Training

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

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

(1) Training and Technical Assistance

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

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

(2) Mental Health Career Pathway Programs

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

(3) Residency and Internship Programs

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

(4) Financial Incentive Programs

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

(5) Workforce Staffing Support

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

In 2024/25, BHS will refund the Workforce Education and Training projects with a transfer of funds into the WET account from CSS. Funds must be spent within 10 years from the date of transfer.

WET Project 1: Training and Technical Assistance Academy

Community Need

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

Project Description

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

Project Components

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

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

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

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

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

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

WET Project 2: Internship and Financial Assistance Program

Community Need:

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

Project Description:

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

Project Components:

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

IX. Capital Facilities and Technological Needs

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

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

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

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

Past CFTN funding has been used to:

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

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

In 2024-25 BHS will refund the Capital Facilities and Technology Needs project fund with a transfer of funds into the CFTN account from CSS. Funds must be spent within 10 years from the date of transfer. Proposed new projects are outlined described below.

CF/TN Project 1: Facility Renovations

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

Project Operational Budget:

CF/TN Project 2: Facility Repair and Upgrades

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

Project Operational Budget:

CF/TN Project 3: Technology Equipment and Software

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

X. MHSA Funds – Reduction of the Prudent Reserve Balance

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

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

- Requirement to establish and maintain a prudent reserve that does not exceed 33 percent of the average community services and support (CSS) revenue received for Local Mental Health Services Fund in the preceding given years, and to reassess and certify the maximum amount every five years.
- Each county must calculate an amount to establish its prudent reserve that does not exceed 33 percent of the average amount allocated to the CSS Component in FY 2013-14, FY 2014-15, FY 2015-16, FY 2016-17, FY 2017-18. To determine the average amount allocated to the CSS Component of those five years a county must calculate the sum of all distributions form the Mental Health Services Fund from July 2013 through June 2018, multiply that sum by 76, and divide that product by five.
- To determine the maximum prudent reserve level, a county must multiply the average amount allocated to the CSS component of the previous five years by 33 percent.

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

San Joaquin County		
Prudent Reserve Maximum		
June 30, 2019 Assessment		
		MHSF Distribution
FY 2013-14		$ 20,588,023.62
FY 2014-15		$ 28,683,962.64
FY 2015-16		$ 23,778,868.00
FY 2016-17		$ 31,240,367.33
FY 2017-18		$ 34,063,364.47
	Total	$ 138,354,586.06
CSS allocation (76%)		$ 105,149,485.41
5-Year Average		$ 21,029,897.08
Prudent Reserve Maximum (33% of 5-yr average)		**$ 6,939,866.04**

XI. Attachments: Evaluation and Planning Reports

Workforce Analysis

2023-24 Cultural Competency Plan Update

2022-2023 Annual PEI Evaluation

Innovation - Assessment and Respite Center – Final Evaluation

Innovation – Progressive Housing – Final Evaluation

XII. Appendix: Community Planning Documents

2023-24 MHSA Community Meeting Flyer

2023-24 MHSA Consumer/Family Member Focus Groups Flyer

2023-24 MHSA Community Training and Planning Presentation

MHSA Community Meeting Input and Recommendations Form and Results Summary

MHSA Community Planning Stakeholder Demographic Form

MHSA Community Planning Stakeholder Demographic Results Summary

MHSA Consumer & Stakeholder Surveys and Results Summary

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT:

I. By Occupational Category - page 1

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. *Unlicensed* Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers):										
Mental Health Rehabilitation Specialist	5.75	0	0							
Case Manager/Service Coordinator	103.75	1	30							
Employment Services Staff	1.00	0	0							
Housing Services Staff	1.00	0	0							
Consumer Support Staff	44.75	1	8							
Family Member Support Staff	8.75	1	4							
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	87.25	1	0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only) ⬇						
Sub-total, A (County)	**252.25**	**4**	**42**	**61.75**	**78.00**	**34.25**	**20.25**	**1.00**	**15.50**	**210.75**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	24.35	0	3							
Case Manager/Service Coordinator	35.25	0	5							
Employment Services Staff	1.00	0	0							
Housing Services Staff	4.50	0	0							
Consumer Support Staff	38.00	0	0							
Family Member Support Staff	2.00	0	0							
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	38.27	0	0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇						
Sub-total, A (All Other)	**143.37**	**0**	**0**	**40.74**	**55.24**	**15.38**	**21.70**	**2.75**	**7.56**	**143.37**
Total, A (County & All Other):	**395.62**	**4**	**42**	**102.49**	**133.24**	**49.63**	**41.95**	**3.75**	**23.06**	**354.12**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 2

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+(7)+(8)+(9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers):										
Psychiatrist, general	14.63	1	9							
Psychiatrist, child/adolescent	5.12	1	6							
Psychiatrist, geriatric	2.00									
Psychiatric or Family Nurse Practitioner	2.75	1	0							
Clinical Nurse Specialist										
Licensed Psychiatric Technician	68.25	1	8							
Licensed Clinical Psychologist										
Psychologist, registered intern (or waivered)										
Licensed Clinical Social Worker (LCSW)	14.75	1	8							
MSW, registered intern (or waivered)	27.25	1	14							
Marriage and Family Therapist (MFT)	27.00	1	8							
MFT registered intern (or waivered)	42.25	1	13							
Other *Licensed* MH Staff (direct service)	6.75	1	6							
Sub-total, B (County)	**210.75**	**9**	**72**	**56.35**	**50.50**	**19.75**	**51.75**	**0**	**19.10**	**197.45**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general	3.25	1	2							
Psychiatrist, child/adolescent	.20	1	3							
Psychiatrist, geriatric										
Psychiatric or Family Nurse Practitioner		1								
Clinical Nurse Specialist										
Licensed Psychiatric Technician	3.75	1	4							
Licensed Clinical Psychologist	2.10									
Psychologist, registered intern (or waivered)										
Licensed Clinical Social Worker (LCSW)	5.85	1	2							
MSW, registered intern (or waivered)	4.65	1	4							
Marriage and Family Therapist (MFT)	21.70	1	2							
MFT registered intern (or waivered)	13.85	1	4							
Other *Licensed* MH Staff (direct service)	0	1	2							
Sub-total, B (All Other)	**55.35**	**9**	**23**	**15.79**	**14.15**	**5.55**	**14.51**	**0**	**5.35**	**55.35**
Total, B (County & All Other):	**266.10**	**18**	**95**	**72.14**	**64.65**	**25.30**	**66.26**	**0**	**24.45**	**252.80**

(*Licensed* Mental Health Direct Service Staff; Sub-Totals Only)

(*Licensed* Mental Health Direct Service Staff; Sub-Totals and Total Only)

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 3

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes' 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+(7)+(8)+(9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers):										
Physician	0									
Registered Nurse	23.50	1	3							
Licensed Vocational Nurse	1.0									
Physician Assistant	0									
Occupational Therapist	1.0									
Other Therapist (e.g., physical, recreation, art, dance)	0									
Other Health Care Staff (direct service, to include traditional cultural healers)	25.0	1	0	(Other Health Care Staff, Direct Service; Sub-Totals Only) ⬇						
Sub-total, C (County)	**50.50**	**2**	**3**	**19.75**	**7.0**	**4.50**	**13.25**	**0**	**3.75**	**48.25**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician	0									
Registered Nurse	0	1	0							
Licensed Vocational Nurse	1.50	1	0							
Physician Assistant	0									
Occupational Therapist	0									
Other Therapist (e.g., physical, recreation, art, dance)	0									
Other Health Care Staff (direct service, to include traditional cultural healers)	1.20			(Other Health Care Staff, Direct Service; Sub-Totals and Total Only) ⬇						
Sub-total, C (All Other)	**2.70**	**2**	**0**	**1.20**	**1.50**					**2.70**
Total, C (County & All Other):	**53.20**	**4**	**3**	**20.95**	**8.50**	**4.50**	**13.25**	**0**	**3.75**	**50.95**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 4

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor.....	13.00									
Supervising psychiatrist (or other physician)	1.00									
Licensed supervising clinician.....	23.00	1	4	(Managerial and Supervisory; Sub-Totals Only) ⬇						
Other managers and supervisors.....	33.00	1	4							
Sub-total, D (County)	**70.00**	**2**	**8**	**33.00**	**11.00**	**5.00**	**11.00**	**2.00**	**2.00**	**64.00**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor.....	6.72									
Supervising psychiatrist (or other physician)	0									
Licensed supervising clinician.....	4.25	1	4	(Managerial and Supervisory; Sub-Totals and Total Only) ⬇						
Other managers and supervisors.....	9.98									
Sub-total, D (All Other)	**20.95**	**1**	**4**	**7.96**	**5.00**	**4.73**	**2.26**	**0**	**1.00**	**20.95**
Total, D (County & All Other):	**90.95**	**3**	**12**	**40.96**	**16.00**	**9.73**	**13.26**	**2.00**	**3.00**	**84.95**
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance.....	**27.75**	**1**	**15**							
Education, training, research	**0**									
Clerical, secretary, administrative assistants	**142.25**			(Support Staff; Sub-Totals Only) ⬇						
Other support staff (non-direct services).....	**28.75**									
Sub-total, E (County)	**198.75**	**1**	**15**	**54.00**	**50.75**	**15.25**	**18.50**	**.75**	**12.75**	**152.00**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance.....	**1.45**									
Education, training, research	**0**									
Clerical, secretary, administrative assistants	**12.95**			(Support Staff; Sub-Totals and Total Only) ⬇						
Other support staff (non-direct services).....	**2.0**									

Sub-total, E (All Other)	**16.40**	**0**	**0**	**6.15**	**2.37**	**1.00**	**1.43**	**0**	**5.45**	**16.40**
Total, E (County & All Other):	**215.15**	**1**	**15**	**60.15**	**53.12**	**16.25**	**19.93**	**.75**	**18.20**	**168.40**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 5

GRAND TOTAL WORKFORCE
(A+B+C+D+E)

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
***County (employees, independent contractors, volunteers)* (A+B+C+D+E).....**	**782.25**	**18**	**140.00**	**224.85**	**197.25**	**78.75**	**114.75**	**3.75**	**53.10**	**672.45**
***All Other (CBOs, CBO sub-contractors, network providers and volunteers)* (A+B+C+D+E) .....**	**238.77**	**12**	**27.00**	**71.84**	**78.26**	**26.66**	**39.90**	**2.75**	**19.36**	**238.77**
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	**1,021.02**	**30**	**167.00**	**296.69**	**275.51**	**105.41**	**154.65**	**6.50**	**72.46**	**911.22**

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

				Race/ethnicity of individuals planned to be served -- Col. (11)						
				White/ Cau-casion	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	All individuals **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			**6,827**	**4,609**	**3,270**	**1,814**	**518**	**791**	**17,829**

II. Positions Specifically Designated for Individuals with Consumer and Family Member Experience:

Major Group and Positions	Estimated # FTE authorized and to be filled by clients or family members	Position hard to fill with clients or family members? (1=Yes; 0=No)	# additional client or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff.....	63.85	1	8
Family Member Support Staff	11.75	1	4
Other *Unlicensed* MH Direct Service Staff.....	0	1	
Sub-Total, A:	**75.60**	**3**	**12**
B. *Licensed* Mental Health Staff (direct service).....	**0**	**0**	
C. Other Health Care Staff (direct service)	**0**	**0**	
D. Managerial and Supervisory.....	**2.50**	**0**	
E. Support Staff (non-direct services).....	**9.15**	**0**	
GRAND TOTAL (A+B+C+D+E)	**87.25**	**0**	**12**

III. LANGUAGE PROFICIENCY

For languages other than English, please list (1) the major ones in your county/city, (2) the estimated number of public mental health workforce members currently proficient in the language, (3) the number of additional individuals needed to be proficient, and (4) the total need (2)+(3):

Language, other than English	Number who are proficient	Additional number who need to be proficient	**TOTAL (2)+(3)**
(1)	(2)	(3)	(4)
1. Spanish (threshold)	Direct Service Staff 126 Others 39	Direct Service Staff 52 Others 0	Direct Service Staff 178 Others 39
2. Cambodian (threshold)	Direct Service Staff 8 Others 2	Direct Service Staff 1 Others 0	Direct Service Staff 9 Others 2
3. Vietnamese	Direct Service Staff 11 Others 1	Direct Service Staff 0 Others 0	Direct Service Staff 11 Others 1
4. Hmong	Direct Service Staff 9 Others 5	Direct Service Staff 0 Others 0	Direct Service Staff 9 Others 5
5. Lao	Direct Service Staff:1 Others: 0	Direct Service Staff: 2 Others 0	Direct Service Staff: 3 Others 0
6.Thai	Direct Service Staff: 3 Others: 0	Direct Service Staff: 0 Others: 0	Direct Service Staff: 3 Ohers: 0 Others
7 Tagalog/Filipino	Direct Service Staff 23 Others 7	Direct Service Staff 0 Others 0	Direct Service Staff 23 Others 7

San Joaquin County Behavioral Health Services
2023-24 Annual Update to the 2010 Cultural Competency Plan

San Joaquin County Behavioral Health Services (BHS) continuously seeks to improve by evaluating, strategizing, and enhancing service delivery. To meet the prevention, intervention, treatment and recovery needs of San Joaquin County residents, BHS provides a broad range of behavioral health services, including mental health and substance use disorder services, in a culturally competent and linguistically appropriate manner.

The 2023-24 Annual Update to the 2010 Cultural Competency Plan (Annual Update) reviews the efforts of Fiscal Year (FY) 2022-2023 and guides upcoming efforts for FY 2023-2024. The Annual Update will focus on the eight criteria laid out by the State's Cultural Competency Plan Requirements of 2010.

Criterion 1: Commitment to Cultural Competence
(CLAS Standard 2, 3, 4, 9, 15)

FY 2022-2023 Accomplishment: Continuance of enhance agency commitment to Cultural Competency by:

1. Measured and monitored cultural competency standards through the 2022-23 MH and SUD Quality Improvement Work Plans via the monthly Quality Assessment & Performance Improvement (QAPI) Council (See Attachment 1 & 2). The addition of this process improved accountability by using measurable objectives in the Annual Update.
2. Conducted a division-wide and program-specific inventory of Cultural Competency knowledge via the California Brief Multicultural Competence Scale (CMCBS) to identify gaps in the knowledge base of BHS staff members and partners BHS continued tracking, monitoring, and measuring strategies via the BHS MH and SUD QI Work Plan.

FY 2023-2024 Strategies:
1. Hire para-professional staff to oversee cultural competency committee, cultural competency plan requirements, and additional health equity needs of BHS by January 31, 2024
2. MHSA Cultural Full Service Partnerships (La Familia and Black Awareness Community Outreach Program) will be fully contracted with cultural Community Based Organizations (CBO's) within the community to enhance community partnership and provide culturally congruent services through local providers by June, 2024

Criterion 2: Updated Assessment of Service Needs
(CLAS Standard 2, 11)

FY 2022-2023 Accomplishments: BHS implemented a comprehensive community planning process with these components:
- 20 community stakeholder discussions about the needs and challenges experienced by mental health consumers, with a focus on the diverse range of consumers served.
- Two targeted discussion groups with mental health consumers, family members
- Review of service needs including utilization, timeliness, and client satisfaction.

BHS reviewed service needs using two methods:

1. The Mental Health Services Act (MHSA) Community Planning Process incorporated discussion with stakeholders on the needs of diverse communities in the County, and gaps in available services. The assessment of service needs is detailed in the 2023-2026 MHSA e Three Year Program and Expenditure Plan, pages 7 through 21. (Attachment 3)
2. Review of San Joaquin County Medi-Cal Approved Claims Data for mental health (MH) and substance use disorders (SUD) utilization, provided by CALEQRO. The data provided by CALEQRO contains Medi-Cal Beneficiaries served by race and ethnicity including penetration rates by age, gender, and ethnicity (See Attachment 5).

Through the MHSA Planning Needs Assessment, BHS found that the diversity of its consumers was similar to the distribution in prior years.

- African Americans are enrolled at higher rates compared to their proportion of the general population (15% of participants while comprising 7% of the population of the County).
- Latino/x are enrolled at lower rates compared to their proportion of the general population (28% of participants while comprising 41% of the population) – though this rate is up slightly from prior years.
- Participation amongst children and youth is more reflective of the racial demographics of the overall population, with over a third of services provided to young Latino/x (35%), suggesting that while stigma, language or cultural barriers, or access to health care services continue to impede access for Latino adults with behavioral health needs, more services are reaching the younger Latino populations.
- Survey Input and Stakeholder feedback displayed race/ethnicity data reflective of the BHS client population. Adult survey respondents were more likely to be Latino/x, African American, Asian, or Native American than is reflective of the general population in San Joaquin County.
- Feedback from self-reported demographics indicated that adult consumers represented 9% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQIA+).

Data provided by CALEQRO for MH Medi-Cal Beneficiaries (CY 21) indicated the following:

- The penetration rate for individuals 60+ continues to be higher than the statewide average, similar to the previous year.
- The penetration rate for Asian/Pacific Islanders is statistically identical with the statewide average.
- The penetration rate for Latino/Hispanic communities (2.23%) is lower than the statewide average of 3.29% and slightly lower with the rate of other large-sized counties (2.84%).

Data provided by CALEQRO for SUD Medi-Cal Beneficiaries CY 2020 (as of this draft CY 2021 was unavailable) indicated the following:

- The penetration rate for individuals 65+ is higher than the statewide average, similar to the previous year.
- The penetration rate for African Americans is higher than statewide rate and medium sized counties averages, similar to the previous year.
- The penetration rate for Latino/Hispanic communities (.93%) is higher that the statewide average (.69%).

FY 2023-2024 Strategies:

- BHS will again host a series of MHSA community planning discussions on the needs and challenges experienced by mental health consumers, with a focus on the diverse range of consumers served by January 15, 2024.

- BHS will develop online and paper stakeholder surveys to reach individuals who are unable to attend community planning sessions, or who may be unwilling or unable to provide public comment in person at meetings, by January 31, 2024.
- BHS will distribute and collect needs assessment surveys by February 15, 2024.
- BHS will complete an annual MHSA assessment of needs by March 1, 2024.
- Distribute and collect SUD needs assessment surveys by April 15, 2024. (Strategy Carryover from 20-21 Plan)
- Complete analysis of SUD assessment survey by May 15, 2024. (Strategy Carryover from 20-21 Plan)

Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural and Linguistic Disparities

(CLAS Standard 1, 10, 14)

FY2022-23 Accomplishments

- In April 2023, BHS began exploratory discussions on Latino/x penetration rates – formally created a subcommittee from QAPI to advance and structure a Performance Improvement Project (PIP) to analyze Latino/x disparities in access.
- In June 2023 – BHS committed monthly Latino/x penetration rate subcommittee formation in an effort to formalize a PIP for Latino/x disparities.

FY 2023-2024 Strategies:

- Finalize Performance Improvement Project (PIP) and begin focus on Latino/a/x Engagement, Access, and Equity by June, 2024
- Define framework of PIP project to encompass Universal, Selective, and Indicated strategies in an effort to increase Latino/a/x penetration rates by June, 2024
- The Cultural Competency Committee will add PIP agenda item to monthly agenda to increase engagement and to provide a continuous feedback loop to the PIP by January, 2024

Criterion 4: County Systems Client/Family Member/Community Committee:

(CLAS Standard 13)

BHS has two avenues to address the cultural competence of its staff and services:

1. The Cultural Competency Committee is comprised of BHS staff, consumers/family members, and other stakeholders.
2. The MHSA Consortium, established in 2007, is comprised of a variety of stakeholders: representatives of community based organizations, consumers and family members, community members and BHS staff.

The Cultural Competency committee was developed in accordance with the requirements of Title IX, CA Code of Regulations, Chap. 11, Article 4 Section 1810.410, (b). BHS policy states that:

1. BHS shall maintain a Cultural Competence Committee that has representation from management staff, direct services staff, consumer/family members, community members and representatives of unserved/underserved populations from the community.
2. The Cultural Competence Committee shall meet regularly (monthly) to review BHS' adherence to the BHS Cultural Competency Plan by reviewing goals and objectives and make appropriate recommendations to BHS Administration regarding management and service provision as it relates to cultural and linguistic services and health equity.
3. The Cultural Competence Committee shall elicit, suggest, review, monitor and support strategies to increase penetration and retention rates for identified community groups.

4. The Cultural Competence Committee will collaborate with the MHSA Consortium and organizations representing various groups within the community.

The MHSA Consortium meets monthly to discuss community-wide behavioral health services in a framework of cultural diversity. Many meetings include presentations on services for diverse racial and ethnic communities and include agenda items focused on cultural competence and language proficiency. The MHSA Consortium has become a vehicle through which the Cultural Competency Committee informs stakeholders about BHS Cultural Competency efforts.

FY 2022-2023 Accomplishments: The Cultural Competency Committee achieved significant successes with the development of two major projects:

- Continuous engagement of SUD services staff at the Cultural Competency Committee
- Maintained direct partnership with QAPI Council to inform QAPI Stakeholders of continued monitoring and discussion of BHS Cultural Competency Plan Requirements

FY 2023-2024 Strategies:

- Host a minimum of eight meetings with representation from management staff, direct services staff, consumers, community members and representatives of culture from the community, by June 30, 2024.
- Hire para-professional staff to oversee cultural competency committee, cultural competency plan requirements, and additional health equity needs of BHS by January 31, 2024
- Recruit consumer representation from SUD Services and community representation to the Cultural Competency Committee
- Collaborate with the Consortium by disseminating Cultural Competency information and strategies at five Consortium meetings by June 30, 2024.

Criterion 5: County Culturally Competent Training Activities

(CLAS Standard 4)

FY 2022-2023 Accomplishments:

- BHS continues to make it mandatory to take three cultural competency training courses offered throughout the county and department.
    a. Diversity and Inclusion (Every 5 Years)
    b. Improving Cultural Competency for Behavioral Health Professionals (Annually)
    c. Limited English Proficiency (for all staff with client contact)
- In addition to the above aforementioned mandatory trainings, BHS offered:
    a. Multicultural Awareness & Diversity – Powerful Strategies to Advanced Client Rapport & Cultural Competency Training (three sessions)
    b. LBGTQ Clients: Clinical Issues and Treatment Strategies (one session)
- Cultural Competency presentations via QAPI and the MHSA Consortium

FY 2023-2024 Strategies:

- Additional trainings scheduled for this fiscal year include:
    a. UCLA – LGBT clients in the SUD system of Care
    b. Valuing Different Perspectives – (Managers)
    c. Cultural Differences – (Managers)
    d. LGBTQ Youth – Clinical Strategies to support Sexual Orientation and Gender Identity
    e. Racial and Generational Trauma Recovery

- Training Coordinator along with Cultural Competency Committee will investigate additional health equity training to expand and enhance the cadre of cultural competency trainings available at BHS.
- Latino/x PIP committee will recommend additional trainings geared towards Latino/x population.

Criterion 6: County Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff

(CLAS Standard 7)

FY 2022-23 Accomplishments:

- BHS Hispanic staff members increased by 38 employees, increasing the percentage of Hispanic staff by nearly 5% points from the previous year.

BHS monitors the development of a multicultural workforce via CalEQRO Data and BHS Utilization along with Staff Ethnicity and Language Reports (Volunteered Data). The table below compares proportionate BHS Employment Data to client data from CALEQRO MH and SUD Beneficiary Data (Attachment 4), and United States Census data. Data shows that BHS Hispanic staff are lower in proportion to Hispanic clientele, however in 22-23, BHS Hispanic staff increased by 5% points.

	BHS staff (Volunteered Data)	BHS staff %	MH Medi-Cal Beneficiaries % (CALEQRO CY2022)	SUD Medi-Cal Beneficiaries % (CALEQRO CY-21)	County % (Census)
Caucasian/White	191	26%	15%	17%	33%
Hispanic	247	34%	47%	47%	41%
Asian/Pacific Islander	138	19%	15%	16%	14.5%
Black/African American	93	13%	9%	10%	7%
Native American	13	.018%	.5%	1%	.5%
Other	47	6%	15	11%	3%
Total	729	100%	100%	100%	100%

FY2023-2024 Strategies:

- Committee will develop and updated Staff Ethnicity Language Report to include voluntary SOGI (Sexual Orientation/Gender Identify) and Consumer/Family Member status data points by March 15, 2024.
- Administration will re-survey BHS Staff with updated Staff Ethnicity/Language Report by April 30, 2024
- The BHS Cultural Competency Committee in partnership with the Recruitment and Retention Committee will develop strategies for increasing the recruitment of staff from the Latinx/Hispanic communities by June 30, 2024.

Criterion 7: County System Language Capacity

(CLAS Standard 5,6,8)

FY 2022-2023 Accomplishments:

- BHS continues to maintain an in-house database of language capacity of BHS Staff
- BHS improved in language capacity in Spanish and Vietnamese.

The BHS Cultural Competency Committee reviewed the language capacity of BHS staff. The data, provided below, shows improvement in language capacity from the previous fiscal year in Spanish and Vietnamese Languages. Cambodian language shows a major disparity from the previous year.

Primary languages spoken by clients and staff	# of Clients	# of BHS Staff Providing Direct Services (2022-23)	Staff to client ratio	# of Clients	# of BHS Staff Providing Direct Services (2021-22)	Staff to client ratio
English	14,843	729	1:20	17,591	559	1:31
Spanish	1105	102	1:9	1,088	99	1:11
Cambodian	138	1	1:138	177	5	1:35
Vietnamese	81	6	1:7	71	4	1:18
Laotian	1	0	n/a	38	4	1:10
Hmong	22	6	1:4	22	7	1:3
Tagalog	3	27	1:1	13	27	1:1
Arabic and Farsi	43	4	1:1	23	3	1:8
Chinese (Mandarin and Cantonese)	3	1	1:3	10	3	1:3
American Sign Language	2	0	n/a	8	4	1:2
Korean	0	1	n/a	3	1	1:3

FY 2023-2024 Strategies:

- The BHS Cultural Competency Committee will partner with the Recruitment and Retention Committee to develop strategies to recruit staff that speak the Cambodian language by June 30, 2024.

Criterion 8: County Adaptation of Services

(CLAS Standard 12)

2022-23 Accomplishments:

- Contracts Management included monitoring contract providers for completion of online Cultural Competency Training.

BHS documented the necessity of cultural and linguistic competency in its contractual requirements (Attachment 5) and monitors contractors to ensure that personnel training is implemented accordingly. BHS has additionally included the requirement for cultural and linguistic competence in each of the project descriptions in its Requests for Proposals (RFP).

FY 2023-2024 Strategies:

- Quarterly reviews of contractor provider services include monitoring the provision of staff training in the areas of cultural and linguistic competency. (Attachment 6)

Attachments:

1. BHS MH QAPI Work Plan
2. BHS SUD QAPI Work Plan
3. 22-23 MHSA Annual Update to the Three Year Mental Health Services Act Program and Expenditure Plan, pages 8-17
4. San Joaquin County-specific Data provided by CALEQRO for MH and SUD
5. Boilerplate Contract Language – Cultural Competency
6. Contract Monitoring Tool – Item 6b/6d

Attachment 1: BHS MH QAPI Work Plan (Sections 5.A.1-5.A.3)

5.Cultual Competency							
5.A. Cultural Competency- The MHP incorporates cultural competency principles in the systems of care		Goals	Target	Status (Met/Not Met)	Frequency of Review	Action Plan	Evaluation
5.A.1	The MHP identifies strategies and resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	Create workforce that is representative of the population.	By 6/30/2023, BHS will increase the Hispanic/Latino proportion of staff to 35%.	Not Met	Quarterly	Enact recruitments for language-specific positions. Assess opportunities for recruitment in cultural arenas of the community and implement two strategies. strategies – partner with recruitment & retention committee (once committee is re-established)	Database that holds our demographic staff data has glitched and are unable to pull current years data. Will work with I.S. to fix the issue and report in the next workplan update.
5.A.2	The MHP implements strategies and uses resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	Improve cultural competency of staff.	By 3/31/2023, BHS will develop an action plan to address the findings of the CBMCS Survey.	Met	Quarterly	Analyze the findings from the CBMCS Survey and develop an action plan to address the findings from the CBMCS Survey- partner with training committee on additional cultural competency, cultural sensitivity, health equity training for BHS (once committee is re-established)	In 22-23 – BHS offered additional cultural comp trainings entitled: 1. Multicultural Awareness & Diversity – Powerful Strategies to Advance Client Rapport & Cultural Competency Training - Three Time in 22-23: 10/28/22, 1/27/23, 5/26/23). 1.LGBTQ Clients: Clinical Issues and Treatment Strategies (2/23/23) Partnered with Training Coordinator to review and commit to additional Cultural Competency Training opportunities for FY 23-24. The following trainings will be offered in the next fiscal year: 1.LGBTQ Youth: Clinical strategies to support sexual orientation and Gender Identity. 2.Cultural Responsive Clinical Supervision: Ethical & Trauma Informed Multicultural supervision strategies 3.Racial & Generational Trauma Recovery: Evidenced-based Somatic Interventions for BIPOC Clients

5.A.3.	The MHP identifies factors contributing to low Hispanic/Latino penetration rates.	Improve Hispanic/Latino penetration rates.	By 6/30/2023, BHS will identify factors contributing to low Hispanic/Latino penetration rates.	Not Met	Quarterly	Develop AdHoc Subcommittee to perform a root cause analysis to identify factors contributing to low Hispanic/Latino penetration rates. Initiate cultural competent quality improvement activities to address health equity.	Latino/a/x ACCESS, Engagement, & Equity PIP was developed in April, 2023 and is considered to be the AdHoc subcommittee to explore and review data, quantitative problems, root-cause analysis, strategy research & development, measure extent to which we are doing intervention and effect on the problem, revise strategy, remeasure, lessons learned, since its inception, the Latinx PIP continues to meet on a monthly meeting and will be reported to the cultural competency committee and QAPI Council on developments and status.

Attachment 2: BHS SUD QAPI Work Plan (Sections 2d, 3a1, 6a-6c)

#	Target	FY 21/22	FY 22/23	Status (Met/Not Met)	Data Source	FY22/23 Action Plan	Evaluation
5a	By 6/30/2023 increase number of Spanish-speaking direct-service staff from one FTE to three FTEs.	5	8	Met	NACT	1. The Plan will review findings in QAPI Council and Cultural Competency Committee to establish recruitment objectives for fiscal year.	The Plan has continued to implement recruitment strategies to increase number of Spanish-speaking staff. Currently SUD has 8 Spanish Speaking staff. 3 of the 8 have been recruited and hired in the 22/23 FY.
5b	By 6/30/2023 100% of staff will be trained in Cultural Competency and new staff will complete it within 12 months of hire.	80%	100%	Met	TPS	1. The Plan's SUD managers and supervisors will track required staff trainings - including Cultural Competenc e - and document staff completion. 2. The Plan will monitor the contractors on a monthly basis to ensure trainings are completed.	100% of CDCC staff have completed cultural competency training within twelve months of hire. 100% of Recovery House and Family Ties staff have completed cultural competency training within twelve months of hire.

5c	By 6/30/2023 Cultural Competency Committee will add four new members.	1	1	Not Met	Cultural Competence Committee meeting minutes and sign in sheets	1. The Plan will actively promote Cultural Competence Committee, providing increased opportunity for staff participation, and posting information in public areas soliciting consumer/family member participation.	Added an additional member (consumer) that represents the community and Behavioral Health Board. Member will formally begin in 23/24. SUD staff will continue to engage consumers/family members/ staff to be part of the cultural competency committee and encourage those interested to part of the BHS Committees process to represent the SUD Division to enhance cultural perspective from SUD staff and beneficiaries.

Community Program Planning and Stakeholder Process

Community Program Planning Process

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

Quantitative Analysis (Program period July 2021 – June 2022):

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

Community Discussions:

- MHSA Showcase
  - September 29, 2022 – MHSA Programs Public Showcase, Stakeholder and Community Engagement Survey

- Behavioral Health Board
  - November 16, 2022 Introduction to MHSA Community Planning
  - MHSA Presentations and Updates on Community Convenings in December, January, February, April, May 2022-23 MHSA Community Planning Meetings and Public Hearing

- Public Forums
  - November 29, 2022 – MHSA Community Planning (Lodi Police Station)
  - November 30, 2022 – MHSA Community Planning (Tracy Community Center)
  - December 1, 2022 – MHSA Community Planning (Manteca Library)
  - December 13, 2022 – MHSA Community Planning (Escalon Library)
  - December 14, 2022 – MHSA Consortium (Zoom Meeting)
  - December 15, 2022 – MHSA Community Planning (Catholic Charities/Spanish Session)
  - December 16, 2022 – MHSA Community Planning (Ripon Library)
  - December 20, 2022 – MHSA Community Planning (General Zoom Meeting)
  - December 21, 2022 – MHSA Community Planning (BHS Behavioral Health Board)
  - December 27, 2022 – MHSA Community Planning (Spanish Zoom Meeting) w/ El Concilio
  - December 28, 2022 – MHSA Community Planning (General Zoom Meeting)
  - January 11, 2023 – MHSA Consortium (Community Stakeholder Feedback Presentation)

- January 18, 2023 – BHS Behavioral Health Board (Community Stakeholder Feedback Presentation)
- January 19, 20203 – BHS Leadership Meeting (Community Stakeholder Feedback Presentation)
- February 16, 2023 – NAACP Stakeholder Meet & Greet (Community Stakeholder Feedback Presentation
- March 2, 2023 – SJC Community Health Leadership Council (Community Stakeholder Feedback Presentation)
- March 16, 2023 – MHSA Community Planning & Community Stakeholder Presentation (Greater Christ Temple Church)
- March 28, 2023 – MHSA Community Planning & Community Stakeholder Presentation (Little Manila Rising/ SJC Transforming Communities Healing Collaborative)

Targeted Discussions:

- Consumer Focus Groups
  - November 15, 2022 - Co-hosted by the Wellness Center
  - November 17, 2022 - Co-hosted by the Martin Gipson Socialization Center

Consumer and Stakeholder Surveys:

- 2022-23 MHSA Consumer and Stakeholder Surveys

Assessment of Mental Health Needs

County Demographics and County's Underserved/Unserved Populations

San Joaquin County, located in California's Central Valley, is a vibrant community with just over 783,000 individuals, with a diverse population. English is spoken by more than half of all residents, just over 180,000 residents are estimated to speak Spanish as their first language. Tagalog, Chinese, Khmer, and Vietnamese are also spoken by large components of the population. 41% of the county population is predominantly centrally situated in Stockton, the largest city in the county. Cities like Lodi, Tracy, and Manteca make up an additional 31% of the county population, while the remaining smaller cities of Ripon, Lathrop, and Escalon make up 7% of the county population. Unincorporated areas of San Joaquin County make up 21% of the remaining balance. San Joaquin County's gender ratio is 99 men to 100 women (99:100) or .99, equal to the California State average of 99:100. San Joaquin County age distribution shows that the 20-54 age group makes up the largest percentage in the county with the 0-19 age group following behind.

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

*Source: San Joaquin Council of Governments

San Joaquin County stakeholders have identified underserved/unserved populations as individuals that are historically part of a vulnerable racial, ethnic and/or cultural group. In addition, underserved/unserved

populations also include immigrants, refugees, uninsured adults, LGBTQIA+ individuals, Limited English Proficient individuals, and rural residents of north and south county.

Population Served

BHS provides mental health services and substance use disorder treatment to nearly 17,600 consumers annually. In general, program access is reflective of the diverse population of San Joaquin County, with a roughly even division of male and female clients. An analysis of services provided in 2021-22 demonstrates the program participation compared to the county population.

Mental Health Services Provided in 2021-22

Services Provided by Age	Number of Clients*	Percent of Clients
Children	2,942	17%
Transitional Age Youth	3,272	19%
Adults	9,395	53%
Older Adults	1,982	11%
Total	**17,591**	**100%**

*Source: BHS Client Services Data

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

Services Provided by Race/Ethnicity	County Population by Race/Ethnicity**	Percent of County Population	Clients Served*	Percent of Clients
White	259,832	33%	5,574	32%
Latino	320,035	41%	5,006	28%
African American	58,409	7%	2,680	15%
Asian	110,669	14%	1,319	7%
Multi-Race/Other	27,237	3%	2,479	14%
Native American	3,672	.5%	469	3%
Pacific Islander	3,852	.5%	64	0.4%
Total	**783,706**	**100%**	**17,591**	**100%**

*Source: BHS Client Services Data

**Source: https://www.dof.ca.gov/Forecasting/Demographics/Projections

The diversity of clients served is similar to the distribution in prior years. African Americans are disproportionately over-represented amongst consumers compared to their proportion of the general population (15% of participants, though comprising 7% of the population of the County). Native Americans are also over-represented within the service continuum (3% of clients are Native American). Latinos are enrolled in mental health treatment services at rates lower than expected, compared to their proportion of the general population (28% of clients versus 41% of the population). Asian clients are also underrepresented by 7%.

Services Provided by City	County Population by City**	Percent of County Population	Clients Served*	Percent of Clients
Stockton	323,884	41%	11,149	63%
Lodi	66,570	8%	1,427	8%
Tracy	94,538	12%	1,353	8%
Manteca	86,589	11%	1,280	7%
Lathrop	31,331	4%	333	2%
Ripon	15,979	2%	167	1%
Escalon	7,362	1%	132	1%
Balance of County	159,170	20%	1,7,50	10%
Total	**784,372**	**100%**	**17,591**	**100%**

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

The majority of clients are residents of the City of Stockton. Stockton is the County seat of government and the largest city in the region, accounting for 41% of the County population. The majority of services and supports for individuals receiving public benefits, including mental health, are located in Stockton.

Stakeholder Involvement:

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

Discussion Group Input and Stakeholder Feedback

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

Community Program Planning for 2022-23:

Behavioral Health Board Agenda Items

At the November 2022 Behavioral Health Board meeting, the MHSA Coordinator announced that the MHSA Plan's community program planning process would begin in November 2022. He shared the methodology and timeline for the annual planning process, which informed the Plan's 2023-26 Program and Expenditure Plan. Promotional flyers with details for both consumer and community discussion groups were distributed to the Board electronically.

Community Stakeholder and Consumer Discussion Groups

There were 20 community discussion groups convened between November 2022 – March 2023, two of which specifically targeted adult consumers and family members. Two of the 20 community discussion groups were held in a Behavioral Health Board meeting so stakeholders could present their input directly to members of the Board.

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

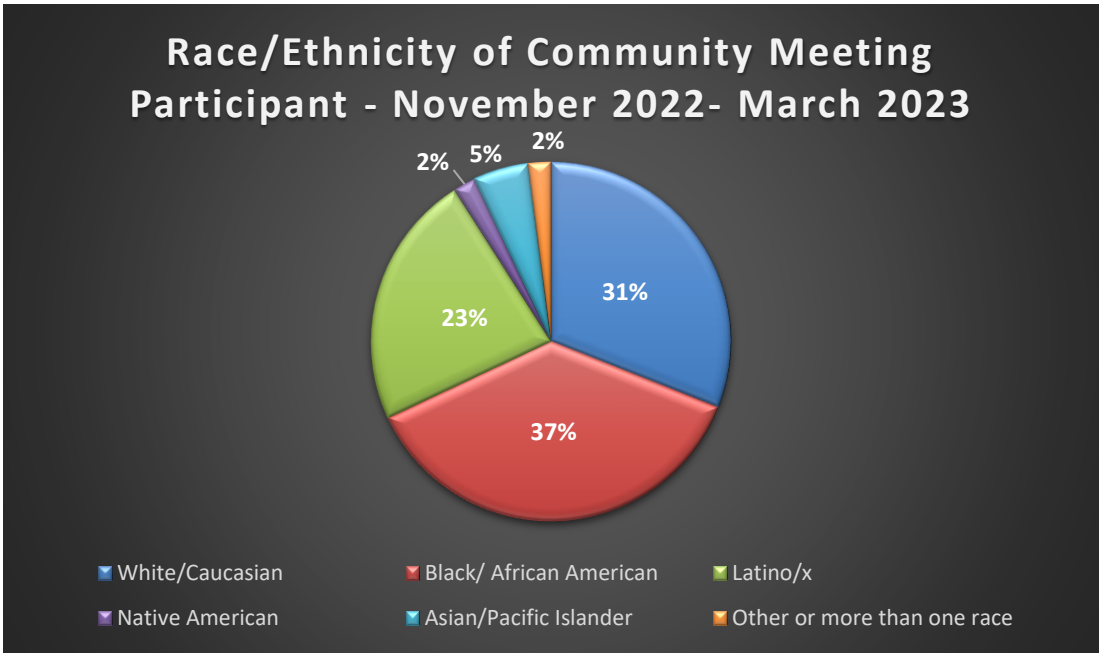
- Funding priorities
- Populations of need
- Regulations guiding the use of MHSA funding

Stakeholder participation was tracked through Sign-In Sheets, Zoom chat and completed anonymous demographic Survey Monkey links. Stakeholder participants were demographically diverse and included representatives of unserved and underserved populations, according to the surveys. The community discussion and focus groups had participation by over 300 individuals, nearly 80% of whom self-identified as a consumer of public mental health services or as a family member of a consumer. The majority of participants identified as adults ages 26-59, 14% were older adults over 59 years of age, and 17% were transitional age youth ages 18-25.

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

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

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



Survey Input and Stakeholder Feedback

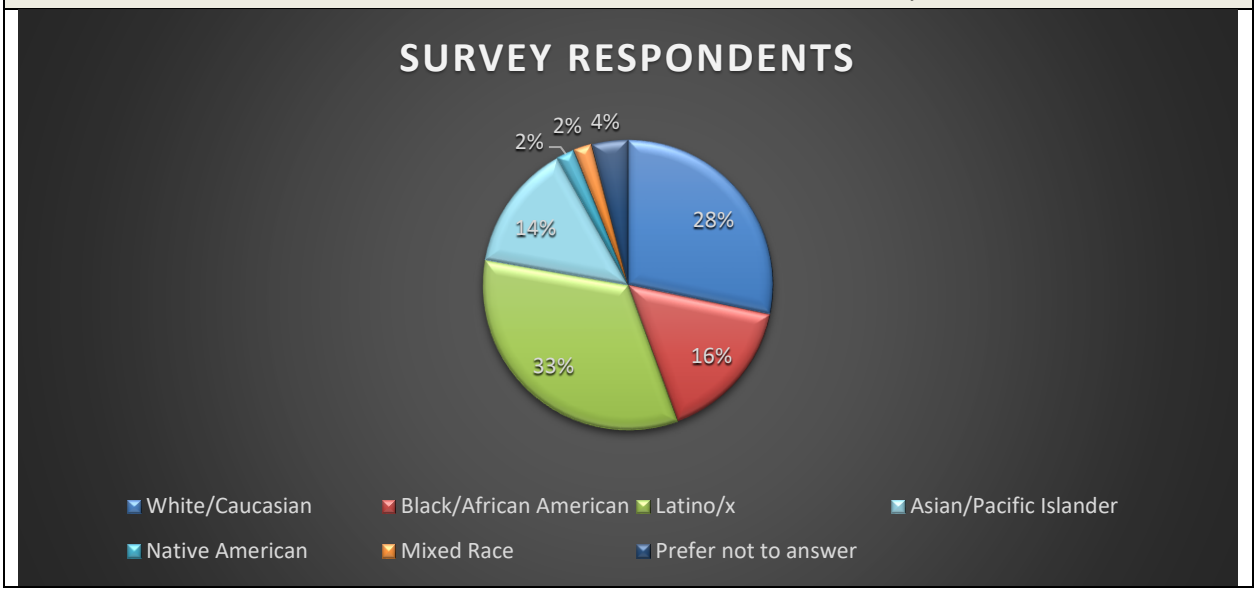
In September 2022 and January of 2023, BHS distributed electronic and paper surveys to consumers, family members, and stakeholders to learn more about the perspectives, needs, and lives of clients served through mental health programs. Surveys were completed online and in person with multiple-choice answers and responses were tallied through Survey Monkey reports. There were 282 surveys completed. Survey instruments can be reviewed in the Appendix.

BHS consumers and their family members reported mid to high levels of satisfaction with the services provided to address mental health and/or substance use disorders, with 89% of respondents reporting that they would recommend BHS services to others. According to respondents, BHS Informational materials such as flyers, brochures and website need to be updated. A large majority of respondents reported that the BHS Lobby and reception areas are friendly and welcoming from a cultural and linguistic perspective. Respondents agreed strongly with statements regarding staff courtesy and professionalism, respect for cultural heritage, and their capacity to explain things in an easily understood manner.

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

Survey respondents were diverse and identified as: White/Caucasian (28%), Latino/x (33%), African American (16%), Asian/Pacific Islander (15%), Native American (2%), and Mixed Race 2%

Self-Reported Race and Ethnicity of Stakeholder Respondents
MHSA 2022-23 Consumer and Stakeholder Surveys



Self-Reported Age/Gender of Stakeholder Respondents

Age Range	Percent
Under 18	1%
18-25	11%
26-59	70%
60 and over	15%
Prefer not to say	3%

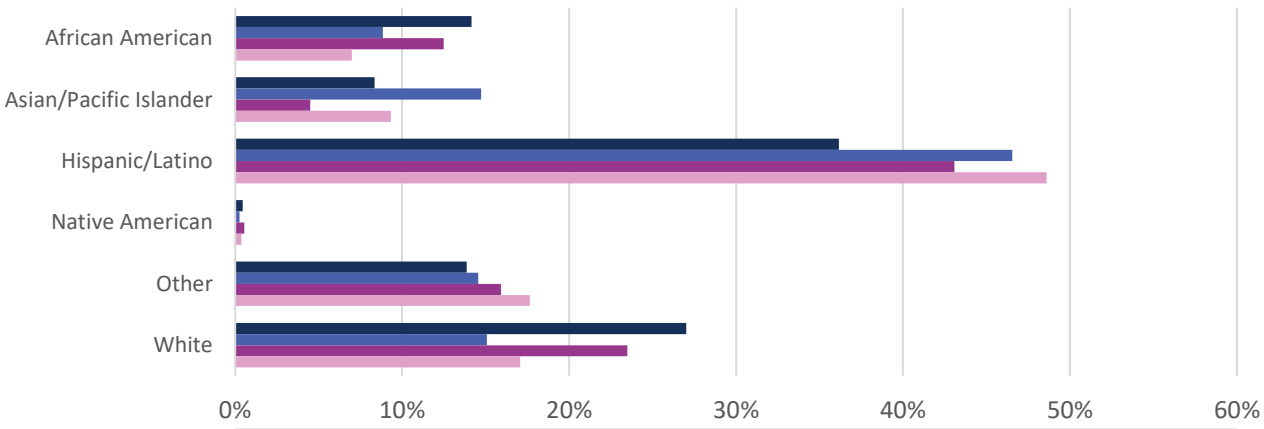
Gender	Percent
Male	28%
Female	70%
Transgender	1%
Non-Binary	0%
Prefer not to say	1%

The 282 respondents surveyed represent the broad diversity of stakeholders in the community and consumers served by BHS. 38% of respondents identify as someone who is receiving, or who needs, mental health treatment services. Less than half of respondents have children, with 53% describing themselves as parents. Consistent with the general population, 9% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQ). Nearly 10% of respondents identified with having a physical or developmental disability. Few are military veterans, with 10% reporting that they have served in the US Armed Forces. 6% of consumers reported experiencing homelessness more than four times or being homeless for at least a year; and 20% of respondents reported having been arrested or detained by the police.

Attachment 4: San Joaquin County Specific Data provided by CALEQRO for MH and SUD

CALEQRO PERFORMANCE MEASURES CY 22 – SAN JOAQUIN MHP

Table 4: MHP Beneficiaries Served by Race/Ethnicity vs State CY 2022

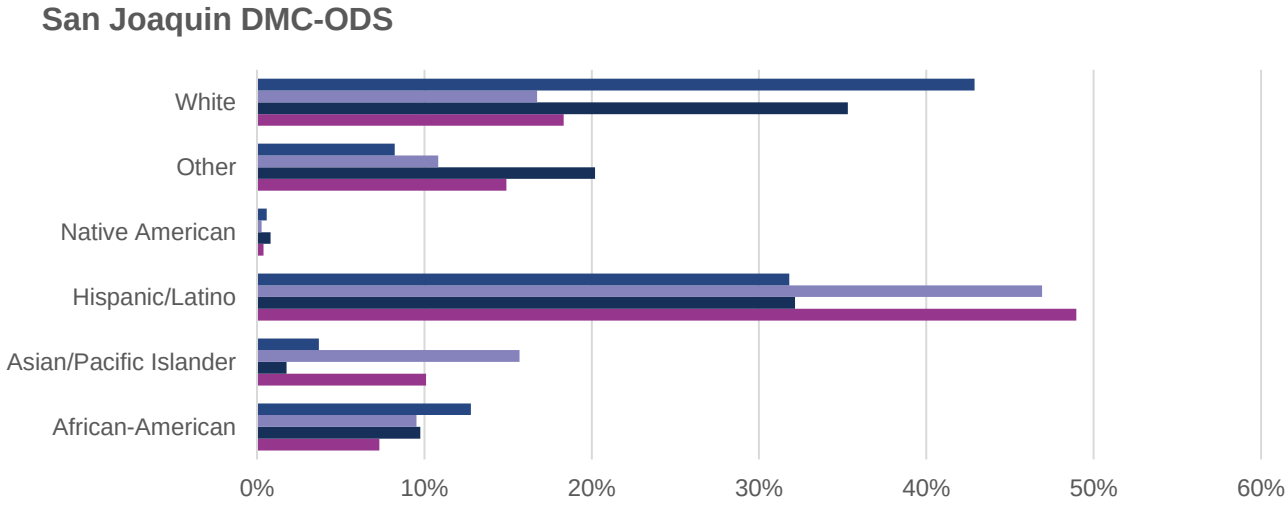


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	27%	14%	0%	36%	8%	14%
MHP % Eligible	15%	15%	0%	47%	15%	9%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

Percentage of Eligibles and Clients Served by Race/Ethnicity, CY 21 (SUD)

Table 1: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Race/Ethnicity, CY 2021

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2021



	African-American	Asian/Pacific Islander	Hispanic/Latino	Native American	Other	White
County % Served	13%	4%	32%	1%	8%	43%
County % Eligibles	10%	16%	47%	0%	11%	17%
State % Served	10%	2%	32%	1%	20%	35%
State % Eligibles	7%	10%	49%	0%	15%	18%

Attachment 5: Boilerplate Contract – Cultural Competency Language - Item #15

15. Cultural and Linguistic Proficiency:

a. To ensure equal access to quality care by diverse populations, CONTRACTOR shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards.

b. When the consumer served by CONTRACTOR is a non-English or limited-English speaking person, CONTRACTOR shall take all steps necessary to develop and maintain an appropriate capability for communicating in that consumer's primary or preferred language to ensure full and effective communication between the consumer and CONTRACTOR staff. CONTRACTOR shall provide immediate translation to non-English or limited-English speaking consumers whose conditions are such that failure to immediately translate would risk serious impairment. CONTRACTOR shall provide notices in prominent places in the facility of the availability of free translation in necessary other languages.

c. CONTRACTOR shall make available forms, documents and brochures in the San Joaquin County threshold languages of English and Spanish to reflect the cultural needs of the community~~.~~

d. CONTRACTOR is responsible for providing culturally and linguistically appropriate services. Services are to be provided by professional and paraprofessional staff with similar cultural and linguistic backgrounds to the consumers being served.

Attachment 6: Contract Monitoring Tool – Annual Site Review Checklist – 6b/6e.

7. Review sample documentation for evidence of compliance with other contract requirements:
a. Employee HIPAA training and confidentiality statements;
b. Employee training including BHS Compliance Training, CANSA, cultural competency and limited English proficiency, and clinical documentation
c. Compliance Sanction Checks up to date (applicable to Medi-Cal providers)
d. Notice of Adverse Benefit Determination (NOABD) practices of agency (applicable to Medi-Cal providers)
e. Adoption of the Federal Office of Minority Health CLAS Standards; policy and practice examples
f. Timeliness standards
g. Presence of required postings and forms available for consumers; free interpretation services, HIPAA Rights, Mon-Discrimination notices, forms for suggestions and satisfaction surveys, Notice of Adverse Benefit Determination, Medi-Cal Beneficiary Brochure

MHSA Prevention and Early Intervention Evaluation Report

San Joaquin County Behavioral Health Services

Fiscal Year 2022/23

Style Definition: Footnote Text: Font: 9 pt

Table of Contents

Introduction

In October 2015 the State of California Office of Administrative Law (OAL) approved new Prevention and Early Intervention (PEI) regulations[1,2]. Under these regulations, San Joaquin County (SJCBHS) must submit an annual Prevention and Early Intervention Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC).

SJCBHS's PEI Projects are classified into specific Program and Strategy categories per State regulation. Each of these Program and Strategy categories has a specific set of reporting requirements. Table 1 illustrates the distribution of SJCBHS's PEI Projects into these seven Program and Strategy categories:

1. Prevention
2. Intervention
3. Outreach for increasing recognition of early signs of mental illness
4. Stigma and discrimination reduction
5. Suicide prevention
6. Access and linkage to treatment programs
7. Timely access to services for underserved populations

This report includes a brief description of each SJCBHS Project along with the required information for each Program and Strategy as specified in Section 3560.010 of the CCR. In addition, this report includes interim evaluation findings for Fiscal Year 2022/23, which will be expanded upon in a Three-Year Program and Evaluation Report due December 31, 2025 per Section 3560.020 of the CCR. It is important to note that few significant qualitative findings or interpretations are included in this preliminary report.

[1] (CCR, Title 9, 3200.245, 3200.246, 3510.010, 3560, 3560.010, 3560.020, 3700, 3701, 3705, 3706, 3710, 3717, 3720, 3725, 3726, 3730, 3735, 3740, 3745, 3750, 3755, 3755.010),

[2] A copy of the regulations may be found at https://mhsoac.ca.gov/wp-content/uploads/PEI-Regulations_As_Of_July-2018.pdf

Table 1. Program and Strategy Categories

San Joaquin County PEI Projects	Program Category	Required Strategies		
		Help Create Access & Linkage to Treatment	Improve Timely Access to Services for Underserved Populations	Use Strategies that are Non-Stigmatizing and Non-Discriminatory
Skill-Building for Parents and Guardians	Prevention	X	X	X
Mentoring for Transitional Age Youth (TAY)	Prevention	X	X	X
Coping and Resilience Education Services (CARES)	Prevention	X	X	X
School Based Interventions	Prevention	X	X	X
Early Intervention to Treat Psychosis (TEIR)	Early Intervention	X	X	X
Community Trauma Services for Adults	Early Intervention	X	X	X
Community Trainings - Outreach	Outreach for Increasing Recognition	X	X	X
Community Trainings - Stigma	Stigma & Discrimination Reduction	X	X	
Suicide Prevention Project	Suicide Prevention	X	X	X
LEAD - Recovery Services for Nonviolent Offenders	Timely Services for Underserved Populations	X		X
Whole Person Care	Access and Linkage to Treatment		X	X

Key Findings

The following is a summary of key findings from fiscal year 2022/23.

Prevention Projects

Skill-building for Parents and Guardians: Three community-based organizations offered 130 courses, served 1,617 individuals, and graduated 835 parents and guardians from evidence-based parenting classes during the fiscal year. Surveys conducted at the beginning and end of the courses revealed that across the programs, 82% of graduating participants had gained knowledge, skills, behaviors, or improved attitudes about parenting.

Transitional Age Youth: In FY 2022/23, two community-based organizations provided evidence-based mentoring to 602 youth aged 16-25 with emotional and behavioral health difficulties. Nearly three-quarters (74%) graduated (completed at least one goal) before concluding their participation.

Coping and Resilience Education Services (CARES): BHS's Children and Youth Services (CYS) provided trauma screening and intensive evidence-based skill-building trainings to caregivers and children who had been exposed to trauma. The program served 239 children and 160 caregivers during the 2022/23 fiscal year. The evaluation found that 88% of children experienced an overall increase in psychosocial functioning (i.e., reduction in PSC-35 score).

School Based Interventions: Three community-based organizations provided prevention services to 578 students through partnerships with schools. Additionally, there were 207 presentations targeting school personnel, and 14 presentations for parents/caregivers. Out of 578 students participating in group programming, 91% graduated (attending at least half of the sessions).

Early Intervention Projects

Early Intervention and Recovery (TEIR): Telecare provided an integrated set of promising practices intended to slow the progression of psychosis to 77 transitional age youth and their family members over the course of the 2022/23 fiscal year. Altogether, 9 clients were discharged during the year, with a total of seven (78%) completing program objectives. Assessments were planned for regular intervals using the Scale of Prodromal Symptoms (SOPS). Of the 13 clients with assessments during the year that could be compared to intake, ten of the participants demonstrated favorable change (77%).

Community Trauma Services for Adults (Trauma Services): Three community-based organizations provided services to 345 adults who were referred for screening due to trauma history and traumatic stress symptoms. A total of 163 clients received therapy or rehabilitation services, with an average of 11 hours of service per client. Providers used the Los Angeles Symptom Checklist (LASC) as screening tool at intake and periodically during therapeutic services to evaluate ongoing progress. Preliminary evaluation found indications of improvements in symptomology.

Outreach for Increasing Early Recognition of Mental Illness & Stigma and Discrimination Reduction Projects

NAMI's Outreach for Increasing Recognition of Early Signs of Mental Illness program: During the 2022/23 fiscal year, San Joaquin County's chapter of National Alliance on Mental Illness delivered 15-hour NAMI Provider Education classes during two sessions to 15 behavioral health providers (potential responders). **NAMI's Stigma and Discrimination Reduction Program** provided In Our Own Voices presentations, Family to Family and Peer to Peer trainings to 153 participants. Program surveys found that 83% of participants showed positive change in attitudes, knowledge and/or behaviors related to mental illness and seeking mental health services.

Suicide Prevention

Suicide Prevention Program: During fiscal year 2022/23, the Child Abuse Prevention Council (CAPC) facilitated a Yellow Ribbon Suicide Prevention Campaign in 15 high-risk high schools within the county, reaching 6,460 individuals. The program trained 292 school personnel and 394 youth "gatekeepers," and additionally, provided more intensive SafeTalk training to 221 community members throughout the county. The evaluation found that, on average, 85% of Yellow Ribbon Campaign recipients demonstrated an increase in ability to recognize signs, symptoms and risks of suicide. A similar portion (84%) demonstrated greater knowledge about professional and peer resources available to help people at risk of suicide. Nearly all (96%) of SafeTalk participants were more knowledgeable about how to intervene as a result of their training. The Suicide Prevention project was responsible for 86 referrals for individuals to a higher level of mental health care.

Timely Services for Underserved Populations

Recovery Services for Nonviolent Offenders (LEAD): During fiscal year 2022/23, LEAD worked with 37 non-serious, nonviolent offenders with high rates of homelessness to provide targeted screening and assessment for behavioral health services and supports. On average, each individual received 30 contacts and 62 hours of service over the course of the year.

Access and Linkage to Treatment

Whole Person Care: The Whole Person Care project provided case management to 83 individuals who are high utilizers of health care services and at high risk for untreated mental illness. On average, individuals received 25 service contacts and 56 hours of service.

Access and Linkage to Treatment Strategy

All Prevention and Early Intervention Programs were required to implement an *Access and Linkage to Treatment Strategy*[3]. The following table provides a summary of fiscal year 2022/23 referrals made by PEI programs to mental health treatment, to County mental health providers in particular, and known linkages to treatment, as defined by having engaged in at least one service within sixty days. In total, there were 421 known referrals to mental health treatment, 310 of which were to SJCBHS administered programs, allowing them to be tracked. Records documented 109 (35%) known linkages to treatment within 60 days of referral.

	Referrals		Linkage	Percent
	To MH treatment	To County MH treatment	To County MH treatment	
Skill-Building for Parents and Guardians	34	27	1	3.7%
Mentoring for Transitional Age Youth (TAY)	178	150	25	16.7%
Coping and Resilience Education Services (CARES)	22	22	13	59.1%
School Based Interventions	2	2	1	50%
Early Intervention to Treat Psychosis (TEIR)	5	4	4	100%
Community Trauma Services for Adults	63	61	48	78.7%
Suicide Prevention Project	86	13	8	61.5%
LEAD - Recovery Services for Nonviolent Offenders	10	10	3	30%
Whole Person Care	21	21	6	28.6%
Totals	**421**	**310**	**109**	**35.2%**

[3] "Access and Linkage to Treatment" means connecting children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs

Timely Services to Underserved Populations

All Prevention and Early Intervention Programs were required to implement a strategy to *Improve Timely Services to Underserved Populations*[4]. Approved claims penetration rates indicate that in San Joaquin County Asian and Hispanic/Latino individuals have lower engagement with County-administered services than the overall County population. For this reason, SJBHS identified these two populations as the focus of the strategy for timely access to services.

State PEI regulations ask counties to report the number of referrals made to underserved populations, including referrals for mental health services and other PEI programs. Altogether, programs made 616 referrals to mental health treatment or other PEI programs. Just over half (52%, n=321) were for Hispanic individuals. Eleven percent (11%, n=69) of referral recipients identified as Asian.

Methods

Each PEI program is expected to keep records of the numbers of individuals served through the various components of programming and to document that information quarterly. In some cases, clinical records and billing information were also used to compile the output figures in this report.

In 2021, SJCBHS designed an application ("PEI App") to standardize and streamline data collection regarding demographic surveys and referrals made to mental health services or other PEI programs. This year marked the second full year using that PEI application to create this report.

Demographic and referral summaries were compiled from demographic surveys and referral information that programs submitted via the PEI App. Client IDs (or names and birthdates) were used to match referrals to billed services. Any billed mental health service that transpired within sixty days of referral date was considered a linkage to service[5].

Following state and federal privacy laws, efforts have been made to exclude personally identifiable information. A supplemental file that contains all required data, including that which was excluded from this narrative report, will be submitted to the state under separate cover.

All projects identified as Prevention and/or Early Intervention include an outcome evaluation. Methodologies used to measure outcomes are described within the individual project sections of the report.

[4] "Improving Timely Access to Services for Underserved Populations" means to increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.

[5] This process of matching provider data to county mental health records could undercount linkages due to discrepancies in how client identifiers were recorded.

Prevention

Skill Building for Parents and Guardians

Project Description

Community-based organizations offer evidence-based parenting classes throughout San Joaquin County with the goal of reducing risk factors for mental illness and increasing protective factors associated with social connectedness, parent and family resilience, and knowledge of child development.

In FY 2022/23, the Skill Building for Parents and Guardian Project was delivered by three community-based providers:

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

Project Outputs

In the 2022/23 fiscal year, the Skill Building project served a total of 1,617 parents and guardians. The following table shows that 835 (52%) graduated. Participants attended an average of 5.1 sessions.

Skill-Building for Parents and Guardians				
Outputs FY 2022/23				
	CAPC-PC	CC-NPP	PBC - Triple P	Total Skill-building
Unduplicated parent/guardian participants	771	370	476	1,617
Parent/guardian participation counts (duplicated)	3,609	2,107	2,501	8,217
Number of unduplicated individuals who completed/graduated*	285	178	372	835
Percent who completed/graduated	37%	48%	78%	52%
Total number of groups delivered	44	22	64	130
Total number of sessions delivered	530	239	387	1,156
Average number of participants per group (group size)	17.5	16.8	7.4	12.4
Average number of sessions delivered per group (dosage offered)	12.0	10.9	6.0	8.9
Average number of sessions attended per participant (dosage received)	4.7	5.7	5.3	5.1

*Graduation definitions: For CC-NPP defined as completing at least 7 of the 10 course topics; For PBC defined as attending 80% of Triple P classes and completing Assessment Tool and a Client Satisfaction Survey; for CAPC defined as attending 50% or more of the 15 Parent Café sessions.

Demographics

Demographic forms were collected upon intake or initiation of services. Based on the information provided in the demographic forms collected[6] (n=1,562), the program population can broadly be described as adults between the ages of 26 and 59 (92%), and predominantly women (83%) . A majority (70%) who answered questions about their ethnic background identified themselves as Mexican/Mexican-American. Ten percent (10%) identified themselves as Black or African American.

Demographic tables from 2022/23 are included in the appendix to this report.

[6] This narrative description is based on the number of participants who provided a response to each demographic category. Between 15% and 43% of participants declined to answer any given demographic question.

Participant Outcomes

Each of the three Skill Building for Parents and Guardians programs followed a different evidence-based curriculum and implemented an applicable validated instrument to measure progress towards intended outcomes[7].

Parent Cafés (Child Abuse Prevention Council)

Participants in CAPC Parent Cafés completed a Protective Factors survey during their first and last session of the program. The table below shows that they were able to survey 285 participants during the year. Highest gains were demonstrated in *parental resiliency* (96% showed improvement). Overall, 92% of participants showed improvement over the course of their engagement in the program.

Skill-Building for Parents and Guardians *Program: Parent Cafés (Child Abuse Prevention Council)*		
Outcomes FY 2022/23		
Instrument: Protective Factors Survey Frequency of administration: First and last session		
Unduplicated individuals served	771	
Number of graduates	285	37%
Number of graduates w/ matched pre/post	285	100%
Number who showed improvement in:		
Knowledge of parenting skills	271	95%
Access to support	265	93%
Parental resiliency	273	96%
Social connections	260	91%
Parent/child relationships	244	86%
Total participants who showed improvement*	**263**	**92%**

* Based on average number who showed improvement in each domain

[7] Each parenting program has selected a validated instrument specific to their own curricula; they are not used for comparing program outcomes across the project.

Nurturing Parenting Program (Catholic Charities)

Participants in Catholic Charities Nurturing Parenting Program completed the Adult Adolescent Parenting Inventory (AAPI) during their first and last session of the program. The table below shows that the program was able to collect matched inventories from 177 participants during the year. Highest gains were demonstrated in *beliefs in corporeal punishment*, showing improvement among 90% of participants. On average, 74% of participants showed improvement over the course of their engagement in the program.

Skill-Building for Parents and Guardians *Program: Nurturing Parenting Program (Catholic Charities)'*		
Outcomes FY 2022/23		
Instrument: Adult Adolescent Parenting Inventory (AAPI) Administered first and last session		
Unduplicated individuals served	370	
Number of graduates	178	48%
Number of graduates w/ matched pre/post	177	99%
Number who showed improvement in:		
Inappropriate expectations	126	71%
Low level of empathy	127	72%
Belief in corporeal punishment	159	90%
Reverse family roles	115	65%
Restricts power and independence	132	75%
Total participants who showed improvement*	**132**	**74%**

* Based on average number who showed improvement in each domain

Positive Parenting Program (Parents by Choice)

The Positive Parenting Program included three components: Triple P (general parenting classes), Parents of Teens, and Family Transitions (co-parenting). Each class used a different tool to measure progress towards outcomes. The largest class was Triple P, with 288 graduates. Eighty percent (80%) of Triple P participants showed improvement. Parents of Teens saw 74% of participants improve. The Family Transitions class saw four of the six participants make improvement (67%).

Skill-Building for Parents and Guardians *Program: Positive Parenting Program (Parents by Choice)*		
Outcomes FY 2022/23		
Unduplicated individuals served	476	
Number of graduates	372	83%
Triple P Regular Graduates w/ matched pre/post	288	
Triple P for Parents of Teens Graduates w/ matched pre/post	78	
Family Transitions Graduates w/ matched pre/post	6	
	Showed improvement	
Regular Triple P classes: Parenting Tasks Checklist (PTC) & Parenting Scale (PS)		
Setting self-efficacy (PTC)	238	83%
Behavioral self-efficacy (PTC)	227	79%
Laxness and Overreactivity (PS)	230	80%
Total*	**232**	**80%**
Parents of Teen classes: Conflict Behavior Questionnaire (CBQ) & Parenting Scale (PS)		
Conflict behavior (CBQ)	56	72%
Laxness and Overreactivity (PS)	59	76%
Total*	**58**	**74%**
Family Transitions: Acrimony Scale & Depression Anxiety Stress Scale (DASS)		
Acrimony Scale	4	67%
DASS (Depression, Anxiety, Stress) Scale	4	67%
Total*	**4**	**67%**
Total participants for all programs who showed overall improvement*	**293**	**79%**

* Based on average number who showed improvement in each domain

Cost/Benefit Analysis

The following table shows several key indicators of performance for the Skill Building Project as a whole, including costs of the project (based on county expenditure reports); cost per participant; cost per graduate; and cost per individual who showed reduced risk factors and/or increased protective factors.

The programs cost $470 per individual served, $910 per graduate, and $1,105 per graduate who demonstrated improvement in parenting skills.

Skill-Building for Parents and Guardians	
Expenditure/Benefit FY 2022/23	
	Total
Program expenditures	*$760,264*
Unduplicated individuals served	1,617
Expenditure per individual served	*$470*
Number who graduated	835
Expenditure per graduate	*$910*
Number who showed improvement*	688
Expenditure per individual who showed improvement	*$1,105*

*As defined under Participant Outcomes

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the Skill Building for Parents and Guardians program during the 2022/23 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made 34 referrals to mental health treatment. Of the 34, 27 of the referrals were for treatment provided, funded, administered, or overseen by County mental health programs. The average duration of untreated mental illness was 11.3 months.
- Of the 27 County-referred individuals, one (4%) was known to have engaged in treatment, defined as attending at least one service within 60 days.
- The interval between referral and service was 44 days.

Skill-Building for Parents and Guardians				
Access and Linkage to Treatment Strategy FY 2022/23				
	CAPC-PC	CC-NPP	PBC - Triple P	Total Project
Referrals to MH treatment				
Individuals referred	0	26	8	34
Duration of untreated mental illness (months)				

Average	-	10.7	18	11.3
Standard deviation	-	7.9	8.5	8.0
# of cases with duration data	-	21	2	23
Linkages to county administered MH treatment				
Individuals referred to county MH treatment	0	19	8	27
# Engaged*	0	1	0	1
% Engaged	-	5%	0%	4%
Calendar days between referral and service				
Average	-	44	-	44
Standard deviation	-	-	-	-

*Engaged in a service within 60 days after referral
n/a= data not available

Timely Access to Services for Underserved Populations Strategy

Approved claims penetration rates indicate that in San Joaquin County Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with County-administered services than the overall County population. For this reason, SJBHS identified these two populations as the focus of the strategy for timely access to services.

The following is a summary of referrals to mental health treatment and PEI programs for these two underserved populations during the 2022/23 fiscal year.

- During the 2022/23 fiscal year, Skill Building for Parents and Guardians referred 46 **Hispanic/Latino** individuals to mental health treatment or another PEI program; this represents 65% of all Skill Building for Parents and Guardians referrals.
- One **Asian and Pacific Islander** individual was referred to mental health treatment or another PEI program (representing 1% of all Skill Building for Parents and Guardians referrals).

More detailed referral and linkage data for underserved populations are included in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Skill Building for Parents and Guardians Project encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations. Here are other examples from the providers[8]:

- Catholic Charities Nurturing Parenting Program: *"Catholic Charities' Parent Support Program continuously offers referral services during class time, especially when sensitive*

[8] Quotations edited for clarity and concision

topics are part of the lesson. Class instructors remind participants about the individual/family referral services at various times and during outreach events."

- CAPC Parent Café encourages access to services by inviting service providers to groups to discuss their services and eligibility requirements. CAPC shared an example of encouraging access in their referrals to the BHS CARES program on behalf of parents who learned about CARES services from their group facilitator. The facilitator emailed the referrals directly to BHS CARES staff for review and follow-up.
- Parents by Choice Triple P: "*Our Family Coaches make sure to present resources and encourage parents to take advantage of these resources during each group."*

Mentoring for Transitional Age Youth

Project Description

Community-based organizations provide intensive mentoring and support to transitional age youth (16-25) with emotional and behavioral difficulties who do not meet the criteria for specialty mental health care. The project targets very high-risk youth to reduce the possibility of youth developing serious and persistent mental illnesses which are associated with adverse childhood experiences, severe trauma or ongoing stress, family or domestic violence, and/or self-harm or suicidal thoughts.

TAY Mentoring uses the evidence-supported Transition to Independence (TIP) service model. Services focus on the five domains that TIP is designed to impact:

1. Employment and Career
2. Educational Opportunities
3. Living Situation
4. Personal Effectiveness and Wellbeing
5. Community Life Functioning

In FY 2022/23, the Mentoring for Transitional Age Youth (TAY Mentoring) Project was delivered by two community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC)
- PREVAIL (Pioneering Restoration and Elevating Voices of Advocacy, Idealism and Leadership)[9]

[9] Previously named Women's Center Youth and Family Services of San Joaquin County

Project Outputs

In FY 2022/23, the TAY Mentoring Project served a total of 602 individuals. The following table shows the number of youths directly served and the number of individual service sessions delivered by each provider. The table also includes TIP model fidelity scores. The Organizational Survey fidelity scores, rated by program managers, are a composite of 9 items related to staffing, services, supervision and other system-level items, and the TIP Practice Probes are a composite of the scores of three interview questions posed to program staff related to their knowledge and practices.

Mentoring for Transitional Age Youth			
Outputs FY 2022/23			
	CAPC	PREVAIL	Total Tay
Unduplicated individuals served	375	227	602
Unduplicated individuals enrolled during fiscal year	302	188	490
Number of individuals who exited program	285	145	430
Number of individuals who graduated*	192	126	318
Percent who graduated	67%	87%	74%
Number of sessions delivered	1,348	1,384	2,732
Average number of sessions delivered per individual	3.6	6.1	4.5
Organizational Survey fidelity scores (average)	N/A	94%	N/A
TIP Practice Probes fidelity scores (average)	84%	95%	89%

*Graduated=completed at least one self-identified goal

Demographics

Demographic forms were collected upon intake or initiation of services. Based on the information provided in the demographic forms collected[10] (n=483), the program population can broadly be described as young adults between the ages of 16 and 25, with 59% identifying as female, 37% male, and 4% identifying as transgender, non-binary or another gender identity. TAY participants are racially and ethnically diverse; twenty-nine percent (29%) identified themselves as Black or African-American, and 44% who answered questions about their ethnic background identified themselves as Mexican/Mexican-American. Nearly one in four (23%) indicated they were homeless.

Demographic tables from 2022/23 are included in the appendix to this report.

Participant Outcomes

The TAY program measured impacts by evaluating progress in three outcome areas: graduation rates, progress toward self-identified goals (measured by TIP Tracker), and reduction in risk (as

[10] This narrative description is based on the number of participants who provided a response to each demographic category. Up to 9% of demographic survey participants declined to answer any given demographic question.

measured by assessing needs and strengths using an abbreviated CANSA). The outcome analysis is presented separately for each of the two providers.

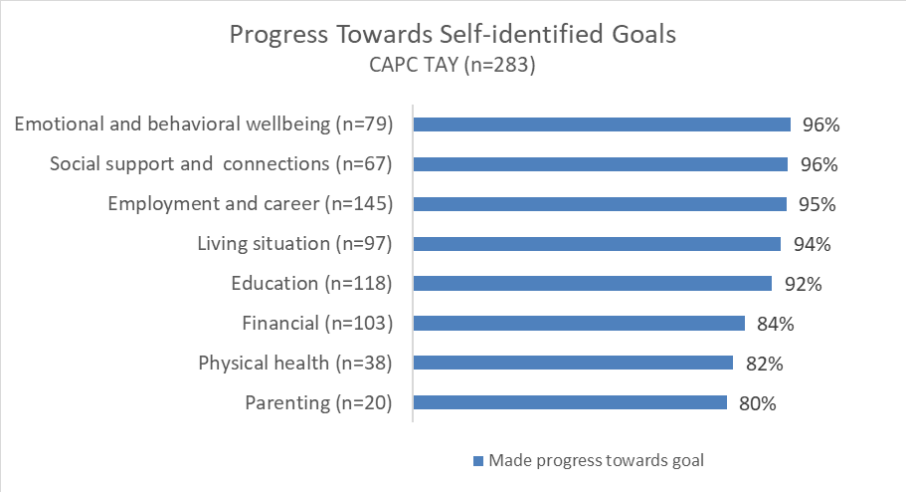
CAPC

Graduation from this program was defined as participants having completed at least one of their self-identified program goals. Altogether, 67% of CAPC TAY participants served in FY2022/23 graduated (completed their goals).

Progress towards self-identified goals

The TIP Tracker rated each participant at discharge on progress towards or the completion of their self-identified goals in up to 8 categories. TAY participants at CAPC demonstrated a high success rate across all areas. They were most successful in the areas of emotional/behavioral wellbeing and education, with 96% of participants who targeted those areas making progress. Participants targeting parenting and physical health had the lowest rate of success, though still a solid majority showed favorable outcomes with 80% and 82% of participants making progress, respectively.

The TIP category of employment and career was the most commonly targeted goal area (as indicated by the total number of participants who identified goals in that category, n=145).



Note: the sample size noted with each set of bars denotes the number of participants who identified a goal in that category.

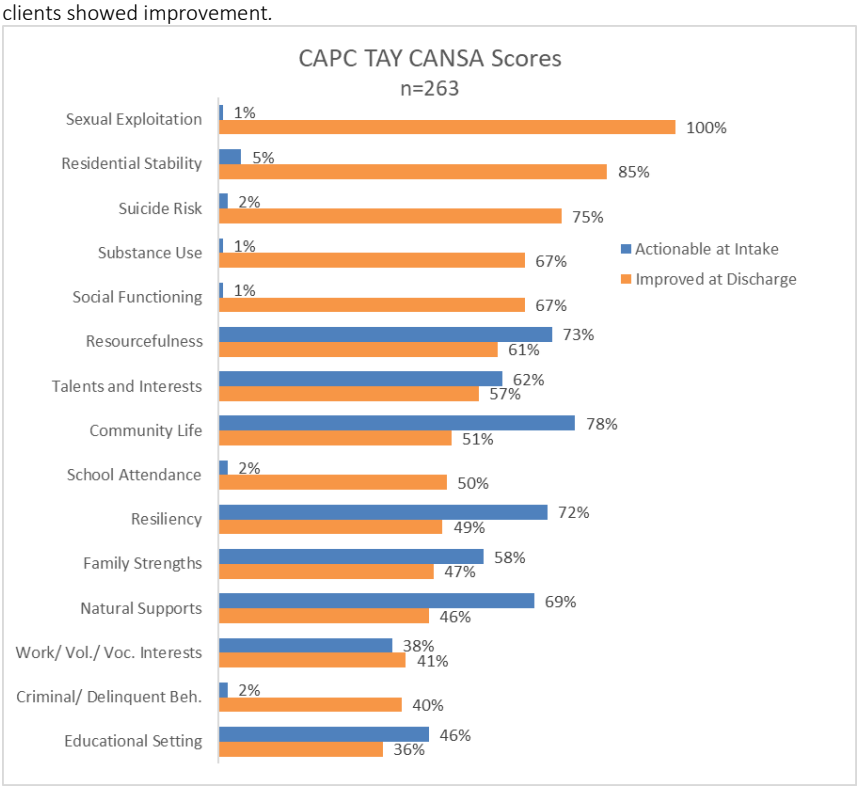
Reduced risk

The third outcome area involves changes in participant needs and strengths, measured with an abbreviated CANSA tool comprised of 15 items that program managers felt could be addressed through the TIP model. At intake and at discharge, participants were scored on these 15 areas.

The figure below shows two measures that are essential to evaluate together when reviewing TAY Outcomes.

- Actionable Needs. CANSA scores range from 0 to 3, with protocol designating a score of a 2 or a 3 as a need in that designated area. This part of the graphic tells us what portion of the clients presented with which needs at intake.
- Improved. For any client with an actionable need, a discharge score that is lower than the intake score is considered an improvement. For example, an intake score of 3, followed by a discharge score of 2, would be considered *improved.*

CAPC saw the highest rates of improvement (orange bars) among clients who demonstrated needs in the areas of *sexual exploitation* and *residential stability*, however neither of these were domains that were particularly common among CAPC clients (blue bars). The most prevalent need area among CAPC TAY clients involved *Community Life;* half (51%) of these clients showed improvement. Another prevalent issue for CAPC Tay clients was *resourcefulness,* where 61% of clients showed improvement.



Calculations were based on participants with complete data for both pre and post assessments (n=263)
* Work calculations were based on a smaller subset based on item relevance (n=107)
**School calculations were based on a smaller subset based on item relevance (n=171)

Improvement was also significant in the areas of sexual exploitation, residential stability, and suicide risk, though a much smaller number of clients presented with these kinds of needs.

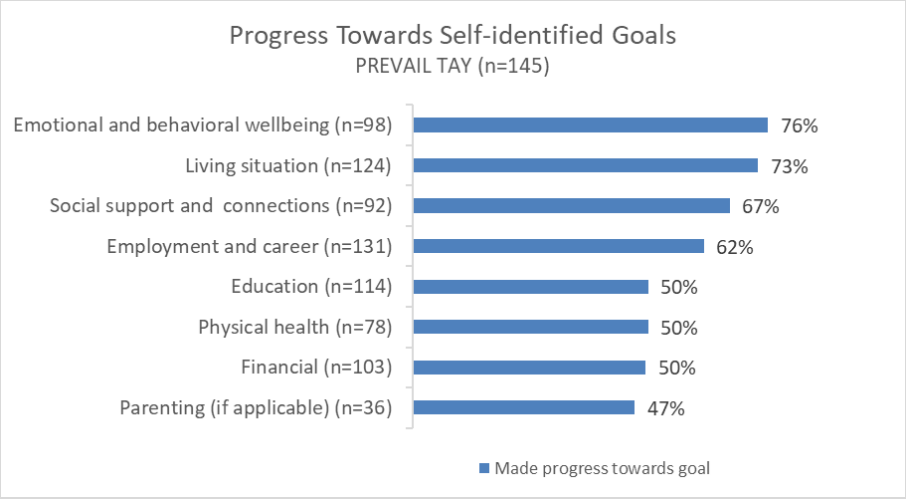
PREVAIL

Graduation from this program was defined as participants having completed at least one of their self-identified program goals. Altogether, 87% of Prevail TAY participants served in FY2022/23 graduated (completed their goals).

Progress towards self-identified goals

The TIP Tracker rated each participant at discharge on progress towards or the completion of their self-identified goals in up to 8 categories. TAY participants at Prevail were most successful in targeting the area of emotional and behavioral wellbeing, with 76% making progress. Another area of success included living situation 73% of participants made progress. The categories that proved most challenging were parenting, financial, and physical health, where roughly half of the graduating participants documented progress.

The TIP category of employment was the most common targeted goal area (as indicated by the total number of participants that identified goals in that category, n=131).



Note: the sample size noted with each set of bars denotes the number of participants who identified a goal in that category.

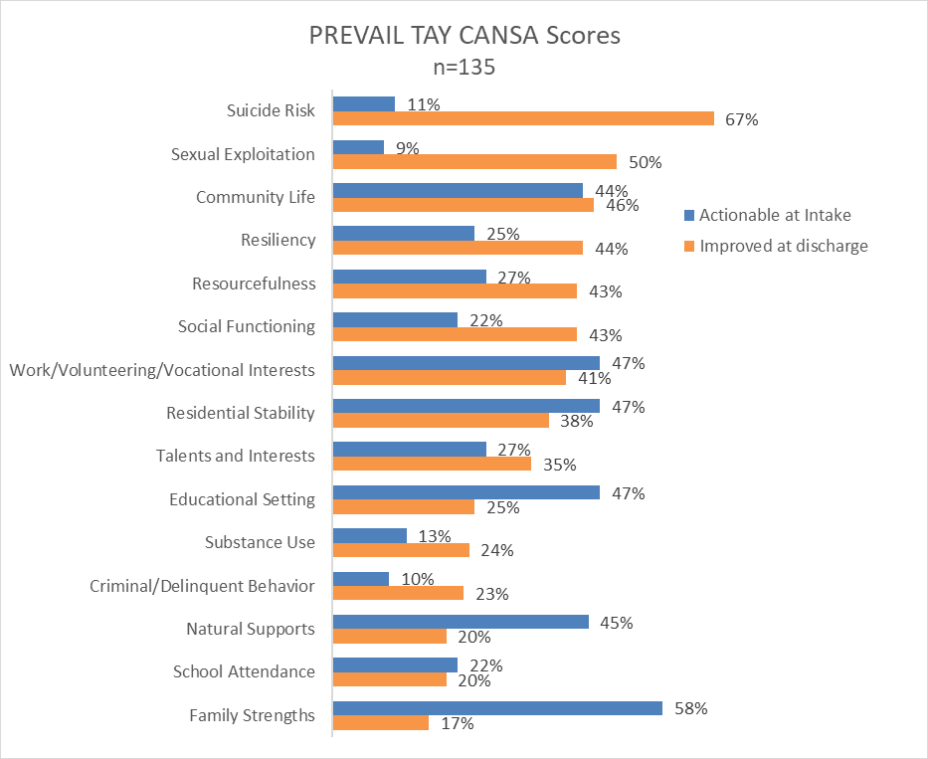
Reduced risk

The third outcome area involves changes in participant needs and strengths, measured with an abbreviated CANSA tool comprised of 15 items that program managers felt could be addressed through the TIP model. At intake and at discharge, participants were scored on these 15 areas.

The figure below shows two measures that are essential to evaluate together when reviewing TAY Outcomes.

- Actionable Needs. CANSA scores range from 0 to 3, with protocol designating a score of a 2 or a 3 as a need in that designated area. This part of the graphic tells us what portion of the clients presented with which needs at intake.
- Improved. For any client with an actionable need (a score of 2 or 3 at intake), a discharge score that is lower than the intake score is considered an improvement. For example, an intake score of 3, followed by a discharge score of 2, would be considered *improved.*

Prevail saw the highest rates of improvement (orange bars) among clients who demonstrated needs in the areas of suicide risk and sexual exploitation, however neither of these were domains that were particularly common among Prevail clients (blue bars). The most prevalent issues faced by Prevail participants involved *family strengths*, followed by *work and vocational interests, residential stability, and educational setting*.



Calculations were based on participants with complete data for both pre and post assessments (n=135)
* Work calculations were based on a smaller subset based on item relevance (n=94)
**School calculations were based on a smaller subset based on item relevance (n=23)

Cost/Benefit Analysis

The following table shows several key indicators of performance for the TAY project as a whole, including costs of the project (based on county expenditure reports) as well as the cost per participant and cost per graduate.

The project cost $1,139 per individual served and $2,156 per graduate.

Mentoring for Transitional Age Youth	
Expenditure/Benefit FY 2022/23	
	Total TAY
Program Expenditures	*$685,711*
Unduplicated individuals served	602
Expenditures per individual served	*$1,139*
Number who graduated	318
Expenditures per graduate	*$2,156*

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the TAY Mentoring Project during the 2022/23 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for 178 participants to mental health treatment, 150 of which were for treatment provided, funded, administered, or overseen by County mental health programs.
- The average duration of untreated mental illness was 23.6 months.
- Of the 150 County-referred individuals, 25 (17%) were known to have engaged in treatment within 60 days, with an average interval of 14 days between referral and treatment.

Mentoring for Transitional Age Youth			
Access and Linkage to Treatment Strategy FY 2022/23			
	CAPC	PREVAIL	Total TAY
Referrals to MH treatment			
Individuals referred	62	116	178
Duration of untreated mental illness (months)			
Average	6.5	45.2	23.6
Standard deviation	9	67.2	48.7
(Count of cases with duration data, used to calculate average and SD)	33	26	59
Linkages to county administered MH treatment			

Individuals referred to county MH treatment	61	89	150
# Engaged*	8	17	25
% Engaged	13%	19%	17%
Calendar days between referral and service			
Average	10	16	14
Standard deviation	11.2	14.6	13.7

*Engaged in a service within 60 days after referral

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2022/23 referrals to Mental Health Treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[11]. Summary tables are included in the supplemental file.

- Forty-three percent (48%) of referrals were made on behalf of **Latino/Hispanic** individuals.
- Ten percent (10%) of referrals were made on behalf of **Asian/Pacific Islander** individuals.

More detailed referral and linkage data for underserved populations are included in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the TAY program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations. Here are two other examples from the providers:

- CAPC: *"Once referrals to other providers are made, staff keep detailed notes in client records to reflect whether the resource has been accessed, and continue to encourage clients to follow up during their weekly interactions."*
- Prevail: *"Processes have been developed with outside agencies to assist client with referrals to parenting, housing. others. Staff have access to the CAL Benefits portal to assist clients in completing applications for government financial, food stamps and Medi-Cal assistance. Staff engage with clients weekly to follow up and make additional referrals as needed."*

[11] Approved claims penetration rates indicate that in San Joaquin County, Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

Coping and Resilience Education Services (CARES)

Project Description

CYS's CARES project serves children and youth (ages 5-18), and their caregivers, who are at risk for CPS involvement, exposed to trauma, or other risk factors , but who do not meet medical necessity for specialty mental health services. Children and youth are screened for trauma-related symptoms and receive a 12- session evidence-informed intervention to address previous traumas and sustain them though difficult situations. Families receive trauma-informed training using the Parents Reach Achieve and Excel through Empowerment Strategies (PRAXES) curriculum. Children participate in the Child Intensive Model or the Youth Intensive Model. Staff provide one-on-one and group support.

Project Outputs

In the 2022/23 fiscal year, the CARES project served a total of 399 individuals—239 children and 160 parents/caregivers. The following table shows the number of individuals who attended an outreach event related to CARES, number who participated in and then completed the children and youth (CIM/YIM) and parents/caregiver (PRAXES) curriculums.

Coping and Resilience Education Services (CARES)	
Outputs FY 2022/23	
Number of individuals who attended an outreach event	2,003
Number of children/youth referred to program	419
Number of children served in the program	239
Number of caregivers served in the program	160
Unduplicated number of participants*	**399**
Number of adults who completed PRAXES curriculum	45
Number of children who completed CIM/YIM curriculum	108
Total number of individuals who completed (graduated) from program**	**153**

*Includes rollovers from previous fiscal year

**Not all individuals were expected to graduate within the fiscal year; individuals who began participation later in the year may graduate during the subsequent fiscal year

Demographics

Demographic forms were collected upon intake or initiation of services. Based on the information provided in the demographic forms collected[12] (n=358), the program population primarily consists of youth under 16 (53%), young adults aged 16-25 (10%), and adults (35)%. Seventy-one percent (71%) of the adults identified themselves as female. Nearly two-thirds (63%) who

[12] Up to 20% of participants declined to answer any given demographic question.

answered questions about their ethnic background identified themselves as Mexican/Mexican-American.

Demographic tables from 2022/23 are included in the appendix to this report.

Participant Outcomes

CARES used the Pediatric Symptom Checklist to measure youth risk. Of the 239 youth served, there were 123 matched pre- and post-screenings. Eighty-eight percent (88%) showed a reduction in symptoms.

Coping and Resilience Education Services (CARES)		
Outcomes FY 2022/23		
Instrument: Pediatric Symptom Checklist Administered at program initiation and completion		
Number of child participants	239	
Number of matched pre and post tests*	123	
	Score	% showing reduced symptoms
Number of individuals showing reduction in symptoms (lower score post test)	108	88%
Average pre score	26.5	
Average post score	17.6	
Average Difference	13.3	
Standard Deviation of Difference	8.7	

*Includes only participants who closed between July 1, 2022 and June 30, 2023 and who had matched pre and post scores

The CARES program used the Parental Stress Index with caregivers at intake and discharge[13]. The index has four sub-domains: Defensive Responding (DR), Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC). All (100%) of the 23 matched pre- and post-tests demonstrated a reduction in stress in the total stress score.

Coping and Resilience Education Services (CARES)						
Outcomes FY 2022/23						
Instrument: Parental Stress Index Administered at program initiation and completion						
Number who completed curriculum 24 Number of matched pre and post tests* 23						
	DR	PD	P-CDI	DC	Total Stress	% showing reduced stress
Number showing reduction in stress (lower score post test)	21	22	21	20	23	100%
Average Pre Score	27.6	35.9	37.5	31.6	110.7	
Average Post Score	23.8	29.7	29.4	26.0	90.5	
Average difference	3.7	6.1	8.1	5.6	20.2	
Standard Deviation of Difference	6.3	4.3	6.3	6.0	9.3	

*Includes caregivers and parents who closed between July 1, 2022 and March 30, 2023 and who had matched pre and post scores

Cost/Benefit Analysis

The following table shows key indicators of performance for the CARES program (based on county expenditure reports), including costs of the project, cost per participant, and cost per individual who showed improved outcomes.

The programs cost $2,041 per individual served and $ 2,268 per participant who demonstrated improvement.

Coping and Resilience Education Services (CARES)	
Expenditure/Benefit FY 2022/23	
Program Expenditures	*$814,355*
Unduplicated individuals served	399
Expenditures per individual served	*$2,041*
Percent who showed improvement*	90%
*Expenditure per individual who showed improvement**	*$2,268*

[13] The CARES program introduced the Pediatric Symptom Checklist for Adults PSC(A) in 2023 and phased out the Parental Stress Index. Results from the PSC(A) will be presented as a part of the three-year report covering programs in FY21/22, FY22/23, FY23/24

*As defined under Participant Outcomes and extrapolated from existing sample of participants with matching pre and post scores

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the CARES program during the 2022/23 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for 22 individuals, all of which were mental health referrals for treatment provided, funded, administered, or overseen by County mental health programs.
- The average duration of untreated mental illness was 3.3 months.
- Of the 22 County-referred individuals, 13 (59%) were known to have engaged in treatment within sixty days. Among these individuals who linked to service, the average duration between referral and service was 11 days.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2022/23 referrals to mental health treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[14].

- Thirty-six percent (36%) of referrals were made on behalf of **Latino/Hispanic** individuals.
- Twelve percent (12%) of referrals were made on behalf of **Asian and Pacific Islander** individuals.

More detailed referral and linkage data for underserved populations are included in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Cares program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

[14] Approved claims penetration rates indicate that in San Joaquin County Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

School Based Intervention for Children and Youth

Project Description

School Based Interventions provide brief mental health counseling, including group and individual skill building and rehabilitative prevention services, for children and youth who have been impacted by adverse childhood experiences, have social-emotional or behavioral issues, and/or are at risk of severe emotional disturbance. The project focuses on a team concept, partnering school personnel with clinical staff in the classroom.

In FY 2022/23, the School Based Interventions Project was delivered by three community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC)
- Parents By Choice (PBC)
- Sow A Seed Community Foundation (SAS)

Project Outputs

In the 2022/23 fiscal year, the School Based Interventions project served a total of 578 students.

School Based Interventions				
Outputs FY 2022/23				
	CAPC	PBC	SAS	Total
Referrals received	239	282	150	671
Enrolled in services	229	210	139	578
Number of students graduated*	208	202	116	526
Percent of students graduated*	91%	96%	83%	91%
Individual services provided (hours)	5,593	6,042	3,583	15,217
Average hours per individual	24	29	26	26
Training				
Number of parent/caregiver trainings/presentations	9	3	2	14
Number of school personnel trainings/presentations	105	6	19	130

*Graduated=attended 50% or more of group sessions provided

Demographics

Demographic forms were collected upon intake or initiation of services. Based on the information provided in the demographic forms collected[15](n=601), the largest ethnic group represented was Mexican/Mexican-American (56%). One in five (20%) said that Spanish is their primary language.

Demographic tables from 2022/23 are included in the appendix to this report.

Participant Outcomes

School-based services were intended to result in reduced needs and increased strengths. These outcomes were measured with an abbreviated 8-item CANSA tool administered at intake and discharge. The eight items that were selected for inclusion in the evaluation were the areas of need that program managers felt could be addressed through the program activities.

This analysis of the CANSA includes two measures; it is helpful to evaluate these two measures together when reviewing outcomes.

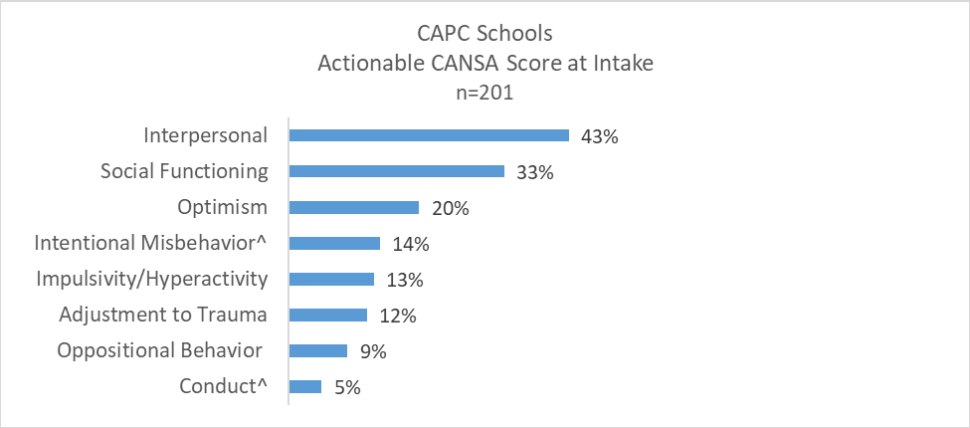
- Actionable Needs. CANSA scores range from 0 to 3; a score of a 2 or a 3 indicates a need in that designated area.
- Improved. For any client with an actionable need, a discharge score that is lower than the intake score is considered an improvement. For example, an intake score of 3, followed by a discharge score of 2, would be considered *improved.*

For the purposes of this interim evaluation update, the detailed CANSA findings are presented separately for CAPC and Parents by Choice[16].

[15] Up to 9% of participants declined to answer any given demographic question.
[16] The Sow A Seed analysis was based on a sample of students that was too small for meaningful summary. The findings were shared directly with Sow A Seed. It is expected that all three providers will be included in the full evaluation presented as a part of the three-year report covering programs in FY21/22, FY22/23, FY23/24

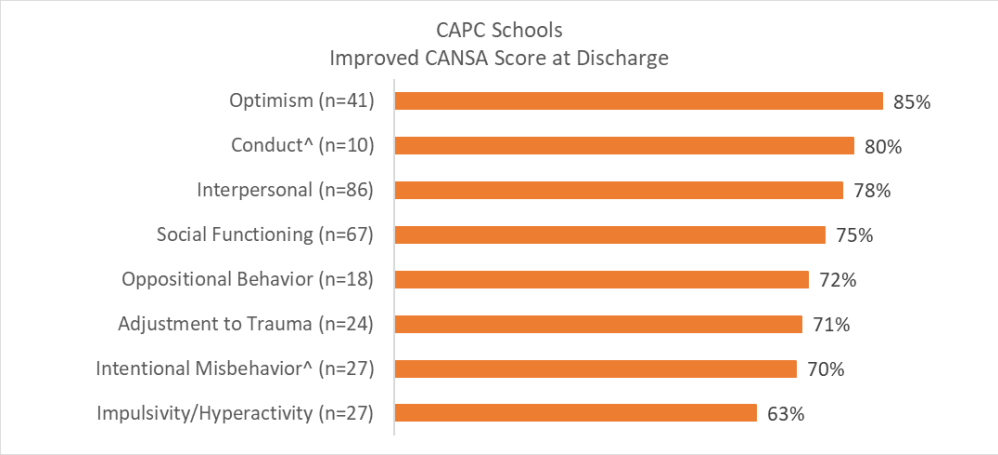
CAPC

CAPC collected 201 matched intake and discharge CANSA assessments. In the figure below, the blue bars show what portion of students had actionable needs at intake. The most prevalent needs included Interpersonal (43%) and Social Functioning (33%).



^ Conduct and Intentional misbehavior were included only for students aged 6+ (n=198)

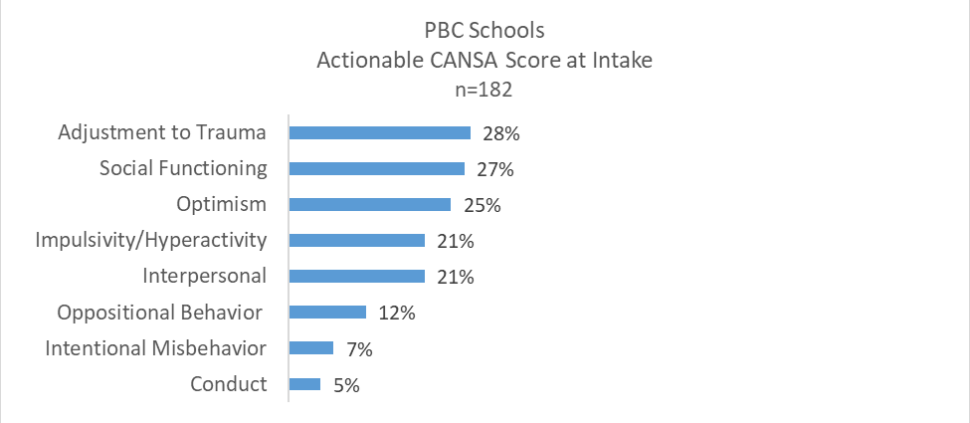
The figure below shows the rate of improvement for those students showing actionable need. Domains with the highest rate of improvement include optimism (85%), Conduct (80%) and Interpersonal (78%). The domain presenting the biggest challenge appears to be Impulsivity/Hyperactivity, where 63% of students saw improvement (among the 27 students where this need was actionable).



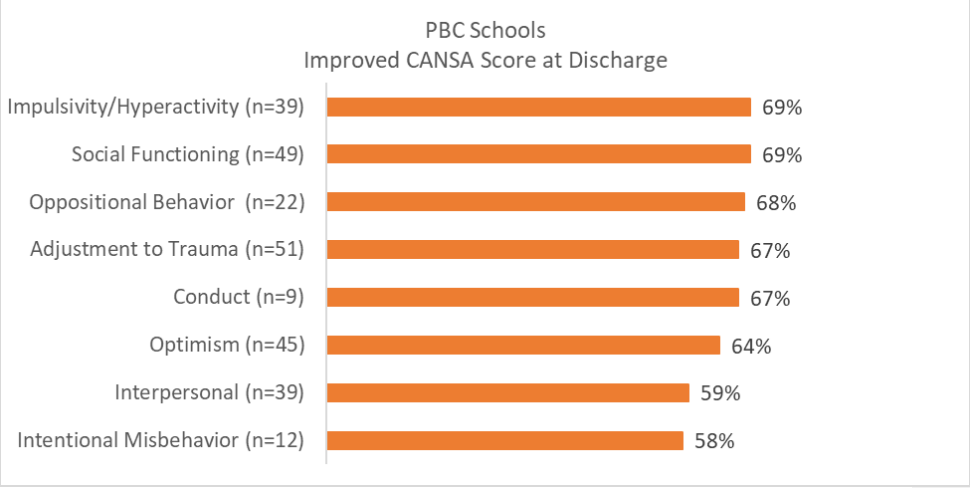
^ Conduct and Intentional misbehavior were included only for students aged 6+ (n=198)

Parents by Choice

Parents by Choice collected 182 matched intake and discharge CANSA assessments. In the figure below, the blue bars show what portion of students had actionable needs at intake. The most prevalent needs included Adjustment to Trauma (28%), Social Functioning (27%), and Optimism (25%).



The figure below shows the rate of improvement for those students showing actionable need. At the higher end, PBC saw improvement in students who had actionable needs in Impulsivity and in Social Functioning (both 69% improved). The domain presenting the biggest challenge appears to be Intentional Misbehavior, where 58% of students saw improvement (among the 12 students where this need was actionable).



Cost/Benefit Analysis

The following table shows several key indicators of performance for the School Based Interventions project (based on county expenditure reports), including costs of the project, cost per participant, and cost per individual who graduated.

The programs cost $1,546 per individual served and $1,699 per participant who graduated (participated in at least 50% of groups sessions).

School Based Interventions	
Expenditure/Benefit FY 2022/23	
Program Expenditures	$893,583
Unduplicated individuals served	578
Expenditures per individual served	$1,546
Percent who graduated	526
Expenditures per graduate*	$1,699

*As defined by attending 50% or more group sessions provided

Access and Linkage to Treatment Strategy

The project made mental health treatment referrals for two individuals, both of which were for treatment provided, funded, administered, or overseen by County mental health programs. One of the individuals was known to have engaged in treatment within sixty days of referral.

Detailed data on referrals, including full demographic information, is provided in the supplemental file.

Timely Access to Services for Underserved Populations Strategy

The School Based Intervention project reported no mental health or PEI referrals to either of the populations identified as underserved[17].

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the School Based Interventions Project encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

[17] Approved claims penetration rates indicate that in San Joaquin County Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with County-administered services than the overall County population. For this reason, SJBHS identified these two populations as the focus of the strategy for timely access to services.

Intervention

Early Intervention to Treat Psychosis (TEIR)

Project Description

The Telecare Early Intervention and Recovery Services (TEIR) Project provides an integrated set of promising practices intended to slow the progression of psychosis. The project follows the evidence-based Portland Identification and Early Referral (PIER) model. The project goal is to identify and provide treatment to individuals who have experienced their first psychotic episode in the past two years or who are showing prodromal symptoms of psychosis in order to prevent disability and the onset of the acute stage of illness.

Project Outputs

In FY 2022/23, the TEIR Project provided early intervention services to a total of 77 unduplicated individuals. The following table shows the number of psychosis screenings, the number of screenings that resulted in program eligibility, and the number of individuals and family members who participated in the program. This table also shows that TEIR provided an average of 110 hours of services per client.

Telecare Early Intervention and Recovery Services (TEIR)	
Outputs FY 2022/23	
Number of consumers found eligible for TEIR screening	29
Number of early psychosis screenings completed (SIPS assessment)	16
Number of screenings that resulted in program eligibility	12
Total unduplicated count of individuals receiving early intervention*	77
Number of family members who participated in program*	88
Total numbers of contacts	6,073
Average number of contacts per individual served	79
Total minutes of service	509,669
Average minutes per individual	6,619
Average hours per individual	110

*Includes individuals continuing services from previous fiscal year

Demographics

Demographic forms were collected at the time of screening for eligibility for services. Based on the information provided in the demographic forms collected[18] (n=31), the program population can broadly be described as young adults under the age of 26, with 47% identifying as male, 47% female, and the balance identifying as transgender, non-binary, questioning, or another gender

[18] Up to 84% of participants declined to answer any given demographic question.

identity. TEIR participants are racially and ethnically diverse; 46% identified as Black or African American and 23% identified as Hispanic or Latino.

Demographic tables from 2022/23 are included in the appendix to this report.

Participant Outcomes

The TEIR program tracked progress toward outcomes two ways: program completion rates and Reduction in Prodromal Symptoms.

Program completion rates

TEIR intends to maximize the number of participants who discharge from services having completed program objectives. The table below shows the status for each of the nine (9) clients discharged during the one-year period. A total of seven discharged clients completed program objectives or otherwise transitioned successfully to another program (78%).

Telecare Early Intervention and Recovery Services (TEIR)		
Program completion rates FY 2022/23		
	n	%
Completed program objectives - did not transition to another mental health program	3	33%
Completed program objectives - transitioned to a lower level of care with BHS	2	22%
Completed program objectives - transitioned to a lower level of care with a community-based resource	1	11%
Did not complete program objectives - voluntarily dropped out of program and did not seamlessly transition to another mental health program	1	11%
Did not complete program objectives - discharged to higher level of care (e.g., IMD/Locked)	0	0%
Did not complete program objectives - discharged to jail or prison	0	0%
Moved out of the area, but successfully transitioned to another early intervention program	1	11%
Can't find client/lost to services	1	11%
Realization that client does not meet minimum program requirements (i.e., no psychosis)	0	0%
Total discharges	9	100%

Reduction in Prodromal Symptoms (SIPS/SOPS)

TEIR participants were assessed using the Structured Interview for Psychosis –Risk Syndromes (SIPS)/ Scale for the Assessment of Prodromal Symptoms (SOPS), referred to briefly as SIPS/SOPS. TEIR expects that clients should be assessed as a part of their intake process with the SIPS, and then assessed with the SOPS on a regular basis (every six months) during their program participation. The findings from the ongoing assessment guides therapeutic planning and goals.

The table below shows that there were thirteen (13) clients with a SOPS conducted in 2022/23 who also had intake SIPS on record[19]. A comparison of the most recent SOPS with the intake SIPS found that on average clients received services for 19.3 months and decreased their scores by 5.5 points. Ten out of thirteen clients (77%) saw a change in score to indicate some improvement.

Telecare Early Intervention and Recovery Services (TEIR)					
Outcomes FY 2022/23					
Instrument: Structured Interview for Psychosis –Risk Syndromes (SIPS)/ Scale for the Assessment of Prodromal Symptoms (SOPS)					
Number of Clients with a matched Pre and Post n=13					
	Intake (SIPS)	Most recent Update in FY22/23 (SOPS)	Time Range between SIPS and SOPS (months)	Change in Score	% showing reduced score
Min	4	0	2.3	-13	77%
Max	19	10	45.8	1	
Average	11.4	5.8	19.3	-5.5	
Std. Deviation	4.45	3.16	12.17	4.67	

Cost/Benefit Analysis

The TEIR program cost $19,014 per individual served.

Telecare Early Intervention and Recovery Services (TEIR)	
Expenditure/Benefit FY 2022/23	
Program Expenditures	*$1,464,109*
Unduplicated individuals served	77
Expenditures per individual served	$19,014

[19] This was the first year that TEIR began including SIPS/SOPS as a part of the outcomes evaluation. It is expected that TEIR will have a greater number/more consistent records of assessment scores as a part of the three-year evaluation report covering programs in FY21/22, FY22/23, FY23/24

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the CARES program during the 2022/23 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for five individuals, four of which were mental health referrals for treatment provided, funded, administered, or overseen by County mental health programs.
- Of the four County-referred individuals, one (25%) was known to have engaged in treatment within sixty days. This individual was linked to service one day after the referral.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2022/23 referrals to mental health treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[20].

- Twenty percent (20%) of referrals were made on behalf of **Latino/Hispanic** individuals.
- Twenty percent (20%) of referrals were made on behalf of **Asian and Pacific Islander** individuals.

More detailed referral and linkage data for underserved populations are included in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the TEIR program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

[20] Approved claims penetration rates indicate that in San Joaquin County Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

Community Trauma Services for Adults

Project Description

Community Trauma Services for Adults (Trauma Services) serves adults who have trauma history and traumatic stress symptoms, a population especially vulnerable to the adverse consequences of mental health challenges. The focus is on individuals from low-income communities and communities of color where systemic oppression and social determinants of health have resulted in negative life outcomes. The project goal is to alleviate symptoms, reduce negative outcomes, and improve life functioning for individuals with emerging, mild, or moderate PTSD or related stress disorders.

FY 2022/23 was the first complete year of the Trauma Services Project. It was delivered by three community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC)
- El Concilio
- Vietnamese Voluntary Foundation, Inc. (VIVO)

Project Outputs

In the 2022/23 fiscal year, the Trauma Services project served a total of 345 individuals with some level of service, including initial screening. A total of 163 clients were served with individual therapy and/or rehabilitation services, with an average of 11 hours of service per client. The outputs table below shows the time spent disaggregated by service type.

The providers offer different models of implementation:

- CAPC Trauma Services clients were primarily referred through other CAPC programs, resulting in targeted and appropriate screenings. All 17 of their screened clients received individual therapy, comprising just over half of service minutes.
- El Concilio screened a higher number of individuals (259), many of whom were then referred to other services or a higher level of care, or (presumably) chose not to participate in therapeutic services. Seventy-five (75) of El Concilio clients received individual therapy, and 19 received rehabilitation services. Some (11) received a combination of both.
- VIVO offered services that were tangentially related to the therapeutic mission of the program (e.g. benefits counseling), resulting in fewer therapy minutes per client.
- VIVO kept track of referrals that were given to various services during the fiscal year, aside from the PEI requirements for tracking mental health or other PEI referrals. VIVO made 260 referrals to providers including DMV, SSI, HAS, HEAP, immigration status, primary care and other health related and community services.

Trauma Services				
Outputs FY 2022/23				
	CAPC	El Concilio	VIVO	Total
All services				
Unduplicated count of individuals	17	259	69	345
Total minutes	38,740	152,184	203,473	394,397
Average minutes per individual	2,279	588	2,949	1,143
Average hours per individual	38	10	49	19
Service time disaggregated				
A. Non-therapeutic service time^				
Unduplicated count of individuals	17	258	69	344
Total minutes	17,975	85,668	174,432	278,075
Average hours per individual	18	6	42	13
B. Therapeutic service time				
Unduplicated count of individuals	17	83	63	163
Total minutes	20,765	60,961	26,551	108,277
Average hours per individual	20	12	7	11
Individual Therapy				
Unduplicated count of individuals	17	75	1	93
Total minutes	20,765	60,255	60	81,080
Average hours per individual	20	13	1	15
Rehabilitation service*				
Unduplicated count of individuals	0	19	63	82
Total minutes	0	6,261	28,981	35,242
Average hours per individual	-	5	8	7

^Includes Engagement, Plan Development, Case Management, Evaluation
*Includes Rehabilitation and Rehab Group

Demographics

Demographic forms were collected upon intake or initiation of services. Based on the information provided in the demographic forms collected (n=221), the program population primarily consists of adults aged 26-59 (71%); an additional 21% were 60+, with a small portion of young adults age 16-25 (8%). Trauma Services clients are ethnically and racially diverse. Half of the clients (50%) who answered questions about their ethnic background identified themselves as Mexican/Mexican-American; most of these clients were served by El Concilio. Thirty-percent identified as Asian (30%); most of these clients were served by VIVO. Sixty-nine percent of clients were female (69%); this was higher at CAPC which has a focus on parents of young children.

Demographic tables from FY2022/23 are included in the appendix to this report.

Participant Outcomes

The Trauma Services project used the Los Angeles Symptom Checklist (LASC) to screen incoming clients. The LASC is a self-report measure of posttraumatic stress disorder (PTSD); clients use a five-point scale to evaluate how problematic each symptom is. Scores provide the program with a classification of full or partial PTSD, based on 17 PTSD symptoms that align with the DSM IV diagnosis of PTSD (e.g. nightmares, trouble trusting others, excessive jumpiness). The LASC also provides a global score of distress and adjustment problems based on the full list of 43 symptoms (e.g. difficulty holding a job, problems with authority, depression).

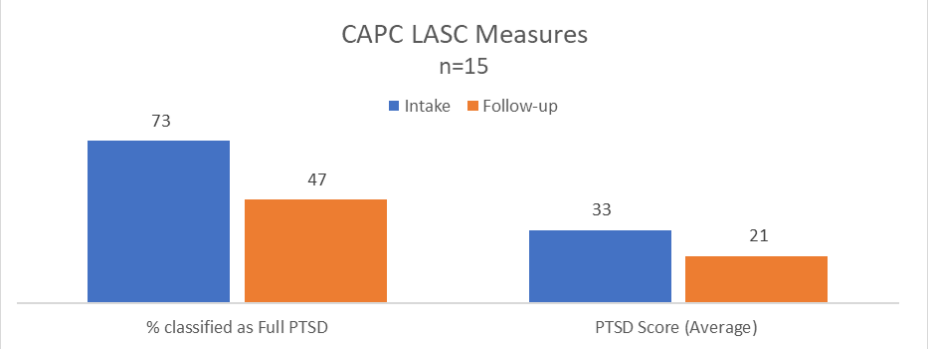
The Trauma Services project used the LASC at intake as a part of the screening process. The project design also intended for the LASC to be used every six months to track progress. Program theory suggests that services should result in reduced symptomatology. Two of the providers were able to track and share their data for this project[21]. Results from this fiscal year are presented separately for each provider below.

[21] It is expected that all three providers will be included in the full evaluation presented as a part of the three-year report covering programs in FY21/22, FY22/23, FY23/24

CAPC

CAPC had fifteen clients who completed both an intake LASC and at least one follow-up LASC. The figure below shows that at intake 73% indicated symptomology consistent with a diagnosis of full PTSD; this dropped to 47% at the most recent follow-up checklist. The PTSD score dropped from 33 to 21.

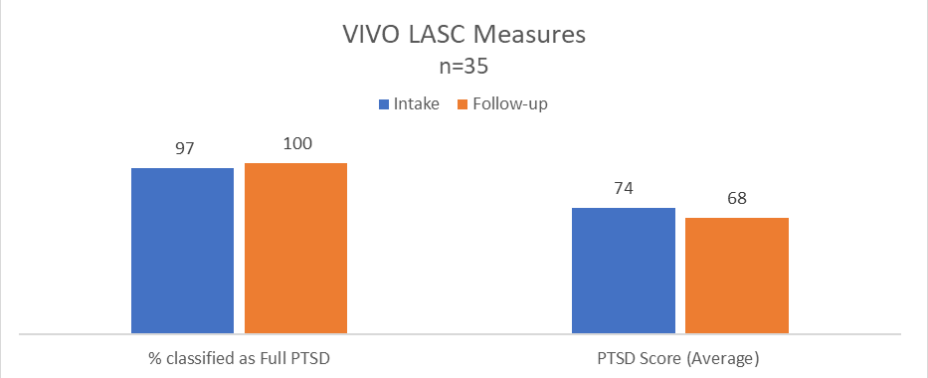
This program is still new, with limited data points for evaluation. A more detailed and robust analysis will be conducted as a part of the full three-year report covering data collected through fiscal year 2023/24.



VIVO

VIVO had thirty-five clients who completed both an intake LASC and at least one follow-up LASC. The figure below shows that at intake 97% indicated symptomology consistent with a diagnosis of full PTSD; this did not decrease. However, the average PTSD score decreased from 74 to 68.

This program is still new, with limited data points for evaluation. A more detailed and robust analysis will be conducted as a part of the full three-year report covering data collected through fiscal year 2023/24.



Cost/Benefit Analysis

The Trauma Services project cost $1,762 per individual screened and $3,430 per individual served with therapeutic services.

Trauma Services	
Expenditure/Benefit FY 2022/23	
Program Expenditures	*$607,962*
Unduplicated individuals served	345
Expenditures per individual served	*$1,762*
Unduplicated individuals served with therapeutic services	163
Expenditures per individual served with therapeutic services	*$3,730*

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the Trauma Services program during the 2022/23 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for 63 individuals, 61 of which were mental health referrals for treatment provided, funded, administered, or overseen by County mental health programs. These were all associated with El Concilio, a provider that offers additional programming for a higher level of care.
- The average duration of untreated mental illness was 3.5 years.
- Of the 61 County-referred individuals, 48 (79%) were known to have engaged in treatment within sixty days. Among these individuals who linked to service, the average duration between referral and service was 1 day.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2022/23 referrals to mental health treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[22].

- Eighty-four percent (84%) of referrals were made on behalf of **Latino/Hispanic** individuals.
- Five percent (5%) of referrals were made on behalf of **Asian and Pacific Islander** individuals.

More detailed referral and linkage data for underserved populations are included in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Trauma Services programs encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

[22] Approved claims penetration rates indicate that in San Joaquin County Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

Outreach for Increasing Recognition of Early Signs of Mental Illness

NAMI Outreach for Increasing Recognition of Early Signs of Mental Illness

Project Description

Outreach for Increasing Recognition of Early Signs of Mental Illness was delivered by National Alliance on Mental Illness San Joaquin (NAMI). NAMI's Provider Education introduces mental health professionals to the unique perspectives of people with mental health conditions and their families. Participants develop enhanced empathy for their daily challenges and recognize the importance of including them in all aspects of the treatment process.

Provider Education is a free, 15-hour program of in-service training taught by a team consisting of an adult with a mental health condition, a family member, and a mental health professional who is also a family member or has a mental health condition themselves.

Project Outputs

NAMI delivered two Provider Education classes to 15 Behavioral Health Providers.

Demographics

Demographic forms were collected during the class. Demographic tables from 2022/23 are included in the supplemental file.

Cost/Benefit Analysis

The following table shows the cost (based on county expenditure reports) for both the *Outreach for Early Recognition (OER) Program* and the *Stigma and Discrimination Reduction (SDR) Program* combined; and the total number of individuals who received training in each of the two programs. The average cost per individual trained in either OER or SDR programming was $236.

Outreach for Increasing Recognition of Early Signs of Mental Illness and Stigma and Discrimination Reduction	
Expenditure/Benefit FY 2022/23	
Program Expenditures (OER and SDR combined)	*$39,630*
Total individuals trained in Stigma and Discrimination Reduction programming (IOOV, F2F, P2P)	153
Total individuals trained in Outreach for Early Recognition	15
Total number of individuals trained	168
Expenditure per individual trained	*$236*

Access and Linkage to Treatment Strategy

The program reported no referrals to a higher level of mental health treatment.

Timely Access to Services for Underserved Populations Strategy

The program reported no mental health or PEI referrals to either of the populations identified as underserved[23].

[23] Approved claims penetration rates indicate that in San Joaquin County Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with County-administered services than the overall County population. For this reason, SJBHS identified these two populations as the focus of the strategy for timely access to services.

Stigma and Discrimination Reduction

NAMI Stigma and Discrimination Reduction Program

Project Description

Community Trainings to reduce stigma and discrimination are provided by NAMI volunteers throughout San Joaquin County.

Project Outputs

A total of 153 individuals were reached through the Stigma and Discrimination Reduction Project in FY 2022/23. The following table shows the type and number of each training/workshop offered and the number of individuals reached.

NAMI Stigma and Discrimination Reduction Program		
Outputs FY 2022/23		
	Number of trainings/ workshops	Number of individuals reached
In Our Own Voice (IOOV) 60-90 minute presentations by two trained speakers describing personal experiences living with mental health challenges and achieving recovery	28	113
Family to Family (F2F) 12-session educational program for family members of adults living with mental illness taught by trained teachers who are also family members.	1	9
Peer to Peer (P2P) 10-session class to help adults living with mental illness challenges achieve and maintain wellness taught by Peer Mentors living in recovery	3	31
TOTAL	32	153

Demographics

Demographic forms were collected during the class. Demographic tables from 2022/23 are included in the appendix to this report.

Participant Outcomes

As indicated in the PEI regulations, Stigma and Discrimination Reduction Programs target the following outcomes:

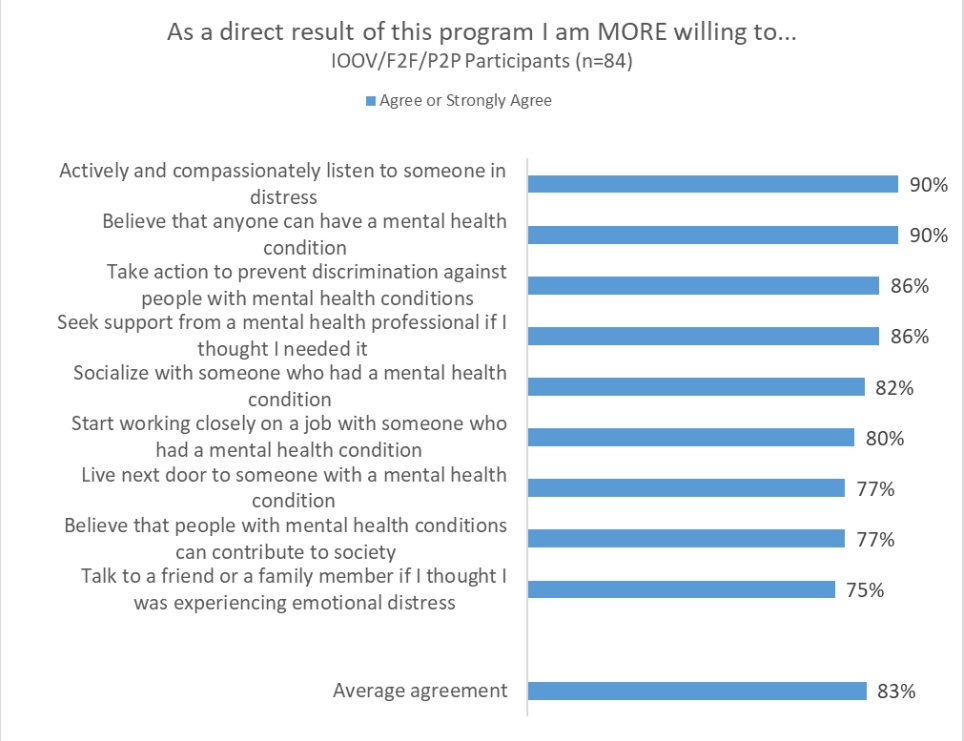
- Improved attitudes, knowledge and/or behavior related to mental illness

- Improved attitudes, knowledge and/or behavior related to seeking mental health services

To measure this, NAMI facilitators distributed evaluation surveys with a set of nine retrospective Likert Scale items asking participants to rate the degree to which their attitudes had shifted as a result of the program. Surveys were distributed at the conclusion of classes and trainings. During the 2022/23 fiscal year, NAMI collected 84 surveys.

Most (90%) indicated that because of programming they are more willing to actively listen to someone in distress and believe that anyone can have a mental health condition.[24]

To arrive at one attitudinal metric, an average was calculated from the survey items. On average, 83% of participants acknowledged improved attitudes, knowledge and/or behavior related to mental illness and seeking mental health services.



[24] Analysis was based on surveys from IOOV (n=57), Family to Family (n=5) and Peer to Peer (n=22)

Cost/Benefit Analysis

The following table shows the cost (based on county expenditure reports) for both the *Outreach for Early Recognition (OER) Program* and the *Stigma and Discrimination Reduction (SDR) Program* combined; and the total number of individuals who received training in each of the two programs. The average cost per individual trained in either OER or SDR programming was $236.

Outreach for Increasing Recognition of Early Signs of Mental Illness and Stigma and Discrimination Reduction	
Expenditure/Benefit FY 2022/23	
Program Expenditures (OER and SDR combined)	*$39,630*
Total individuals trained in Stigma and Discrimination Reduction programming (IOOV, F2F, P2P) (See tab 6b)	153
Total individuals trained in Outreach for Early Recognition	15
Total number of individuals trained	168
Expenditure per individual trained	*$236*

Access and Linkage to Treatment Strategy

The program reported no referrals to a higher level of mental health treatment.

Timely Access to Services for Underserved Populations Strategy

The program reported no mental health or PEI referrals to either of the populations identified as underserved[25].

..

[25] Approved claims penetration rates indicate that in San Joaquin County Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with County-administered services than the overall County population. For this reason, SJBHS identified these two populations as the focus of the strategy for timely access to services.

Suicide Prevention

Suicide Prevention In Schools

Project Description

The CAPC-led project involved the evidence-based Yellow Ribbon (YR) Suicide Education Campaign and ancillary Be a Link Adult Gatekeeper and Ask 4 Help Youth Gatekeeper Trainings. In addition, CAPC provided SafeTALK workshops to youth over age 15 to assist in the recognition of individuals with suicidal thoughts and to connect them to mental health resources. The Suicide Prevention Project also provided depression screenings, referrals, and school-based depression support groups.

Project Outputs

In the 2022/23 fiscal year, the Suicide Prevention Project reached 6,460 participants. The following table presents a detailed breakdown of the number of individuals reached by various program activities. The Yellow Ribbon Campaign was the largest component, reaching 5,947 students.

Suicide Prevention	
Outputs FY 2022/23	
Total reached (duplicated count)	7,211
Total reached (unduplicated count)	6,460
Yellow Ribbon Campaign Messaging	5,947
Be a Link® Adult Gatekeeper Training	292
Ask 4 Help® Youth Gatekeeper Training	394
SafeTalk Training	221
Depression Screening	328
Break Free from Depression Support Group Participants	29
Billboard Campaign Estimated Impressions	14,664,000

Demographics

Demographic forms were collected at the time of the service. Based on the information provided in the demographic forms collected[26](n=7,128), the program population can broadly be described as racially and ethnically diverse. Over half (51%) of participants in the presentations identified themselves as Hispanic or Latino. Fifteen percent (15%) identified as Asian, 7% Black or African American, 22% white, and 31% indicated more than one race.

[26] This narrative description is based on the number of participants who provided a response to each demographic category. Up to 15% of participants declined to answer any given demographic question.

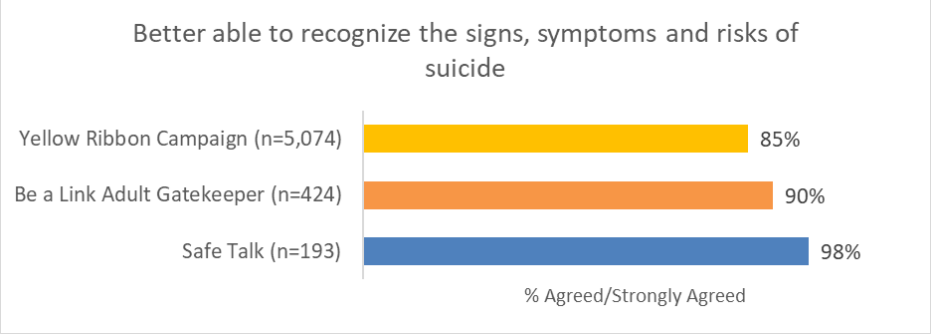
Complete demographic tables from FY2022/23 are included in the appendix to this report.

Participant Outcomes

The overall goal of the program is to identify and refer individuals at risk for self-harming and suicidal behaviors and to reduce stigma associated with help-seeking behavior. In 2022/23, the Suicide Prevention Project evaluated their progress towards three intended outcomes: (a) increased knowledge of warning signs, symptoms and risks; (b) knowledge about professional and peer resources available to help people at risk of suicide; and (c) knowledge of how to intervene.

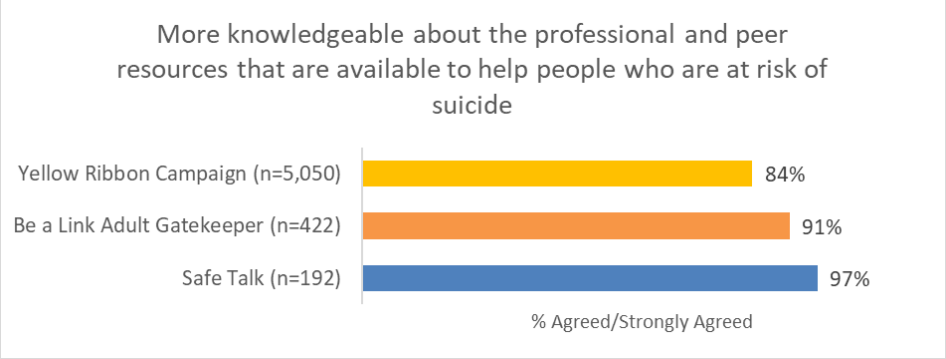
Increased knowledge of warning signs, symptoms and risks

Participants were asked to indicate, as a result of the training, the extent to which they were better able to recognize the signs, symptoms and risks of suicide. The figure below shows that a solid majority (85%) of students participating in the Yellow Ribbon Campaign *agreed* or *strongly agreed* that they were better able to recognize the symptoms and risks of suicide. An even larger portion felt this way after participating in Safe Talk (98%).



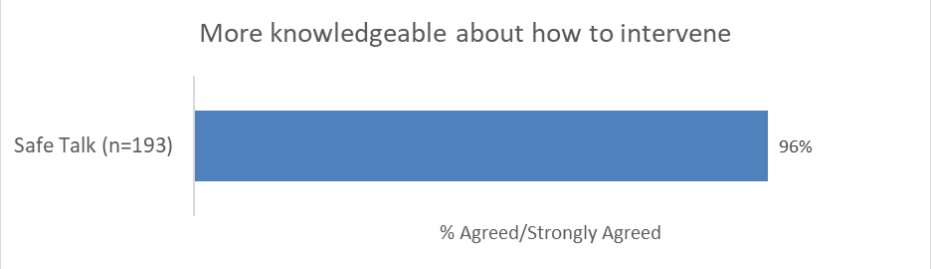
Increased understanding of how to ask for help

Suicide Prevention programming is intended to increase awareness about professional and peer resources that are available to help people who are at risk of suicide. The figure below shows that 84% of students in the Yellow Ribbon Campaign *agreed* or *strongly agreed* that they were more knowledgeable about resources available for people who are at risk of suicide. A slightly larger proportion (91%) of participants in Be a Link felt this way, and it was nearly unanimous among the participants in SafeTalk (97%).



Increased knowledge about how to intervene

SafeTALK is a 3-hour training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. The vast majority (96%) *agreed* or *strongly agreed* that they were more knowledgeable about how to intervene as a result of the training.



Cost/Benefit Analysis

The following table shows several key indicators of performance (based on county expenditure reports). The programs cumulatively cost $99 per individual served or $112 per participant who demonstrated improvement in intended outcomes.

Suicide Prevention	
Expenditure/Benefit FY 2022/23	
Program Expenditures	*$640,657*
Total Reached*	6,460
Expenditure per individual served^*	*$99*
Percent who showed improvement/positive change**	85%
*Expenditure per individual who showed improvement/positive change**^*	*$112*

*Some individuals may have been counted more than once due to participation in multiple programs
^Based on 96% of total budget. 2% of total individuals served were given depression screenings with no measurable outcomes.

**As defined under Participant Outcomes and extrapolated from existing sample

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the Suicide Prevention Project during the 2022/23 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- Taken together across the Presentations and the Individual Screenings, the Suicide Prevention project made referrals for 86 participants to mental health treatment. Thirteen (13) of the 86 mental health referrals were for treatment provided, funded, administered, or overseen by County mental health programs.
- The average duration of untreated mental illness was 11.4 months.
- Of the 13 County-referred individuals, 8 (62%) were known to have engaged in treatment, defined as receiving services within 60 days.
- On average, the first mental health service was 10.5 days after referral.

Suicide Prevention in Schools			
Access and Linkage to Treatment Strategy FY 2022/23			
	Presentations	Individual Screening	Total Suicide Prevention
Referrals to MH treatment			
Individuals referred	12	74	86
Duration of untreated mental illness (months)	-	-	-
Average	26.7	7.9	11.4
Standard deviation	35.4	10.4	18.6
Linkages to county administered MH treatment			
Individuals referred to county MH treatment	1	12	13
# Engaged*	1	7	8

% Engaged	100%	58%	62%
Calendar days between referral and service			
Average	7	11	10.5
Standard deviation	-	18.3	17.0

*Engaged in a service within 60 days after referral

n/a= data not available

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2022/23 referrals to mental health treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[27].

- During the 2022/23 fiscal year, the Suicide Prevention Project referred 125 **Hispanic/Latino** individuals to mental health treatment or another PEI program; this represents 53% of the Suicide Prevention Project's 237 referrals.
- During the 2022/23 fiscal year, the Suicide Prevention Project referred 43 **Asian and Pacific Islander** individuals to mental health treatment or another PEI program; this represents 18% of all 179 referrals.
- More detailed referral and linkage data for underserved populations are included in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Suicide Prevention Project encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations. In addition, Mental Health Specialists engaged with school contacts to ensure they were receiving referrals and connecting with students. Depending on the severity of symptoms, project staff followed up within one week, and at 30-60-90 day intervals in order to ensure connection to appropriate services.

[27] Approved claims penetration rates indicate that in San Joaquin County, Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

Timely Access to Services for Underserved Populations

Recovery Services for Nonviolent Offenders (LEAD)

Project Description

BHS works with San Joaquin County Courts, District Attorney, and local Law Enforcement Agencies to provide targeted outreach and engagement, screening and assessment, and linkage to appropriate behavioral health services and supports for nonviolent offenders. Brief interventions are offered to individuals identified with emerging mental health concerns. A significant portion of the target population is assumed to be homeless and/or have co-occurring mental health, physical health, and substance use disorders.

The goal of the project is to engage repeat non-serious, nonviolent offenders with behavioral concerns and provide rehabilitation services that help to reduce negative outcomes associated with untreated mental health concerns such, as arrest, incarceration, homelessness, and prolonged suffering.

Project Outputs

In the 2022/23 fiscal year, the LEAD project served 37 individuals, 27 of whom were admitted in the previous fiscal year and 10 in this fiscal year. On average, each individual received 30 contacts and 62 hours of service over the course of the year.

Recovery Services for Nonviolent Offenders (LEAD)	
Outputs FY 2022/23	
Total individuals served*	37
Individuals admitted during fiscal year	10
Total numbers of contacts	1,124
Average number of contacts per individual served	30
Total minutes of service	138,368
Average minutes per individual	3,740
Average hours per individual	62

*Includes individuals continuing services from prior fiscal year

Demographic forms were collected at the time of initiating services. Demographic tables from 2022/23 are included in the supplemental file.

Cost/Benefit Analysis

The following table shows costs of the project and cost per individual served. In FY2022/23 the LEAD program cost $9,311 per individual served.

Recovery Services for Nonviolent Offenders (LEAD)	
Expenditure/Benefit FY 2022/23	
Program Expenditures	*$344,509*
Unduplicated individuals served	37
Expenditures per individual served	$9,311

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the LEAD program during the 2022/23 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for all 10 individuals newly enrolled in Whole Person Care to treatment provided, funded, administered, or overseen by County mental health programs.
- Of the 10 County-referred individuals, 3 (30%) were known to have engaged in treatment, defined as attending at least one mental health service within 60 days.
- Additional analysis looked at how many of LEAD clients linked to county mental health services during the year, regardless of when they entered the program or when the referral was made.

Recovery Services for Nonviolent Offenders (LEAD)	
Access and Linkage to Treatment Strategy FY 2022/23	
Referrals to MH treatment	
Individuals referred	10
Duration of untreated mental illness (months)	-
Average	n/a
Standard deviation	n/a
Linkages to county administered MH treatment within 60 Days	
Individuals referred to county MH treatment	10
# Engaged	3
% Engaged	30%
Calendar days between referral and service	-
Average	8.67
Standard deviation	10.21
Linkages to county administered MH treatment within Fiscal Year	

Individuals referred to county MH treatment	39
# Engaged	14
% Engaged	36%

n/a= data not available

Timely Access to Services for Underserved Populations Strategy

None of the 10 intake referrals were to the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[28][29]. However, because LEAD works closely with unhoused clients we also looked at timely access for that group as an underserved population.

The table below shows that all ten of the referrals were for clients known to be homeless, representing 100% of all LEAD intake referrals. Three (30%) of these individuals were known to have engaged in treatment, with an average interval of 9 days between referral and service.

Recovery Services for Nonviolent Offenders (LEAD)	
Timely Access to Services for Underserved Populations FY 2022/23	
Individuals referred to MH treatment or PEI	10
Underserved population: Homeless	
Underserved individuals referred to MH treatment or PEI	10
Proportion of referrals to MH treatment or PEI	100%
Individuals referred to county administered MH treatment	10
Linkages to County administered MH treatment	
# Engaged*	3
% Engaged	30%
Interval between referral and treatment (days) - Average	8.7
Standard deviation	10.2

*Engaged in a service within 60 days after referral

Encouraging Access to Services and Follow Through

LEAD provides intensive case management, navigation and warm handoffs for clients to all referral destinations. Case management involves helping clients schedule or reschedule appointments and transportation as needed. Case managers build trust and rapport in order to

[28] Approved claims penetration rates indicate that in San Joaquin County, Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

[29] Missing demographic information suggests this may underestimates the proportion of underserved clients who received referrals.

convey the importance and benefits of services. The program addresses a wide array of psycho-social stressors, including food, clothing, and shelter, since Maslow's Hierarchy of Needs suggest they these concerns may inhibit clients' ability to engage in services. Clients in crisis are immediately linked to services

Access and Linkage to Treatment

Whole Person Care

Project Description

This project provides match funding for San Joaquin County's Whole Person Care Pilot Project, approved by DHCS in 2016. The purpose of San Joaquin County's Whole Person Care pilot project is to test interventions and create a care management infrastructure to better support individuals who are at high risk of untreated mental illness and are high utilizers of health care services, but otherwise underserved. Program services target adult Medi-Cal beneficiaries with frequent use of emergency department services, who have mental health and/or substance use disorders, or who are currently homeless or at risk for homelessness upon discharge from an institution.

Project Outputs

In the 2022/23 fiscal year, the WPC project served 83 individuals, 62 of whom continued services from the prior fiscal year and 21 who initiated services in 2022/23. On average, individuals received 25 service contacts and 56 hours of service.

Whole Person Care (WPC)	
Outputs FY 2022/23	
Total unduplicated individuals served*	83
Individuals admitted during fiscal year	21
Total numbers of contacts	2,038
Average number of contacts per individual served	25
Total minutes of service	279,715
Average minutes per individual	3370
Average hours per individual	56

*Includes individuals continuing services from prior fiscal year

Demographic forms were collected for 21 individuals at the time of initiating services. Complete demographic tables from 2022/23 are included in the appendix to this report.

Cost/Benefit Analysis

The following table shows costs of the project and cost per individual served. In FY2022/23 the Whole Person Care program cost $8,171 per individual served.

Whole Person Care (WPC)	
Expenditure/Benefit FY 2022/23	
Program Expenditures	*$678,168*
Unduplicated individuals served	83
Expenditures per individual served	$8,171

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the WPC program during the 2022/23 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for all 21 individuals newly enrolled in Whole Person Care to treatment provided, funded, administered, or overseen by County mental health programs.
- Of the 21 County-referred individuals, 6 (29%) were known to have engaged in treatment, defined as attending at least one mental health service within 60 days.
- Additional analysis looked at how many of Whole Person Care clients linked to county mental health services during the year, regardless of when they entered the program or when the referral was made. Nearly half (47%) of Whole Person Care clients were linked to other treatment services during the year.

Whole Person Care (WPC)	
Access and Linkage to Treatment Strategy FY 2022/23	
Referrals to MH treatment	
Individuals referred	21
Duration of untreated mental illness (months)	
Average	n/a
Standard deviation	n/a
Linkages to county administered MH treatment within 60 Days	
Individuals referred to county MH treatment	21
# Engaged	6
% Engaged	29%
Calendar days between referral and service	
Average	29.2
Standard deviation	20.8
Linkages to county administered MH treatment within Fiscal Year	
Individuals referred to county MH treatment	83
# Engaged	39
% Engaged	47%

Timely Access to Services for Underserved Populations Strategy

None of the 21 intake referrals were to the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[30][31]. However, because Whole Person Care works closely with unhoused clients, we also looked at timely access for that group as an underserved population. The table below shows that 18 of the 21 referrals were for clients known to be homeless, representing 86%[32] of all initial enrollment referrals.

All eighteen of these referrals were to county administered mental health treatment, and six (33%) of these individuals were known to have engaged in treatment, with an average interval of 29 days between referral and service.

Whole Person Care (WPC)	
Timely Access to Services for Underserved Populations FY 2022/23	
Individuals referred to MH treatment or PEI	21
Underserved population: Homeless	
Underserved individuals referred to MH treatment or PEI	18
Proportion of referrals to MH treatment or PEI	86%
Individuals referred to county administered MH treatment	18
Linkages to County administered MH treatment	
# Engaged*	6
% Engaged	33%
Interval between referral and treatment (days) - Average	29
Standard deviation	20.8

*Engaged in a service within 60 days after referral

More detailed referral and linkage data for underserved populations are included in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Whole Person Care program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations. Additionally, WPC case managers provide warm handoffs to help clients link to services to which they are referred.

[30] Approved claims penetration rates indicate that in San Joaquin County, Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

[31] Missing demographic information suggests this may underestimates the proportion of underserved clients who received referrals. The program has adjusted data collection protocols to capture more comprehensive demographics moving forward.

[32] Missing demographic information suggests this likely underestimates the proportion of clients who are homeless

Appendix: Demographic Tables

Skill-Building for Parents and Guardians

Methodological note: Data on demographic groups with fewer than 10 members in any program are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Skill-Building for Parents and Guardians				
Demographics FY 2022/23				
	CAPC-PC	CC-NPP	PBC - Triple P	Total Skill-building
Number of participants (unduplicated)	771	370	476	1,617
Number of demographic forms collected	742	346	474	1,562
Age				
0-15	X	X	X	X
16-25	19	11	32	62
26-59	578	291	347	1216
60 and older	33	X	X	41
Decline to answer	112	41	88	241
Race				
American Indian or Alaska Native	X	X	X	X
Asian	X	X	X	15
Black of African American	56	X	69	126
Native Hawaiian or other Pacific Islander	X	X	X	X
White	176	143	75	394
Other	333	73	178	584
More than one race	34	X	35	71
Decline to answer	133	124	102	359
Ethnicity				
Hispanic or Latino				
Caribbean	X	X	X	X
Central America	18	X	14	40
Mexican/Mexican-American	419	281	167	867
Puerto Rican	X	X	X	X
South American	X	X	X	10
Other Hispanic or Latino	17	X	30	47
Non-Hispanic or Non-Latino				
African	34	X	51	85
Asian Indian/South Asian	X	X	X	X
Cambodian	X	X	X	X

Chinese	X	X	X	X
Eastern European	X	X	X	X
European	15	X	17	32
Filipino	X	X	X	X
Japanese	X	X	X	X
Korean	X	X	X	X
Middle Eastern	X	X	X	X
Vietnamese	X	X	X	X
Other Non-Hispanic or Latino	X	X	X	X
Other	23	X	X	34
More than one ethnicity	42	X	53	97
Decline to Answer	160	47	120	327
Primary language				
English	253	26	289	568
Spanish	371	265	91	727
Other	X	X	X	11
Decline to Answer	115	49	92	256
Sexual orientation				
Gay or Lesbian	X	X	X	14
Heterosexual or Straight	573	211	321	1105
Bisexual	14	X	18	35
Questioning or unsure of sexual orientation	X	X	X	X
Queer	X	X	X	X
Other	X	X	X	X
Decline to answer	145	130	124	399
N/A	X	X	X	X
Disability*				
Difficulty seeing	26	X	11	41
Difficulty hearing	X	X	X	14
A mental disability	39	X	14	54
A physical/mobility disability	23	X	X	30
A chronic health condition	18	X	10	31
Other Disability	15	X	12	27
Decline to answer	288	176	211	675
No Disability	505	247	327	1079
Veteran status				
Yes	X	X	X	11
No	617	287	367	1271
Decline to answer	118	58	102	278

N/A	X	X	X	X
Sex assigned at birth				
Male	97	31	95	223
Female	535	274	284	1093
Decline to answer	110	41	95	246
Gender identity				
Male	94	31	95	220
Female	534	272	281	1087
Transgender	X	X	X	X
Genderqueer/Non-Binary	X	X	X	X
Questioning or unsure of gender identity	X	X	X	X
Other	X	X	X	X
Decline to answer	111	43	96	250
N/A	X	X	X	X
Homeless				
Yes	137	X	27	169
No	485	279	346	1110
Decline to answer	120	62	101	283

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

Mentoring for Transitional Age Youth

Methodological note: Data on demographic groups with fewer than 10 members in any program are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Mentoring for Transitional Age Youth			
Demographics FY 2022/23			
	CAPC	PREVAIL	Total TAY
Number enrolled	302	188	490
Number of demographic forms collected	293	190	483
Age			
0-15	X	X	X
16-25	288	188	476
26-59	X	X	X
60 and older	X	X	X
Decline to answer	X	X	X
Race			
American Indian or Alaska Native	X	X	10
Asian	21	X	28
Black of African American	57	78	135
Native Hawaiian or other Pacific Islander	X	X	X
White	32	37	69
Other	118	18	136
More than one race	58	29	87
Decline to answer	X	12	18
Ethnicity			
Hispanic or Latino			
Caribbean	X	X	X
Central America	X	X	X
Mexican/Mexican-American	124	59	183
Puerto Rican	X	X	X
South American	X	X	X
Other Hispanic or Latino	15	X	22
Non-Hispanic or Non-Latino			
African	47	31	78
Asian Indian/South Asian	X	X	X
Cambodian	X	X	X
Chinese	X	X	X
Eastern European	X	X	X
European	X	X	11
Filipino	X	X	11

Japanese	X	X	X
Korean	X	X	X
Middle Eastern	X	X	X
Vietnamese	X	X	X
Other Non-Hispanic or Latino	X	X	X
Other	X	X	12
More than one ethnicity	51	23	74
Decline to Answer	15	52	67
Primary language			
English	224	179	403
Spanish	59	10	69
Other	X	X	X
Decline to Answer	X	X	X
Sexual orientation			
Gay or Lesbian	X	15	24
Heterosexual or Straight	214	132	346
Bisexual	36	20	56
Questioning or unsure of sexual orientation	X	X	X
Queer	X	X	X
Other	15	X	22
Decline to answer	14	10	24
N/A	X	X	X
Disability*			
Difficulty seeing	X	X	12
Difficulty hearing	X	X	X
A mental disability	24	24	48
A physical/mobility disability	X	X	X
A chronic health condition	X	X	X
Other Disability	X	X	16
Decline to answer	24	59	83
No Disability	239	121	360
Veteran status			
Yes	X	X	X
No	284	154	438
Decline to answer	X	34	42
N/A	X	X	X
Sex assigned at birth			
Male	116	66	182
Female	169	121	290
Decline to answer	X	X	11
Gender identity			

Male	113	63	176
Female	164	115	279
Transgender	X	X	10
Genderqueer/Non-Binary	X	X	X
Questioning or unsure of gender identity	X	X	X
Other	X	X	X
Decline to answer	X	X	X
N/A	X	X	X
Homeless			
Yes	17	93	110
No	266	62	328
Decline to answer	10	35	45

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

Coping and Resilience Education Services (CARES)

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Coping and Resilience Education Services (CARES)	
Demographics FY 2022/23	
Number of participants (unduplicated, including those rolled over from the previous year)	399
Number of demographic forms collected	358
Age	
0-15	187
16-25	34
26-59	124
60 and older	X
Decline to answer	X
Race	
American Indian or Alaska Native	X
Asian	16
Black of African American	24
Native Hawaiian or other Pacific Islander	X
White	164
Other	69
More than one race	50
Decline to answer	27
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	15
Mexican/Mexican-American	197
Puerto Rican	X
South American	X
Other Hispanic or Latino	16
Non-Hispanic or Non-Latino	
African	14
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	14

Filipino	X
Japanese	X
Korean	X
Middle Eastern	X
Vietnamese	X
Other Non-Hispanic or Latino	X
Other	X
More than one ethnicity	23
Decline to Answer	46
Primary language	
English	221
Spanish	128
Other	X
Decline to Answer	X
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	159
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Decline to answer	68
N/A	113
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	X
Other Disability	17
Decline to answer	71
No Disability	276
Veteran status	
Yes	X
No	168
Decline to answer	X
N/A	187
Sex assigned at birth	
Male	113
Female	227
Decline to answer	18

Gender identity	
Male	61
Female	169
Transgender	X
Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Decline to answer	X
N/A	112
Homeless	
Yes	X
No	344
Decline to answer	10

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

School Based Intervention for Children and Youth

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

School Based Interventions				
Demographics FY 2022/23				
	CAPC	Parents By Choice	Sow a Seed	Total
Referrals received	239	282	150	671
Number of participants (unduplicated)	229	210	139	578
Number of demographic forms collected	256	222	123	601
Age				
0-15	249	160	111	520
16-25	X	61	X	76
26-59	X	X	X	X
60 and older	X	X	X	X
Decline to answer	X	X	X	X
Race				
American Indian or Alaska Native	X	X	X	X
Asian	12	X	X	24
Black of African American	50	20	X	76
Native Hawaiian or other Pacific Islander	X	X	X	11
White	73	29	23	125
Other	110	118	46	274
More than one race	X	27	15	46
Decline to answer	X	16	22	39
Ethnicity				
Hispanic or Latino				
Caribbean	X	X	X	X
Central America	X	X	X	X
Mexican/Mexican-American	123	121	65	309
Puerto Rican	X	X	X	X
South American	X	X	X	X
Other Hispanic or Latino	37	11	X	52
Non-Hispanic or Non-Latino				
African	45	13	X	61
Asian Indian/South Asian	X	X	X	X
Cambodian	X	X	X	X
Chinese	X	X	X	X

Eastern European	X	X	X	X
European	13	X	X	14
Filipino	X	X	X	12
Japanese	X	X	X	X
Korean	X	X	X	X
Middle Eastern	X	X	X	X
Vietnamese	X	X	X	X
Other Non-Hispanic or Latino	X	X	X	X
Other	15	14	X	34
More than one ethnicity	X	28	X	42
Decline to Answer	X	23	25	53
Primary language				
English	228	144	89	461
Spanish	27	67	25	119
Other	X	X	X	15
Decline to Answer	X	X	X	X
Sexual orientation				
Gay or Lesbian	X	X	X	X
Heterosexual or Straight	42	94	23	159
Bisexual	X	27	X	29
Questioning or unsure of sexual orientation	X	11	X	11
Queer	X	X	X	X
Other	X	X	X	X
Decline to answer	X	17	X	26
N/A	212	63	89	364
Disability*				
Difficulty seeing	X	11	X	11
Difficulty hearing	X	X	X	X
A mental disability	X	X	X	X
A physical/mobility disability	X	X	X	X
A chronic health condition	X	X	X	X
Other Disability	X	12	X	21
Decline to answer	X	X	21	31
No Disability	255	192	103	550
Veteran status				
Yes	X	X	X	X
No	X	61	X	72
Decline to answer	X	X	X	X
N/A	249	160	111	520
Sex assigned at birth				
Male	147	75	71	293

Female	108	144	50	302
Decline to answer	X	X	X	X
Gender identity				
Male	22	48	20	90
Female	21	101	13	135
Transgender	X	X	X	X
Genderqueer/Non-Binary	X	X	X	X
Questioning or unsure of gender identity	X	X	X	X
Other	X	X	X	X
Decline to answer	X	X	X	X
N/A	212	63	89	364
Homeless				
Yes	X	15	X	19
No	253	207	106	566
Decline to answer	X	X	15	16

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Telecare Early Intervention and Recovery Services (TEIR)

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Telecare Early Intervention and Recovery Services (TEIR)	
Demographics FY 2022/23	
Number of participants (unduplicated, including those rolled over from the previous year)	77
Number of demographic forms collected	31
Age	
0-15	X
16-25	13
26-59	X
60 and older	X
Decline to answer	16
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	X
Native Hawaiian or other Pacific Islander	X
White	X
Other	X
More than one race	X
Decline to answer	18
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	X
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	X
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X
Filipino	X

Japanese	X
Korean	X
Middle Eastern	X
Vietnamese	X
Other Non-Hispanic or Latino	X
Other	X
More than one ethnicity	X
Decline to Answer	18
Primary language	
English	14
Spanish	X
Other	X
Decline to Answer	16
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	X
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Decline to answer	26
N/A	X
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	X
Other Disability	X
Decline to answer	19
No Disability	12
Veteran status	
Yes	X
No	12
Decline to answer	17
N/A	X
Sex assigned at birth	
Male	X
Female	X
Decline to answer	19
Gender identity	

Male	X
Female	X
Transgender	X
Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Decline to answer	16
N/A	X
Homeless	
Yes	X
No	14
Decline to answer	17

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

Community Trauma Services for Adults

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Community Trauma Services for Adults				
Demographics FY 2022/23				
	CAPC	El Concilio	VIVO	Total
Total unduplicated count of individuals receiving services	17	259	69	348
Number of demographic forms collected	17	132	72	221
Age				
0-15	X	X	X	X
16-25	X	15	X	17
26-59	14	104	40	158
60 and older	X	13	32	46
Decline to answer	X	X	X	X
Race				
American Indian or Alaska Native	X	X	X	X
Asian	X	X	66	67
Black of African American	X	X	X	15
Native Hawaiian or other Pacific Islander	X	X	X	X
White	X	12	X	14
Other	X	110	X	114
More than one race	X	X	X	11
Decline to answer	X	X	X	X
Ethnicity				
Hispanic or Latino				
Caribbean	X	X	X	X
Central America	X	X	X	X
Mexican/Mexican-American	5	106	X	111
Puerto Rican	X	X	X	X
South American	X	X	X	X
Other Hispanic or Latino	X	12	27	45
Non-Hispanic or Non-Latino				
African	X	X	X	X
Asian Indian/South Asian	X	X	X	X
Cambodian	X	X	X	X
Chinese	X	X	X	X
Eastern European	X	X	X	X
European	X	X	X	X

Filipino	X	X	X	X
Japanese	X	X	X	X
Korean	X	X	X	X
Middle Eastern	X	X	X	X
Vietnamese	X	X	22	23
Other Non-Hispanic or Latino	X	X	X	X
Other	X	X	17	21
More than one ethnicity	X	X	X	X
Decline to Answer	X	X	X	X
Primary language				
English	16	47	X	64
Spanish	X	85	X	86
Other	X	X	71	71
Decline to Answer	X	X	X	X
Sexual orientation				
Gay or Lesbian	X	X	X	X
Heterosexual or Straight	13	130	X	146
Bisexual	X	X	X	X
Questioning or unsure of sexual orientation	X	X	X	X
Queer	X	X	X	X
Other	X	X	X	X
Decline to answer	X	X	63	63
N/A	X	X	X	X
Disability*				
Difficulty seeing	X	X	X	X
Difficulty hearing	X	X	X	X
A mental disability	X	X	X	X
A physical/mobility disability	X	X	13	15
A chronic health condition	X	X	13	14
Other Disability	X	X	X	X
Decline to answer	X	X	74	77
No Disability	16	126	X	144
Veteran status				
Yes	X	X	X	X
No	17	131	71	219
Decline to answer	X	X	X	X
N/A	X	X	X	X
Sex assigned at birth				
Male	X	37	32	69
Female	17	95	40	152
Decline to answer	X	X	X	X

Gender identity				
Male	X	36	33	69
Female	17	96	39	152
Transgender	X	X	X	X
Genderqueer/Non-Binary	X	X	X	X
Questioning or unsure of gender identity	X	X	X	X
Other	X	X	X	X
Decline to answer	X	X	X	X
N/A	X	X	X	X
Homeless				
Yes	X	X	X	X
No	16	130	62	208
Decline to answer	X	X	X	X

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NAMI Outreach for Increasing Recognition of Early Signs of Mental Illness

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

NAMI Stigma and Discrimination Reduction Program

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

NAMI Stigma and Discrimination Reduction Program				
Demographics FY 2022/23				
	IOOV	F2F	P2P	Total
Number of participants (unduplicated)	113	X	31	153
Number of demographic forms collected	169	X	27	202
Age				
0-15	X	X	X	X
16-25	10	X	X	11
26-59	35	X	15	54
60 and older	23	X	X	32
Decline to answer	101	X	X	105
Race				
American Indian or Alaska Native	X	X	X	X
Asian	X	X	X	10
Black of African American	11	X	X	14
Native Hawaiian or other Pacific Islander	X	X	X	X
White	37	X	11	52
Other	X	X	X	X
More than one race	X	X	X	X
Decline to answer	104	X	X	110
Ethnicity				
Hispanic or Latino				
Caribbean	X	X	X	X
Central America	X	X	X	X
Mexican/Mexican-American	X	X	X	10
Puerto Rican	X	X	X	X
South American	X	X	X	X
Other Hispanic or Latino	X	X	X	X
Non-Hispanic or Non-Latino				
African	X	X	X	10
Asian Indian/South Asian	X	X	X	X
Cambodian	X	X	X	X
Chinese	X	X	X	X
Eastern European	X	X	X	X

European	10	X	X	16
Filipino	X	X	X	X
Japanese	X	X	X	X
Korean	X	X	X	X
Middle Eastern	X	X	X	X
Vietnamese	X	X	X	X
Other Non-Hispanic or Latino	X	X	X	X
Other	X	X	X	11
More than one ethnicity	13	X	X	17
Decline to Answer	117	X	10	128
Primary language				
English	66	X	22	94
Spanish	X	X	X	X
Other	X	X	X	X
Decline to Answer	97	X	X	102
Sexual orientation				
Gay or Lesbian	X	X	X	X
Heterosexual or Straight	36	X	X	36
Bisexual	X	X	X	X
Questioning or unsure of sexual orientation	X	X	X	X
Queer	X	X	X	X
Other	X	X	X	X
Decline to answer	119	X	27	152
N/A	X	X	X	X
Disability*				
Difficulty seeing	X	X	X	X
Difficulty hearing	X	X	X	X
A mental disability	18	X	13	32
A physical/mobility disability	X	X	X	10
A chronic health condition	X	X	X	10
Other Disability	X	X	X	X
Decline to answer	105	X	X	113
No Disability	36	X	X	47
Veteran status				
Yes	X	X	X	X
No	65	X	22	92
Decline to answer	99	X	X	103
N/A	X	X	X	X
Sex assigned at birth				
Male	25	X	10	37

Female	47	X	13	64
Decline to answer	97	X	X	101
Gender identity				
Male	25	X	X	35
Female	45	X	14	63
Transgender	X	X	X	X
Genderqueer/Non-Binary	X	X	X	X
Questioning or unsure of gender identity	X	X	X	X
Other	X	X	X	X
Decline to answer	98	X	X	103
N/A	X	X	X	X
Homeless				
Yes	X	X	X	X
No	63	X	22	91
Decline to answer	99	X	X	103

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Suicide Prevention in Schools

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Suicide Prevention in Schools		
Demographics FY 2022/23		
	Presentations	Individual Screening
Number of participants (unduplicated)	7,211	328
Number of demographic forms collected	7,128	336
Age		
0-15	4,680	171
16-25	1,835	161
26-59	375	X
60 and older	41	X
Decline to answer	197	X
Race		
American Indian or Alaska Native	132	X
Asian	970	44
Black of African American	449	30
Native Hawaiian or other Pacific Islander	83	X
White	1,419	76
Other	1,325	49
More than one race	2,010	104
Decline to answer	740	22
Ethnicity		
Hispanic or Latino		
Caribbean	14	X
Central America	154	X
Mexican/Mexican-American	2792	137
Puerto Rican	53	X
South American	37	X
Other Hispanic or Latino	65	X
Non-Hispanic or Non-Latino		
African	231	17
Asian Indian/South Asian	225	X
Cambodian	138	16
Chinese	41	X
Eastern European	X	X
European	320	10

Filipino	278	16
Japanese	29	X
Korean	11	X
Middle Eastern	75	X
Vietnamese	64	X
Other Non-Hispanic or Latino	X	X
Other	532	15
More than one ethnicity	1,029	45
Decline to Answer	1,040	42
Primary language		
English	5,228	254
Spanish	1,204	44
Other	344	12
Decline to Answer	352	26
Sexual orientation		
Gay or Lesbian	X	X
Heterosexual or Straight	X	44
Bisexual	X	10
Questioning or unsure of sexual orientation	X	X
Queer	X	X
Other	X	X
Decline to answer	7,123	272
N/A	X	X
Disability*		
Difficulty seeing	359	22
Difficulty hearing	80	X
A mental disability	274	30
A physical/mobility disability	49	X
A chronic health condition	70	X
Other Disability	85	X
Decline to answer	1,611	58
No Disability	5,572	250
Veteran status		
Yes	35	X
No	2,145	157
Decline to answer	268	X
N/A	4,680	171
Sex assigned at birth		
Male	3,203	99
Female	3,568	228
Decline to answer	357	X

Gender identity		
Male	3,158	101
Female	3,368	207
Transgender	46	X
Genderqueer/Non-Binary	119	X
Questioning or unsure of gender identity	58	X
Other	37	X
Decline to answer	338	X
N/A	X	X
Homeless		
Yes	36	X
No	6,702	328
Decline to answer	390	X

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Recovery Services for Nonviolent Offenders (LEAD)

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Whole Person Care

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Whole Person Care (WPC)	
Demographics FY 2022/23	
Number of demographic forms reported	21
Age	
0-15	X
16-25	X
26-59	16
60 and older	X
Missing/Decline to answer	X
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	X
Native Hawaiian or other Pacific Islander	X
White	12
Other	X
More than one race	X
Missing/Decline to answer	X
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	X
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	X
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X
Filipino	X
Japanese	X
Korean	X

Middle Eastern	X
Vietnamese	X
Other Non-Hispanic or Latino	X
Other	X
More than one ethnicity	X
Missing/Decline to answer	X
Primary language	
English	21
Spanish	X
Other	X
Missing/Decline to answer	X
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	20
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Missing/Decline to answer	X
N/A	X
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	X
Other Disability	X
Missing/Decline to answer	X
No Disability	X
Veteran status	
Yes	X
No	19
Missing/Decline to answer	X
Sex assigned at birth	
Male	X
Female	19
Missing/Decline to answer	X
Gender identity	
Male	X
Female	19
Transgender	X

Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Missing/Decline to answer	X
N/A	X
Homeless	
Yes	18
No	X
Missing/Decline to answer	X

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

The San Joaquin County Homeward Bound Initiative

Deliverable 14: Year 5 Evaluation Report

San Joaquin County Homeward Bound Year 4 Evaluation Report
Submitted by the UC Davis Behavioral Health Center of Excellence on 6/29/2023

Executive Summary

Background

The main aims of the Homeward Bound Initiative included: 1) improving access and engagement in behavioral healthcare amongst residents of San Joaquin County, 2) increasing behavioral healthcare utilization amongst historically underserved groups, 3) reducing convictions and recidivism, 4) improving client outcomes, and 5) delivering services with a high degree of client satisfaction. The Initiative aimed to achieve these goals by delivering a host of services including residential and outpatient respite care, case management, psychotherapy, sobering services, substance use disorder (SUD) counseling, and medication-assisted treatment (MAT). These services were delivered by Community Medical Centers (CMC), a federally qualified health center (FQHC) with an established track record in providing health and social care to San Joaquin County residents in collaboration with San Joaquin County Behavioral Health Services (SJCBHS). These services were accessible via a multitude of pathways and were supported by extensive links with other community and governmental agencies. The provision of these additional services was expected to lead to improved functional and recovery outcomes for consumers, high levels of treatment satisfaction amongst clients, and reduced convictions and recidivism amongst those that receive care. The current report details the results of the Homeward Bound Initiative over a five-year project period.

Major Findings

Over the past four years, the Homeward Bound Initiative has continued its progress towards meeting the project goals and objectives. In total, 2,355 unique individuals have been enrolled in the Homeward Bound Initiative, 1,780 clients have received some form of behavioral health counseling, 801 have received MAT, 1,257 have received case management, and 2,009 have received physical health services. Since the opening of the Respite Residential Care Program in October 2021, 66 unique clients have enrolled in respite residential services. In total, 12.2% of clients identified as Black or African American, which is an over-representation relative to San Joaquin County population estimates. However, Asian and Hispanic/Latinx clients were under-represented. To date, the program has been highly successful at engaging clients who identify as homeless (n=544, 23.1% of the sample). Once engaged in care, individuals from these historically underserved groups engaged and remained in behavioral health counseling at levels at least comparable to those who report not being homeless, and other racial and ethnic groups.

In total, 67.0% of clients reported previously being convicted of a crime. Recidivism rates of individuals with a prior conviction were 8.1% at 12-months post-baseline, and 15.4% at 24-months. Due to the nature of the data, it is not possible to make direct comparisons to the

published literature, however these figures appear relatively low. Homeward Bound clients reported clinically and statistically significant reductions in depressive symptoms after one month of enrolling in Homeward Bound services, with further reductions evident the longer they remained in care. Finally, amongst the 349 clients assessed, satisfaction with the care delivered by the Homeward Bound Initiative was remarkably high, with 86.3% of clients reporting the highest level of satisfaction possible, and 99.4% reporting at least moderately high level of satisfaction. Across the primary Waterloo Road primary hub site, and the Tracy Clinic spoke site, the Homeward Bound initiative generated approximately $626,000 worth of revenue for the financial year of 2021-2022 through service billing, not including revenue from the residential respite services.

The successes of the Homeward Bound Initiative are particularly notable given the backdrop of the Coronavirus Disease-2019 (COVID-19) and the subsequent shelter-in-place mandates that significantly impacted client needs, the delivery of services, and the effectiveness of collaborations with other community agencies.

Conclusions

Overall, the Homeward Bound Initiative is successfully delivering a broad range of behavioral healthcare services to individuals with mild-to-moderate behavioral health conditions, many of whom report having a history of interaction with the criminal justice system. These findings suggest that the Homeward Bound Initiative may represent an important step towards addressing a significant gap in the San Joaquin County Behavioral Health System-of-Care, delivering services in a manner that is successfully engaging historically underserved groups, improving outcomes, and providing services with a very high degree of client satisfaction.

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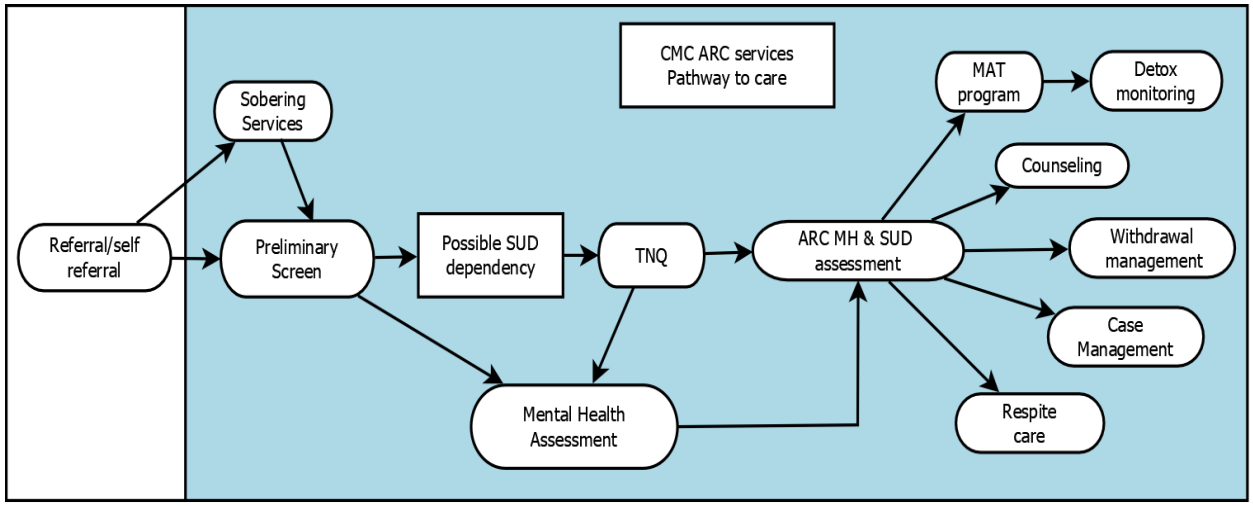
Project Description

The Homeward Bound Initiative represents a significant expansion of community-based behavioral health services, designed to improve population-level behavioral health outcomes for the residents of San Joaquin County. The overarching goal of the Homeward Bound Initiative is to improve access to substance use and mental health services for county residents with mild-to-moderate behavioral health concerns by expanding services and increasing low-barrier pathways to care. The program emphasizes supporting vulnerable and underserved populations, including 1) non-serious, non-violent offenders with trauma or other mental health concerns, 2) high-risk individuals with substance use disorders (SUD) who are homeless, and/or who have frequent contacts with law enforcement, and 3) African American and Latinx individuals who are underserved through traditional, existing behavioral health services.

The Homeward Bound Initiative focuses on 1) *service expansion* through the creation of the Assessment and Respite Center (ARC) with co-located withdrawal management services, 2) *system strengthening* through shared data use agreements and expedited referral pathways between providers, and 3) *service enhancement* by delivering wrap-around housing and case management services for those individuals that require intensive services to achieve recovery from behavioral health conditions. The ARC is a community-based treatment facility managed by Community Medical Centers (CMC), a not-for-profit healthcare network with an established track record of delivering health and social care services to individuals in the Stockton area for over 50 years. A conceptual model detailing the new system of care delivered by CMC via the Homeward Bound Initiative is presented below in Figure 1.

Figure 1: The Homeward Bound Initiative CMC/ARC Pathway to Care

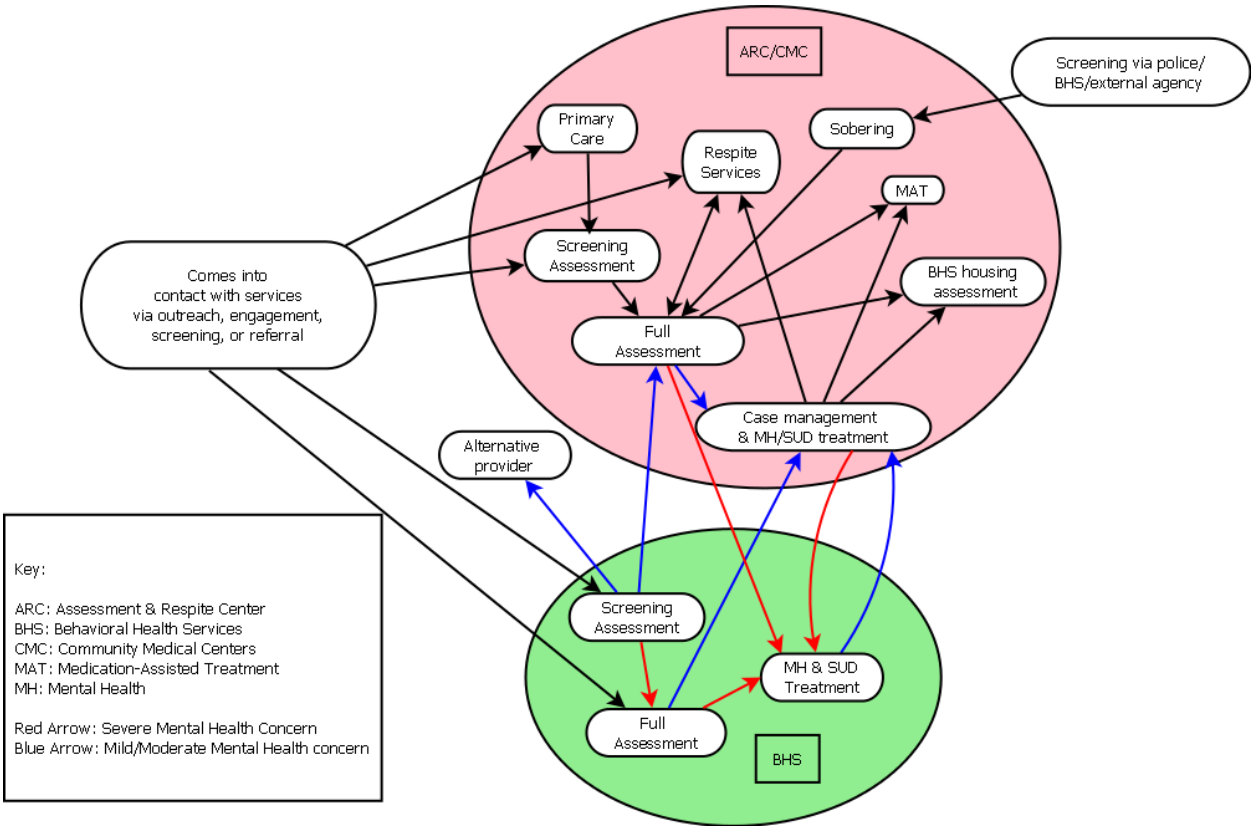


ARC = Assessment and Respite Center; CMC = Community Medical Centers; MAT = Medication Assisted Treatment; SUD = Substance Use Disorder; TNQ = Treatment Needs Questionnaire.

The Homeward Bound system of care allows consumers to access services delivered by the ARC via a multitude of entry pathways. These include service referrals via community partners (e.g., Stockton Shelter for the Homeless, St. Marys' Dining Room, etc.), emergency services, San Joaquin County Behavioral Health Services (SJCBHS), law enforcement, the county court system, CMC primary care, and self-referral. If the individual accessed CMC services while intoxicated, they were offered sobering services, consisting of sobering beds available on the premises. Once sober, or if they accessed services when not intoxicated, they were offered a brief screening assessment to identify treatment needs, in addition to access to services that are designed to address immediate basic needs (e.g., thirst, hunger, hygiene). In the event of a positive screen, or based on the clinician's clinical judgment, the individual was offered a full behavioral health assessment, followed by services that could include MAT, withdrawal management, case management, and/or other forms of therapy, dependent upon need. In the final phase of the project, CMC respite residential care services was also available for individuals that require short-term residential care during periods of withdrawal. This service represents the first residential treatment services available in San Joaquin County designed for individuals with co-occurring mild-to-moderate mental health disorders. Individuals in receipt of services delivered under the Homeward Bound system of care were eligible for both physical and mental health care, delivered by existing CMC co-located primary care services.

In addition to the expansion and enhancement of services offered by CMC, a second critical component of the Homeward Bound Initiative includes the establishment of expedited referral pathways between CMC and SJCBHS. Figure 2 depicts how ARC services fit within the broader context of available care delivered under the Homeward Bound Initiative. If an individual with a severe mental health condition engaged with services at CMC, they were offered an expedited referral to SJCBHS including a "warm hand-off," with details from the CMC assessment passed on to SJCBHS to minimize any duplicate assessment. In cases where a screening or full assessment at SJCBHS took place, and the individual was deemed to be experiencing a mild-to-moderate behavioral health concern, the individual was referred directly to CMC with a "warm hand-off." Minimizing these barriers to appropriate care was implemented improve access and engagement to appropriate treatment, with the aim of leading to better outcomes overall.

Figure 2: The Homeward Bound Initiative Full System of Care

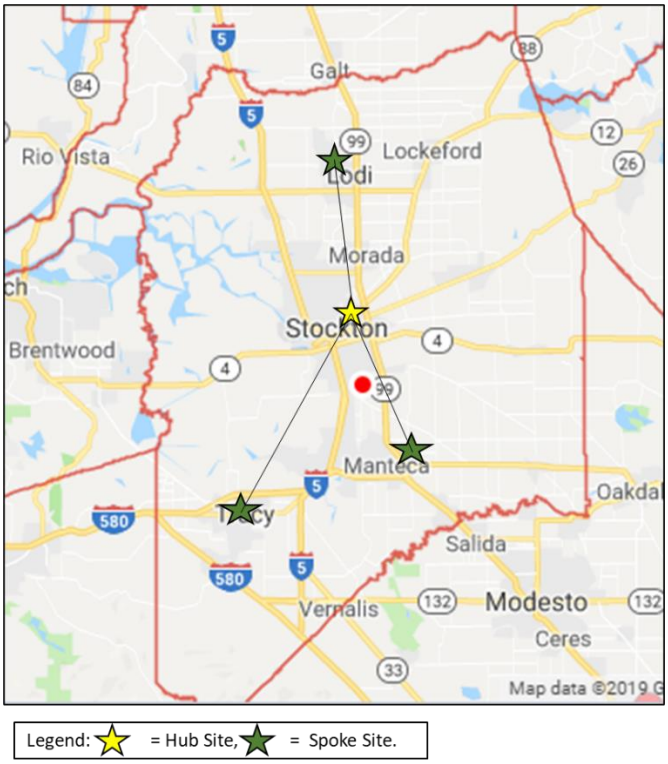


The Three-Phase Approach to the Implementation of the Homeward Bound Initiative

In Homeward Bound proposal, the implementation of the project was designed to follow three discrete stages. In the first phase, CMC developed a primary "hub" site for Homeward Bound services situated in the county capital, Stockton. This site is co-located with the CMC Waterloo Road primary care clinic and includes most of the services presented in Figure 2. Following the establishment of the hub clinic, the expansion of Homeward Bound services to cover the breadth of San Joaquin County was developed through a "hub and spoke" model of service delivery. A visual representation of this model is presented in Figure 3. This included the expansion services to satellite CMC clinics across San Joaquin County (the "spokes"), including Lodi, Tracy, and Manteca. Under this model, clients could either be initially seen at the hub site and then referred out to one of the satellite clinics at the convenience of the client, or else they could be referred into the system of care at the spoke site directly. The spoke site typically utilizes the technical expertise and additional resources of the hub to best respond to the needs of the clients' treatment. In the third and final Phase of the proposal, CMC opened a short-term

residential care service to support clients experiencing significant symptoms of withdrawal in the city of Stockton, available to all clients that receive care within the hub and spoke system.

Figure 3: Visual Representation of the "Hub and Spoke" Model of Homeward Bound Service Delivery Across San Joaquin County



Defining Mild-to-Moderate and Severe Mental Health Concerns

One component of the Homeward Bound Initiative involves a direct referral pathway between CMC and SJCBHS to ensure each consumer receives the appropriate level of care for their behavioral health concern promptly. Individuals determined to have a mild-to-moderate mental health diagnosis, or have a primary diagnosis of SUD, will receive treatment at CMC. Individuals identified as having a severe mental health diagnosis will typically receive treatment at SJCBHS. Individuals are identified as meeting the criteria for a severe mental health concern based upon the Beacon criteria, which are as follows:

> The individual will be considered to have a severe mental health concern if:
>
> 1) The consumer has at least one mental health disorder diagnosis.
>
> AND

2a) If the duration of illness is less than one year, then they must exhibit at least four moderate, two severe or one extreme impairment in the following domains:

i. Feeling, mood, affect
ii. Thinking
iii. Family/living environment
iv. Interpersonal relationships
v. Performance of daily activities
vi. Social and legal
vii. Basic needs and self-care

OR

2b) If the consumer is identified as having a duration of mental illness of over one year, then they must exhibit at least two moderate, or one severe impairment in the domains listed above.

Indicators of Severe or Extreme Impairment

Indicators of severe or extreme impairment include mental health symptoms that substantially interfere with daily activities; highly disorganized, impulsive, or aggressive behaviors with a decline in self-control; suicidal or self-harming behaviors; disruptions in self-care; and substantial disruptions in interpersonal relationships.

Indicators of Mild-to-Moderate Impairment

Indicators of mild-to-moderate impairments may include manageable mental health symptoms that are attributable to social stressors (i.e. loss of job, bereavement, management of a chronic medical condition); an expectation of a resolution of symptoms within six months; an ability to manage daily activities despite the presence of symptoms; no or minimal impact on interpersonal relationships; the absence of emergency psychiatric admissions in the past 12 months; stable adherence to medication for over 12 months or medications no longer required.

Reducing Convictions amongst Clients with a Criminal Justice History

In addition to improving care access and the range of services available, one of the key aims of the project was to reduce recidivism amongst individuals with behavioral health disorders. For this study, recidivism was defined in the following way:

> "The conviction of a new felony or misdemeanor committed within a specified period of the intake assessment of the Homeward Bound program."

Goals and Objectives

The Homeward Bound Initiative combines project goals as stated in the "Project Evaluation Plan" section of the Proposition 47 grant proposal (Proposition 47), submitted to the California Board of State and Community Corrections in February 2017, and the goals and objectives stated in the *Purpose of the Innovation* section of the Assessment and Respite Center Innovation Plan Document, submitted to the California Mental Health Services Oversight and Accountability Commission (MHSOAC). Where goals and objectives are closely related or overlap with each other they have been combined and synthesized for clarity.

Goal 1. Reduce systemic gaps which lead to the underutilization of mental health services.
Objectives:

- To address structural limitations of the current model of care that leads to the underutilization of appropriate services in people with mental illnesses and co-morbid SUDs.
- To provide stabilization services, respite residential care, withdrawal management, housing, and case management, when necessary, to facilitate consumer engagement in mental health treatment.

Goal 2. Improve access to mental health services for underserved groups.
Objectives:

- To provide mental health services to non-violent offenders with trauma or other mental health concerns.
- To provide mental health services to high-risk individuals with SUD who are homeless, and/or have frequent law enforcement contact associated with their behavioral health concerns.
- To increase the number and proportion of Latinx and Black and African American and individuals who utilize community behavioral health services.

Goal 3. Reduce gaps in the substance use disorder continuum of care.
Objectives:

- To provide effective SUD treatment services, ensuring that providers are trained in effective treatment practices, and are assigned to deliver services.
- To provide effective SUD treatment services, allowing former offenders to receive diversion programming and/or direct their own recovery efforts.

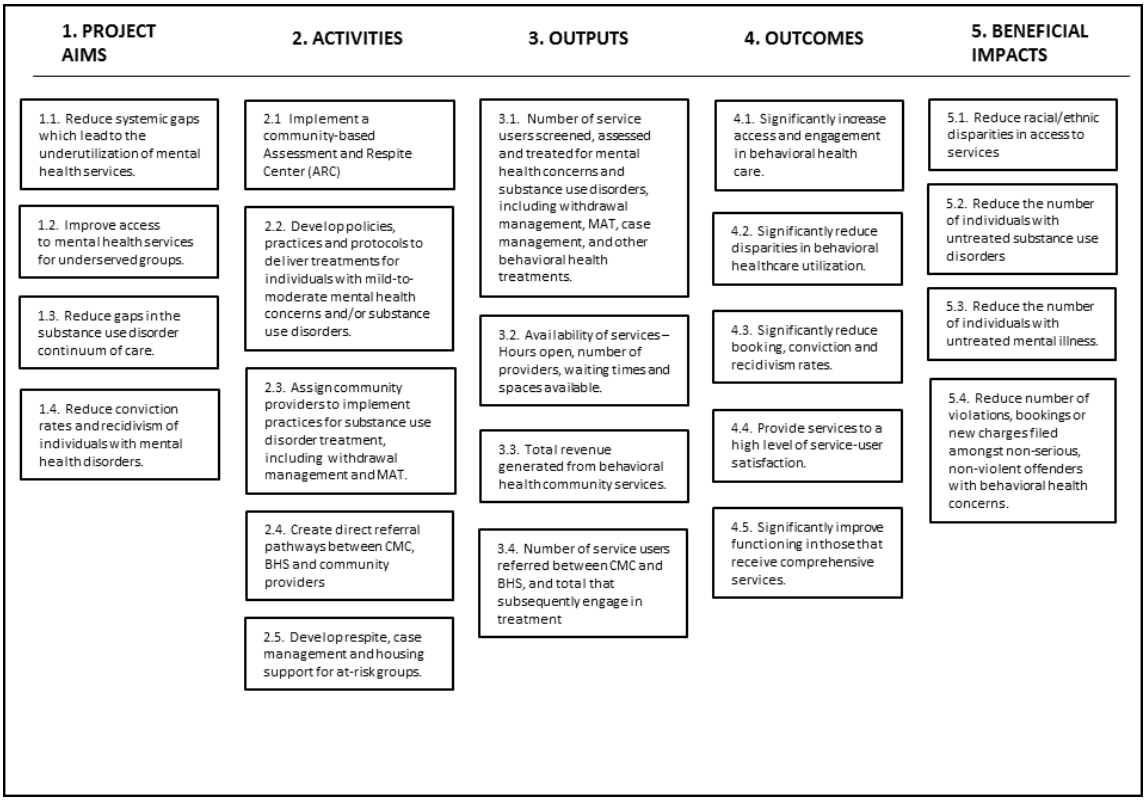
Goal 4. Reduce conviction rates and recidivism of individuals with mental health disorders.
Objectives:

- Improve the quality of life of non-violent consumers with prior convictions; individuals with SUD; those that are homeless or at risk of homelessness; and any other populations that have frequent contact with law enforcement associated with their behavioral health concerns.
- Reduce the number of incarcerations among non-violent offenders with untreated mental health and/or SUD and reduce the rate of recidivism in this population.

Logic Model

The logic model for the formative and summative evaluation of the Homeward Bound Initiative is detailed in Figure 4. The figure details the original aims of the project, the proposed activities designed to meet those aims, a measure of how successful the project has been at producing those activities ("outputs"), and the impact of the activities delivered (the "outcomes"). The "beneficial impacts" column lists the wider, system-level changes one may hope or expect to see based on the success of the previous components of the logic model as outlined.

Figure 4: Logic Model of the Homeward Bound Initiative



Key: ARC, Assessment and Respite Center; BHS, Behavioral Health Service; CMC, Community Medical Centers; MAT, Medication-Assisted Treatment.

Modifications to the Delivery of Homeward Bound Services because of the COVID-19 Pandemic

At the beginning of the COVID-19 pandemic, states began to implement shelter-in-place orders to reduce the rate of transmission. By mid-March 2020, CMC had implemented a significant restructuring of its services to safeguard the health of providers and consumers, and to comply with shelter-in-place mandates. To understand the scope of these amendments, and their impact on the evaluation, members of the evaluation team interviewed the CMC project lead on two separate occasions. The first took place on April 21, 2020, not long after the protocol changes had been implemented. In this meeting the focus was on understanding the immediate changes that had taken place, and the potential short-term impact of the pandemic on the project. The second interview took place on October 1, 2020, to better understand the medium-to-long term impacts of the pandemic and the service changes, including the period from July to August 2020, when COVID-19 reported cases were at their first peak in San Joaquin County. The findings of these interviews are detailed in the results section.

Methods/Data Collection

Study Design

This report represents a formative and summative evaluation of the Homeward Bound Initiative. The outputs evaluate the staged implementation and expansion of the proposed activities. The outcomes evaluated in this report follow directly from the goals outlined in the *Goals and Objectives* section of this document and were outlined in detail in Section 4 of the *San Joaquin County Homeward Bound Initiative Evaluation Plan,* beginning on page 25. Those outcomes are listed below:

Outcome 1: Improvements in Access and Engagement in Care
Outcome 2: Reducing Disparities in Behavioral Healthcare Services Utilization
Outcome 3: Reducing Criminal Justice Bookings, Convictions, and Recidivism
Outcome 4: Delivering High Levels of Consumer and Provider Satisfaction with New Models of Care
Outcome 5: Functional Improvements Following Treatment

Target Population

All adults who accessed services delivered through the Homeward Bound Initiative were eligible for inclusion in the analysis. The analysis will include all service data collected between the point when the Homeward Bound program's data was incorporated into the CMC electronic medical record (EMR), from 08/01/2018 until 12/31/2022. The clients included in this evaluation included everyone who was either referred or self-referred to one of the Homeward Bound program's hub or spoke sites to receive care, or utilized Homeward Bound sobering facilities during a period of intoxication.

Services Delivered by the Homeward Bound Initiative

The original components delivered as part of the Homeward Bound Initiative included MAT, withdrawal management, sobering, case management, outpatient respite services, mental health treatment, and SUD counseling from a recovery counselor. The services delivered are consistent with the American Society of Addiction Medicine (ASAM) guidelines at both Level 1 and Level 2 degrees of intensity ("ambulatory withdrawal management with and without extended on-site monitoring") (Mee-Lee et al., 2013). In the third and final implementation stage of the project, service delivery was extended to include residential respite services, enabling care consistent with ASAM Level 3.1 and 3.2 services (i.e., "clinically managed low-intensity residential services"). In conjunction with these additional services, consumers were eligible, based on need, to receive ongoing co-located physical and mental health care as part of CMC's existing services.

MAT is the use of medications in combination with supportive therapies to treat SUD. The ARC primarily administered two medications: suboxone (buprenorphine and naloxone) for the treatment of opioid use disorders and naltrexone for the treatment of alcohol use disorders. Buprenorphine suppresses the physical signs and symptoms associated with opioid withdrawal and is an effective intervention in the maintenance treatment of opioid dependence (Mattick et al., 2014). Naltrexone blocks feelings of intoxication and euphoria and has been found to reduce self-reported cravings and alcohol use (Hendershot et al., 2017).

The recovery counseling component of care was delivered both in a group format and on a one-to-one basis. Both treatment formats were delivered by qualified recovery counselors, and the focus of these treatments were to support the individual in their recovery from SUD. If either during the assessment or ongoing SUD treatment the consumer is identified as having additional mental health needs, then they were referred to a CMC behavioral health clinician where they can receive additional services.

For those who presented to the ARC intoxicated either via a self-referral, or a referral from law enforcement or other community partners, they were offered a safe space to achieve sobriety. Once sober, an assessment and additional care services was offered, based on need.

In addition to mental health and SUD treatment, the Homeward Bound Initiative provided a range of additional supportive services delivered as part of case management and respite care. This included addressing immediate basic needs (i.e., providing food, basic hygiene support, etc.) to providing long-term case management, housing support, and employment assistance. Depending upon the nature of the support required, these services were delivered by ARC case managers or referred out to community partners. One of the primary aims of this component of care was to establish early engagement with the consumer, develop rapport, address basic needs, and provide an additional pathway to treatment for SUD and/or mental health treatment. As major component of this work included housing, vocational, and transportation support to facilitate engagement in care, address homelessness and housing insecurity, and support functional outcomes.

In the final stage of the project a short-term residential facility was established in Stockton to support substance withdrawal care for consumers where 24-hour monitoring was assessed to be clinically necessary (i.e., ASAM Criteria Level 3.1 and 3.2). In this facility, trained medical and behavioral health staff were on hand to medically manage consumer withdrawal, after which they could be triaged to Homeward Bound community services - including services detailed above - to support consumer recovery.

Data Collection Procedures

CMC Electronic Medical Record (EMR) Data Collection Procedures

CMC provided the evaluation team with a client-level, de-identified dataset pulled directly from the services medical record, covering the study period from August 2018, until January 2023. In this dataset each client was assigned a unique study ID code enabling client-level linkage to other CMC-hosted datasets and includes an array of data, including service history, sociodemographic information, and a series of self-report measures. Consequently, this data represents the core components of the evaluation conducted.

In line with current practices, if the consumer does not already have an EMR at CMC, one is created at the first appointment. The EMR contains all of the consumer's demographic information and an ongoing record of their care. During their first appointment, the consumer completes the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder Scale (GAD-7). During this, or any subsequent appointments, if it becomes evident the consumer may be experiencing a SUD, they are encouraged to complete the Treatment Needs Questionnaire (TNQ). If this screening form identifies any intravenous drug use, prior receipt of MAT, use of cocaine or benzodiazepines, or alcohol misuse, then the consumer is referred to complete a full behavioral health assessment. During the assessment, the consumer is instructed to complete the Client Satisfaction Questionnaire (CSQ-8), the Drug Abuse Screening Test (DAST) (for a more detailed exploration of their drug use history if they reported prior drug use), and the CAGE Substance Abuse Screening Tool (CAGE) if they report a history of alcohol problems. The individual will then be referred to receive either withdrawal management, MAT, counseling, case management, and/or respite care, based on the outcome of the assessment. Individuals referred to receive MAT will complete the Office-Based Opioid Treatment Stability Index (OBOT) at the initiation of treatment, and then at monthly intervals to review patient stability and recovery outcomes. As part of ongoing care, all consumers complete the PHQ-9 at every appointment, and the GAD-7 every six months. These data are used to both inform care, and track symptom progression over time. All the data are stored within the CMC EMR, and at each reporting stage, this data was extracted by CMC analysts and provided to the evaluation team for analysis.

Data Collection Procedures for Case Management and Respite Residential Services

While the CMC EMR dataset contains most elements relevant to reviewing the numbers of services delivered, notably this does not include the range of case management services delivered. These services include the provision of housing assistance to support clients either homeless or at risk of homeless, other forms of financial aid, hygiene support, employment support, and assistance around transportation to and from treatment. These components of care represent a critical component of care delivered by the Homeward Bound program and are considered crucial to maintaining engagement in treatment and supporting recovery outcomes.

To incorporate these components of care into the evaluation, providers at CMC maintained a case management dataset that details the range of services provided.

Secondly, while the location of service delivery is available in the CMC EMR dataset, this is automatically updated as clients shift to different locations of care. Consequently, while it is possible to identify those either currently receiving respite residential services, or those that received such care and were discharged from CMC straight afterwards, the majority of clients were transferred to their community primary care sites, meaning the total figure would be a significant under-representation of the total number actually served. To address this, similarly to the Case Management Dataset, CMC staff have produced and maintained a spreadsheet detailing the date of admission and discharge from respite residential care. Data is available from all clients that have received services at this location since October 2021.

Data Collection Procedures for Recidivism Data

In the original proposal, convictions data was proposed to be sourced through the State of California Department of Justice records. However, due to state policy changes, Health Insurance Portability and Accountability Act (HIPAA) requirements, and significant barriers concerning release of information requests, this approach was not considered feasible for this project. Consequently, in January 2019, CMC and the evaluation team modified their data collection practices in the following ways. First, as part of the intake assessment, in addition to asking consumers whether they had a criminal history, they were also asked for the most recent date of release from prison or placement on supervision. This data was then later extracted from the intake assessment form and added to a dedicated excel sheet used to track convictions data. This approach was considered feasible, given the evidence supporting the validity of self-reported arrest data (i.e., Daylor et al., 2019).

To track subsequent convictions, CMC staff manually checked the Superior Court of San Joaquin County public court records for consumers every 12 months post the baseline assessment. These records were available at the following address: https://cms.sjcourts.org/fullcourtweb/mainMenu.do?&PageSize=0&Index=0. In cases where the consumer was convicted of a new felony or misdemeanor post assessment, this information was added to the convictions data excel sheet.

To link both the recidivism and EMR datasets, an analyst based at CMC assigned all consumers a unique identification (ID) number. Once the evaluation team received the datasets, they were merged via anonymized unique identifiers.

The CMC Financial Dataset

With the CMC Financial dataset, we aimed to address Output 3 of the logic model, concerning the total Revenue generated from Homeward Bound related activities. The dataset includes a monthly snapshot of the monthly revenue generated and the associated costs of care delivery from May 2021 to May 2022 at the primary Waterloo Road hub clinic and the Tracy recovery

spoke site. This period was selected as it represents the project at the point of maturation, therefore providing the most accurate assessment of what ongoing costs and income could be expected to be going forwards. Total monthly revenue generated includes both the total funds generated, and the funds generated excluding grant funds. This therefore allows for an assessment of the program current financial position of the project, in addition to an assessment of the possible shortfall that may exist once the grant expires.

Measures

In the current evaluation, the following client self-report and clinician administered surveys were utilized:

Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) is a brief, nine-item instrument designed to diagnose depression and measure depression severity. Items concern different features of depression such as anhedonia, depressed mood, and loss of appetite. Depression is diagnosed by a PHQ-9 score of 10 or greater. As a severity measure, the scale ranges from 0-27, with a higher score indicating more severe depression. In this evaluation, all clients completed the PHQ-9 at the point of assessment, and then at each appointment until the point of discharge from Homeward Bound Services.

Generalized Anxiety Disorder Scale (GAD-7)

The Generalized Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006) is a seven-item questionnaire designed to both diagnose and measure the severity of anxiety the responder has experienced over the past two weeks. Items relate to symptoms such as uncontrollable worrying, irritability, and restlessness. Each item is rated on a scale of 0 (“not at all” bothered) to 3 (bothered “nearly every day”). A score of 1-4 is considered to indicate minimal anxiety, 5-9 mild, 10-14 moderate, and 15-21 severe. The authors suggest a score of 10 or higher as a reasonable cut-off point for identifying cases of GAD. The scale was administered to all clients at the point of assessment amongst those who present with anxiety, as determined by the assessing clinician.

The Drug Abuse Screening Test (DAST)

The Drug Abuse Screening Test (DAST; Skinner 1982) is a 20-item self-report questionnaire designed to measure the degree of problems the client experiences because of their drug use. Each item requires a dichotomous yes/no response and includes items relating to interpersonal conflicts, occupational problems, criminal activities, side effects, guilt, addiction, and treatment related to drug use. American Society of Addiction Medicine (ASAM) placement criteria suggest that a score ≤ 5 indicates a low-level impact of drug abuse, 6-10 indicates moderate, 11-15 indicates substantial, and ≥ 16 indicates a severe impact, with the individual likely requiring intensive treatment services. Clients completed the DAST at CMC at the intake assessment.

The CAGE Substance Abuse Screening Tool

The CAGE Substance Abuse Screening Tool (Ewing, 1984) is a four-item questionnaire used to identify responders who may potentially be misusing alcohol. Each item requires a dichotomous yes/no response and asks the responder whether they have ever felt that they should cut down on their drinking, if they get annoyed because people criticize their drinking, if they have felt guilty regarding drinking, or if they have ever had a drink first thing in the morning to alleviate symptoms of alcohol addiction or a hangover. The typical cutoff used for the CAGE is two positive answers. Clients completed the CAGE in CMC at the intake assessment.

Client Satisfaction Questionnaire (CSQ-8)

Clients' satisfaction will be assessed using the CSQ-8 (Larsen et al., 1979). The CSQ is an eight-item Likert questionnaire where responders rate each item from 1-4, with a higher score representing greater satisfaction with treatment. The CSQ-8 has been extensively used in various healthcare settings and has been validated for use in SUD populations (Wilde and Henriks, 2005). Clients receiving services at SJCBHS completed the CSQ-8 during their full assessment. Clients receiving care at CMC completed the CSQ-8 at the point of assessment.

Analysis Plan

The analysis detailed in the current report comprised of two discrete sections, which include the formative and the summative evaluation. The formative evaluation focused on the following areas: summarizing the impact of COVID-19 on program implementation, detailing the number of and types of services delivered over time, and summarizing the sociodemographic and clinical presentation of the sample to ensure the program has been successful at engaging the intended target population.

The impact of COVID-19 on program delivery was explored utilizing semi-structured qualitative interviews with program leadership in a longitudinal design to capture both the short- and longer-term impacts. The interviews were recorded, with the main findings outlined in a narrative summary. Next, a review of the implementation and expansion of Homeward Bound services was conducted. This included utilizing basic summary statistics to detail the number of consumers enrolling in different components of care over time, and the expansion of services across the hub and spoke sites. Additionally, summary statistics detailing consumer engagement in different Homeward Bound services and 6-month retention rates were examined, with retention calculated as the difference between the month of their first appointment, and the last appointment date recorded for that specific intervention in the consumers EMR.

The sociodemographic details of the sample, including consumer age, race and ethnicity (combined as single variable), gender, and housing status, were examined utilizing simple summary statistics, based on consumers' self-report at the baseline assessment stage. Finally,

the clinical presentation of the sample at the baseline stage was examined using the PHQ-9 to capture depressive symptoms, the GAD-7 to measure symptoms of anxiety, the DAST to record the degree of problems experienced related to drug use, and the CAGE to record the degree of problems related to alcohol use.

The outcomes evaluation focused on the following areas: improve behavioral healthcare utilization amongst underserved groups, summarize the recidivism and reconviction rates of Homeward Bound consumers, provide services to a high degree of consumer satisfaction, and improve clinical outcomes amongst Homeward Bound consumers over time.

In the first part of the summative evaluation, referral, and engagement rates of consumers from historically underserved groups were compared to the total population. In the context of this evaluation, historically underserved groups included homeless individuals, Black, and Latinx individuals. Engagement was defined as the consumer attending the first session of the program, with plans made to receive ongoing care. To evaluate the efforts to engage underserved populations, the total proportion of individuals that identify as belonging to each of these groups were reported. With regards to race and ethnicity, this was compared to population rate and the service utilization rate at SJCBHS, based on the assumption that the behavioral health needs across the different racial and ethnic groups would be broadly consistent. To evaluate efforts to engage individuals from these underserved groups into different components of care, engagement rates of each sub-group were compared to the remaining population using Chi-square tests.

Analysis of behavioral healthcare service utilization among underserved populations was accomplished by examining the demographics of the consumer population, including the share of consumers in mental health treatment and SUD counseling for at least six months. We assessed the utilization of services by underserved groups by comparing the Homeward Bound Initiative's service utilization by race and ethnicity to their respective rates within the general population.

Analysis of reconviction among clients with a criminal justice history focuses on the share of persons with a criminal justice history among all clients over time, and the reconviction rate at 12 and 24 months from enrollment.

In the evaluation of consumer satisfaction, simple summary statistics were utilized to explore the degree of satisfaction consumers had with services, as measured using the CSQ-8. In this analysis satisfaction scores were analyzed as a single summary score, in addition to item-level analysis. Additionally, the proportion of consumers that scored at least a mean score of '3' on the CSQ-8, indicating moderately high levels of satisfaction, was reported.

In the final part of the summative evaluation, the analysis of functional improvements in consumers with mild-to-moderate behavioral health concerns was limited to consumers with mild-to-moderate depression. Consumers with mild-to-moderate depression were identified

using the PHQ-9 questionnaire administered during the consumer's initial assessment; we define this initial PHQ-9 as the consumer's baseline PHQ-9 score. We assessed the share of consumers receiving the PHQ-9 questionnaire in each month since their baseline month, where a consumer's baseline PHQ-9 is indexed as month one. We also estimated the mean month-to-month change in subsequent PHQ-9 scores relative to the mean baseline PHQ-9 score using fixed-effects panel regression to control for unobserved consumer characteristics that were constant in time and correlated with PHQ-9 scores.

Formative Evaluation - Results

Impact of COVID-19 on Homeward Bound Program Implementation

To detail both the short- and longer-term impact of COVID-19 on the implementation of the Homeward Bound Initiative two rounds of semi-structured qualitative interviews with CMC Leadership were conducted. The first took place on April 21, 2020, while the second took place on October 1, 2020. A summary of the findings from these interviews is detailed below.

April 21, 2020, Meeting Between the CMC Program Lead and the Evaluation Team

By the middle of March 2020, to minimize potential COVID-19 exposure to consumers and providers inside the ARC, CMC implemented an outdoor triaging service where consumers were screened before coming in for their appointments or assessments. In addition, many appointments that were previously conducted in-person, either on-site or in the community, were changed to be delivered over the phone. At the time, the program director suggested that this shift to telemedicine had been received well by consumers with minimal impact on service engagement.

Regarding services that were either reduced or canceled, CMC was no longer able to offer the "Shower of Love" service, which entails making showers available every Wednesday with the provision of fresh clothing. To minimize the impact of this, they started to provide "Health Kits" that included sanitary products and hand sanitizer as an alternative. Sobering services were restricted to one patient per room, which significantly reduced the service capacity. Additionally, the hours of operation were shortened from 24 hours a day to running from 8 a.m. to 5 p.m.

The CMC Program Lead reported a significant shift in the population served, and the reported needs of the consumers. This change was attributed primarily to four factors: 1) the reduced hours of operation, 2) the closure of local liquor stores, 3) the change in referral pathways, and 4) the shift in need toward housing and nutritional support due to increased unemployment/lack of work, the need to be off the streets during a pandemic, and other agencies either closing or reducing services.

As stated previously, due to staffing and sanitation needs, CMC changed the hours of operation of the ARC from 24 hours to 8 a.m. to 5 p.m. Anecdotally, the experience of the program lead was that these new hours limited access for people who normally scheduled evening appointments, or walked-in after 5 p.m. This was considered to represent a particular barrier to those employed during standard work hours, albeit with the impact mitigated to some extent through the expansion of telehealth services.

Additionally, CMC noticed a rise in the number of consumers seeking help with their alcohol use disorder, and greater consistency in appointment attendance amongst those who had previously been inconsistent. Some of the factors that were attributed to this included the closure of local liquor stores reducing the accessibility of alcohol, the greater flexibility afforded by the availability of telemedicine, and a decline in other competing ways consumers were able to spend their time. In response, an additional provider was brought into the MAT program to manage the increased demand. CMC were also in the progress of hiring more SUD counselors to respond to the increased need.

The typical referral pathway into the Homeward Bound program experienced a significant shift because of the pandemic. The main changes included a greater number of referrals coming from emergency departments (ED), and the absence of consumers being referred by the county law courts after their closure in March. Regarding the changes in ED referrals, part of this change was attributed to the significant outreach that CMC had been conducting with local hospitals immediately prior to the start of the pandemic. However, another factor was ED personnel more actively referring housing-insecure consumers to Homeward Bound services who were either exposed to COVID-19 or were experiencing non-serious COVID-related symptoms to facilitate isolation. This was considered an important factor in the shift towards an increase in demand for housing services, relative to before the pandemic. Regarding the county court closures, not only did this mean a previous referral source was unavailable to the project, but it also reduced the proportion of the treated population that report having a criminal history, particularly those who are released from custody/placed on supervision within three years of treatment initiation.

One of the biggest changes was the shift from referrals for SUD needs to housing-related needs. Because CMC was one of the few programs still providing services to the community at the time, there was a higher demand for respite services and housing. Through the help of Proposition 47 and Mental Health Services Act (MHSA) Innovation grants, the county allowed them to use hotel vouchers to house consumers. CMC was also purchasing food, providing laundry vouchers and soap, and providing pet food, which increased costs but expanded the scope of CMC's services.

October 1, 2020, Meeting Between the CMC Program Lead and the Evaluation Team

The evaluation team interviewed CMC leadership again on October 1, 2020, to get an update on how the pandemic continued to affect services and implementation. Notably, costs

increased due to the need to buy equipment for staff to work from home long-term, such as laptops and cell phones. Referral pathways had also changed. The County courts opened in May 2020, resulting in a flux of court referrals beginning in September. In September 2020, police began to refer individuals again now that more knowledge about COVID-19 and preventative measures had been disseminated. Heightened police referrals led to an increase in sobering utilization.

CMC hired more staff, all of whom specialize in addiction. Even with the additional staff, there had been staffing shortages, and an increase in staff anxiety and burnout as the pandemic continued. Many staff had children and had balanced family responsibilities with children at home full-time, and remote working. CMC offered time off to help with burnout, but many staff declined the offer because there were no travel opportunities during the pandemic. Those who did take time off did so for family obligations, and therefore were not resting, leading to further burnout. CMC opted to allow some staff to come back into the office, while maintaining distance to alleviate the double burden of working while aiding in childcare.

Consumers were initially excited to have the service remain open, but over time it was noted that consumers found the situation increasingly challenging, resulting in a higher rate of relapse and increased demands upon staff. SUD patients that previously had consistent, regular appointments adjusted well to remote sessions. However, newer consumers had trouble engaging via phone. Moreover, there was an influx of consumers who were predominantly seeking housing, not treatment. Once assessments and treatment started, many of these consumers opted to leave, increasing dropout rates.

Staff had also needed to educate consumers on confidentiality and finding a safe space to engage in remote sessions. Consumers sometimes called in to sessions in public or near family, compromising the confidentiality of sessions. Staff encouraged consumers to find private locations, but when not available, staff documented the circumstances of the session (i.e., family in earshot, etc.). Another issue with remote sessions had been making sure consumers have enough minutes on their cell phones to last a full session.

For consumers who were going into CMC, there had been issues surrounding transportation. CMC used to utilize Lyft for consumer transportation; however, during the pandemic there had been a shortage of Lyft drivers. Furthermore, buses limited how many individuals could ride at a time, furthering transportation limitations.

Impact of COVID-19 on Homeward Bound Implementation – Summary

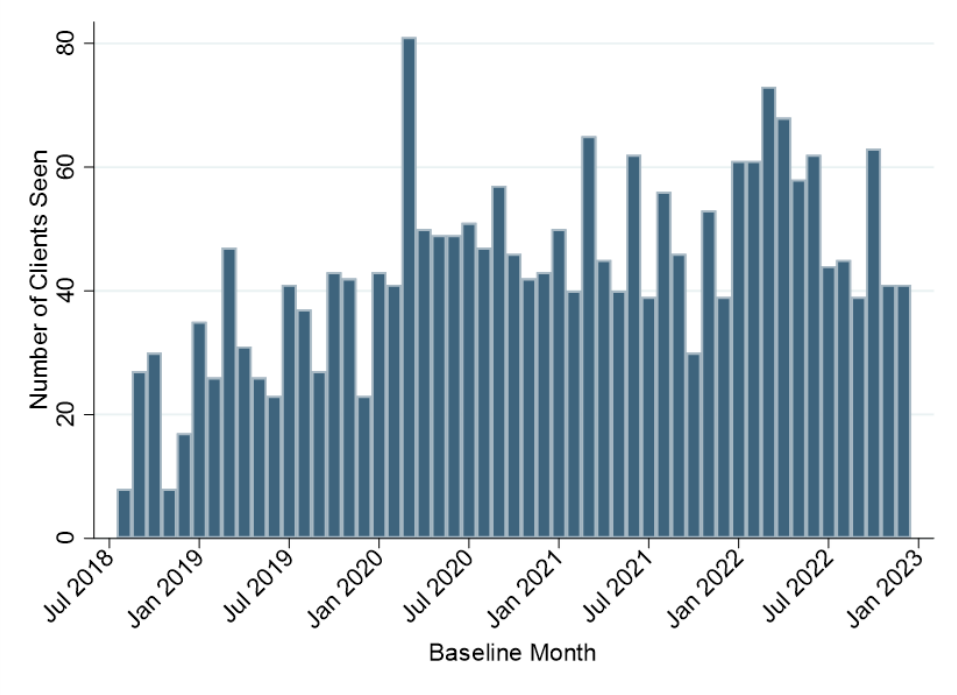
The pandemic is likely to have impacted the evaluation findings in multiple important ways. First, the experiences reported by the Program Lead during both interviews indicate that a significant change in the case-mix of new consumers occurred. In the early stages of the pandemic, a larger proportion of consumers who were entering into the system had significantly more housing needs—and a greater focus on addressing their housing situation—as opposed to substance use disorder needs, relative to pre-COVID consumers. In addition, a

greater number of referrals came from EDs, and none from the county court system. These changes in the case-mix was suggested to lead to significant changes in the data in terms of how consumers engaged in treatment, modified treatment response trajectories, and reduced the proportion of people with a criminal history, which in turn impacted recidivism outcomes. In the October 2020 interview, the prolonged experience of working and living through a pandemic, and the subsequent shelter-in-place mandates, were found to lead to significant burnout among providers and increased frustration among consumers. In both cases, this could again negatively impact staff turnover, treatment engagement, and subsequent treatment outcomes. In addition, it is also important to consider the impact of the changes in services delivered both by Homeward Bound and community partners on the evaluation itself. For example, the switch from in-person appointments to telehealth may represent barriers to consumers who do not have phones, have limited minutes on their pre-paid phone plans, or frequently lose access to their phones. In addition, CMC reported that while existing consumers had managed to remain engaged in treatment, engaging new referrals via telemedicine was more challenging, suggesting that higher dropout rates during this period for new consumers was expected. Social distancing requirements had led to a significant reduction in the availability of sobering beds, which significantly reduced the number of consumers who both receive these services, and other services, as a consequence of coming in via this pathway. The closure and restriction of services delivered by other community agencies was also likely to have resulted in fewer additional needs of the consumers being met. Overall, consistent with the changes in the case-mix of consumers, these changes are likely to have negatively impacted meeting consumer needs, treatment engagement, and treatment outcomes. Were appropriate, these factors were considered in the interpretation of the findings presented in this report.

Service Delivery and Expansion over Time

from July 2018 to January 2023, 2,355 unique individuals were enrolled in the Homeward Bound Initiative. The number of individuals enrolled over time during this period can be found in Figure 5. During the period depicted, there was a significant increase in enrollment over time until the start of the COVID-19 pandemic in April 2020, at which point a very slight downward trend began. As vaccine eligibility expanded and stay-at-home orders were lifted at the beginning of 2022, there was an increase in enrollments.

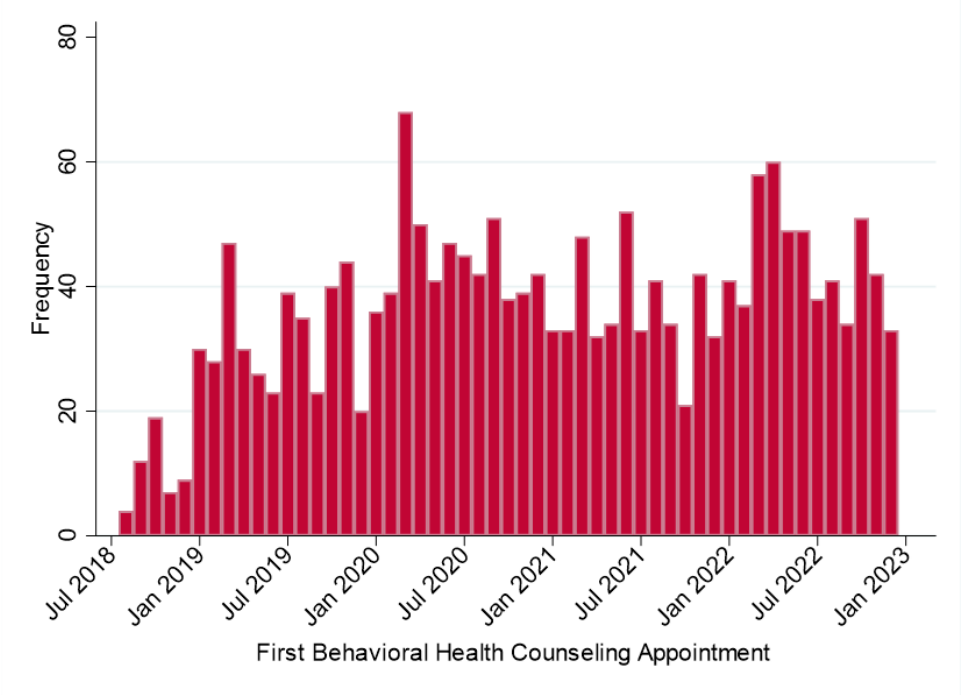
Figure 5: Number of New Clients Enrolled into the Homeward Bound Initiative over Time



In total, 2,228 clients attended at least one mental health or substance abuse counseling session, representing 94.6% of the total population that engaged in Homeward Bound services. Of these, clients attended a median of 3 appointments (IQR 1-7).

The first appointment date was available for 1,976 clients (88.7% of all the clients that attended a behavioral health appointment). The rate of engagement in such services is presented in Figure 6. As expected, these trends are consistent with enrollment figures. Over time, there appears to be a gradual increase in clients seen each month until January 2020, after which approximately 38 clients attended a first appointment each month.

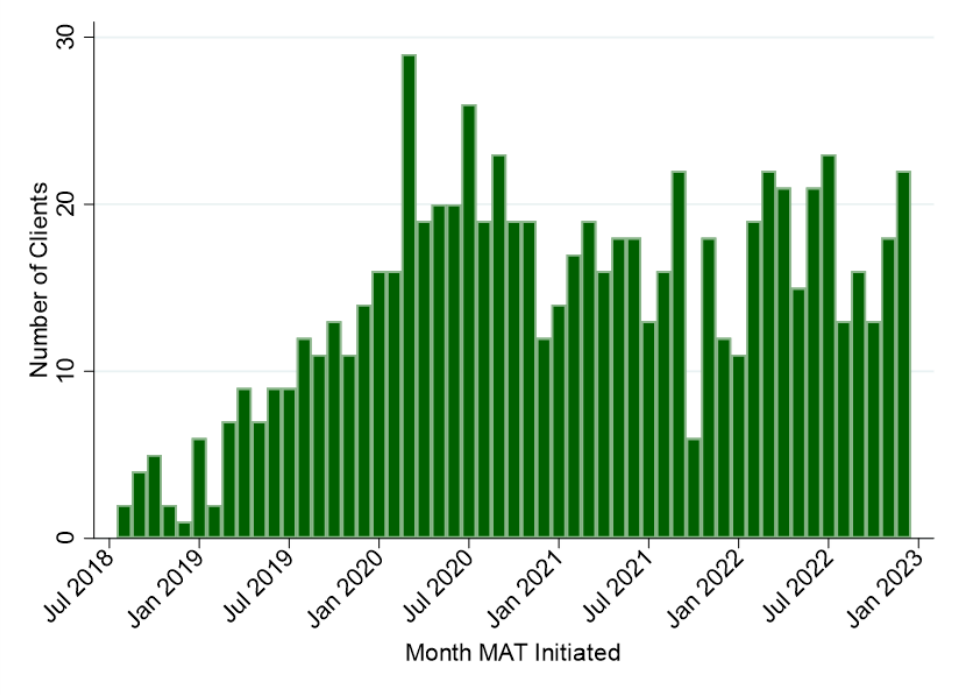
Figure 6: Number of clients completing a Behavioral Health Assessment over Time



From August 2018 to April 2023, 801 clients enrolled in the Homeward Bound MAT program. Not including Homeward Bound clients that initiated MAT prior to the initiation of Homeward Bound, this represents 34% of the total sample. Of these, 417 clients (52.1%) were prescribed Suboxone, and 384 (47.9%) were prescribed Naltrexone. Clients initiating MAT attended a median of three appointments (IQR 1-8).

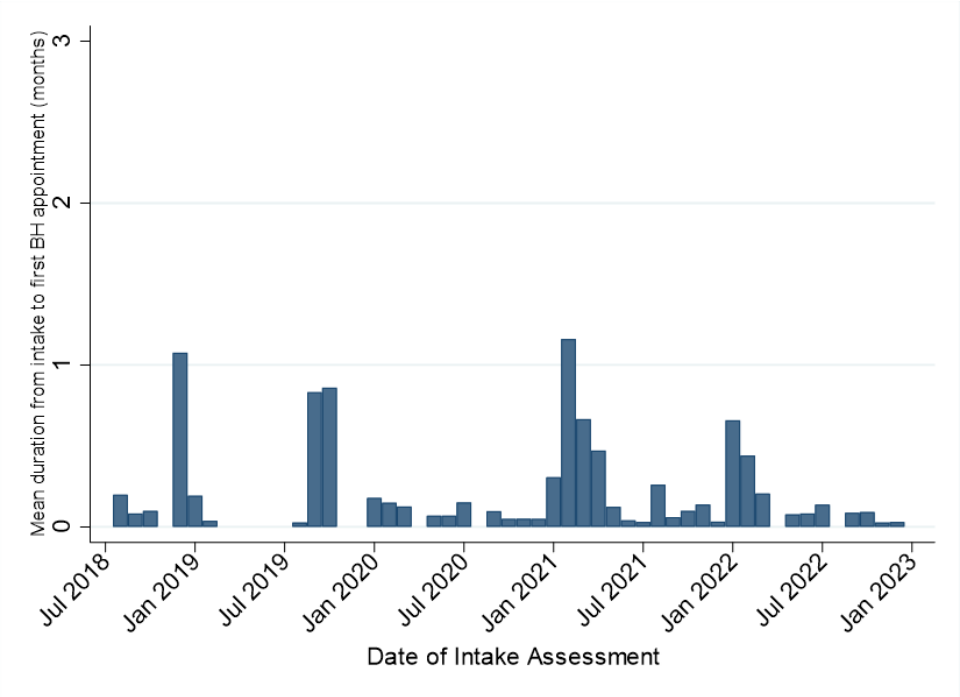
Enrollment into the MAT program over time is presented in Figure 7. Consistent with other metrics, the number of clients seen over time consistently increased until approximately January 2020, after which approximately 18 new clients were seen per month, albeit with substantial variability. Collectively, the data presented in Figures 5-7 appear to indicate that maturation of the project appeared to occur by January 2020, approximately 18 months after project initiation.

Figure 7: Number of Clients who Initiated Medication Assisted Treatment (MAT) over Time



Finally, the mean duration of time between attending the Homeward Bound Initiative intake assessment and the start of behavioral health counseling by month is presented in Figure 8. Throughout the duration of the project, clients were found to consistently engage with behavioral health services within one month of their initial appointment, suggesting that the program has been successful at funneling clients into behavioral health services from the point of contact.

Figure 8: Mean duration between the Intake assessment and the Start of Behavioral Health Counseling, by Month



Delivery of Inpatient Respite Residential Care

At the end of October 2021, the Homeward Bound Initiative opened its Respite Residential Care Program, which represents the third and final implementation phase of the Homeward Bound Inititiave. Data was manually collected by providers at the respite residential service from its opening in October 2021, and has been consistently maintained until November 2022. However, limitations in how this data was recorded meant that between October 2021 and May 2022, it was not possible to consistently determine what proportion of individuals referred went on to receive residential care, and which ones either disengaged, did not meet criteria, or alternatively received outpatient services. Therefore, the following data represents only a subgroup analysis of care delivery following a period of 6 months, from June 2022 until October 2022. During this period, approximately 66 consumers received respite residential services to support substance use withdrawal, which equates to approximately 11 consumers per month.

Delivery of Case Management Services

The delivery of case management services was manually collected by case managers from program initiation until December 2022. In total, case managers reported that 1,257 Homeward Bound consumers received some form of case management services. Of these, at least some information regarding what was provided was available for 382 consumers (30.4% of the total). The most frequently reported service provision included the delivery of some form of housing services (n=278 of consumers), which included referrals to local housing organizations such as the Central Valley Low Income Housing Cooperation (CVLIC), supporting clients to access local

shelters, providing vouchers for people to stay in motels, and rental assistance. The next most frequently provided service included help with transportation (n=184 consumers), supporting people to access healthcare appointments and remain engaged in Homeward Bound services. Finally, case managers recorded providing some form of employment support to 137 consumers, which included conducting career assessments, helping consumers craft resumes, supporting consumers to enroll in vocational training, assisting in job searches, and helping consumers complete applications and prepare for interviews. In the last nine months of the evaluation (April 2022 – December 2022), additional information regarding case managers supporting consumers with documentation assistance, including helping individuals get copies of the birth certificates, other forms of ID, and social security cards was collected. During this period, the available documentation indicates that case managers supported at least 64 consumers in this domain.

Overall, given the challenges in systematic data collection and the substantial amount of missing data, these figures are likely to represent a significant underreporting of the range of case management services delivered. Despite this important caveat, these data help to highlight the volume and range of critical case management services provided to Homeward Bound consumers.

CMC Primary Care Services Received by Participants of the Homeward Bound Initiative

In addition to the various behavioral health appointments Proposition 47 eligible Homeward Bound consumers attended, 2,009 (85.3%) also attended primary care visits at CMC. Individuals that attended primary care visits, on average, attended 5 (IQR = 2 - 12) appointments each. Due to the nature of the data, we are unable to determine what proportion of consumers were existing CMC primary care consumers, and what proportion are new consumers that were enrolled into CMC primary care via the ARC. Regardless, engagement in CMC care via either pathway should be considered important. Amongst Homeward Bound clients who were new CMC consumers engaging in primary care via the ARC, the subsequent increase in billable primary care services represents an important component of the sustainability plan for the ARC. Amongst Homeward Bound clients who were already receiving primary care services at CMC, then given the previous gaps in SUD continuum of care across San Joaquin County, this may represent a low-barrier pathway addressing an important, previously unmet need amongst many CMC consumers.

Development of the “Hub and Spoke” model of Homeward Bound Service Delivery

A review of the development of the “hub and spoke” model to Homeward Bound care delivery is presented in Table 1. While the first client to be entered into the updated EMR took place on August 1, 2018, the first Homeward Bound Initiative client was seen in January 2018 at the Waterloo Road hub site. Since then, services were first delivered at the Lodi site in August 2018 before the broader expansion in March 2019. At the Manteca site, the first Homeward Bound client was served in December 2018, and in Tracy, the first client received services in

September 2019. In January 2020, clients from out-of-county who were originally seen at the Stockton hub site were referred to CMC sites in neighboring counties, including the cities Dixon and Vacaville in Solano County. Despite these additional sites, it is notable that almost all clients involved in the program were served at the Hub Waterloo Road site. The Stockton Hub Site in Table 1 includes multiple sites within Stockton, but are reported as one.

Table 1: Expansion of the Homeward Bound Initiative Across Hub and Spoke Sites

CMC Clinic Site	n	%	First Date of Service
Hub Site			
Stockton	2,000	84.93.%	Jan-2018
San Joaquin Spoke Site			
Lodi	17	0.72%	Aug-2018
Manteca	10	0.42%	Dec-2018
Tracy	227	9.65%	Sep-2019
Out-of-County Spoke Site			
Dixon	21	0.89%	Jan-2020
Vacaville	79	3.35%	Jan-2020
Other Locations	1	0.04%	

Client Retention in the Homeward Bound Initiative

The six-month retention rates of consumers served between August 2018 and August 2022 across different intervention types are presented in Figure 9. Of the 1,780 consumers who received behavioral health services during this period, 575 (32.3%) were still receiving services at least six months later. Of the 696 individuals who received MAT services, 290 (41.6%) were still receiving services six months later. This degree of retention in MAT is comparable to retention rates reported in the literature (Timko et al., 2016), and is important given a longer duration of receiving MAT has been associated with improved outcomes (World Health Organization, 2009).

Figure 9: Six Month Retention for Behavioral Health, SUD, and MAT Treatment

Figure 9.1 BH six-month Retention

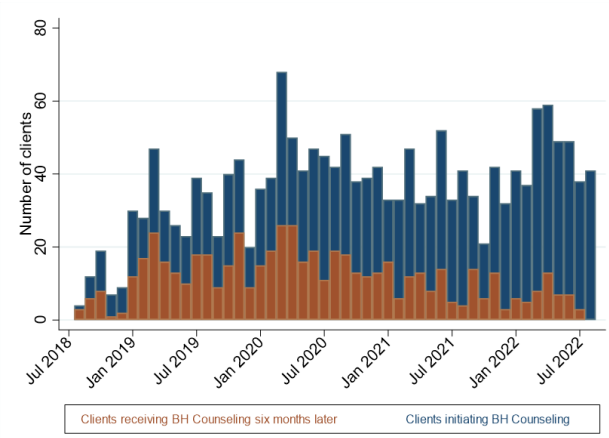
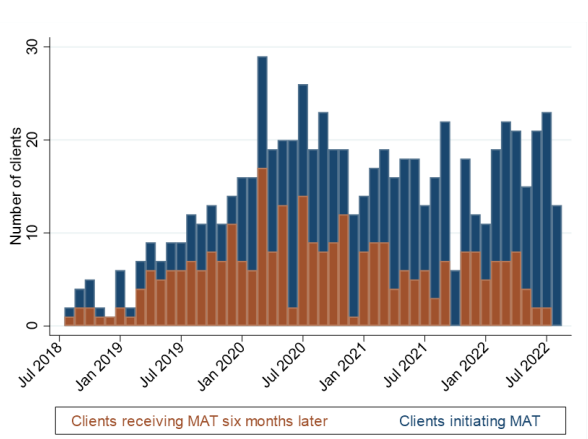


Figure 9.2 MAT Six Month Retention



Service Delivery and Expansion of Services over Time Summary

Throughout the Homeward Bound Initiative, a substantial increase in the number of unique consumers entering the program each month was evident up until the start of the pandemic at the beginning of 2020. At this point, only a slight decrease in consumers seen was evident, despite the substantial upheaval in healthcare delivery caused by the pandemic. The high degree of engagement with consumers over much of the duration of the project is likely to be attributable to the expansion of service availability, the successful implementation of the 'hub and spoke' model expanding program outreach, and the extensive outreach and engagement efforts implemented by staff at CMC. Notably, the relatively high level of enrollment throughout 2020 suggested the program was able to adapt quickly to the associated challenges of the COVID-19 pandemic. Many other services in the area were shut down during the shelter-in-place mandate, likely increasing engagement in Homeward Bound via some pathways during this period (i.e., the local ERs).

Secondly, the wait times for services across the whole duration of the project were relatively short. These findings indicate that the pathways through care within the Homeward Bound Initiative were efficient and that the program had sufficient capacity to meet the needs of the population referred. Importantly, these transitions into care did not appear to have been substantially impacted by COVID-19, or the subsequent shift to telehealth due to the shelter-in-place mandates.

Overall, engagement in psychological and pharmacological services designed to support clients experiencing behavioral health concerns appeared high. Although only 32.3% of consumers continued to receive behavioral health services 6 months later; due to limitations in the data, it is unclear if this is attributable to clients terminating treatment early, or successfully graduating

from the treatment programs within the assessed period. In addition, 41.6% of consumers who started MAT remained engaged in treatment for at least 6 months, which compares relatively positively with the literature which has shown a high degree of variability in treatment retention (Timko et al., 2016). This finding suggests that CMC has been relatively successful at identifying and engaging consumers in MAT at the appropriate stage in their recovery. Anecdotally, the extensive array of Homeward Bound services available including case management, housing support, and respite care was also considered to be an important factor in MAT treatment retention based on anecdotal reports from providers.

Finally, despite notable challenges regarding data collection of case management and residential services, the available data suggests the program was successful at providing critical services related to consumer basic needs, housing assistance, assistance with securing documentation, vocational support, and assistance with transport. Additionally, the respite residential data indicated that the project was successful at implementing the third phase of the project, successfully delivering residential care services for individuals in need of higher levels of care during substance withdrawal.

Sociodemographic Breakdown of Homeward Bound Clients

The sociodemographic details of all individuals that received Homeward Bound services are presented in Table 2. The mean age of the sample was 40.2 years old (SD=13.07). Across race and ethnicity, 40.9% of individuals identified as white non-Hispanic, 21.2% as Hispanic/Latinx, 12.2% as Black or African American, 3.9% identified as Asian, 2.4% as Alaskan Native or Native American, 1.2% identified as Native Hawaiian or other Pacific Islander, and 6.1% as having more than one race. In total, 62.6% of clients identified as Male. At the point of the assessment, 67.9% reported having a history of criminal justice system involvement, and 23.1% identified as homeless.

Table 2: Sociodemographic Details of all Clients Enrolled in the Homeward Bound Program

Variable			
Sex (n, %)			
	Male	1,475	62.6
	Female	880	37.4
	Other	0	0
Age (M, SD)		40.22	13.1
Race/Ethnicity (n, %)			
	White	962	40.9
	Hispanic/Latinx (all races)	500	21.2
	Black/African American	287	12.2
	Asian	92	3.9
	Native American/Alaskan Native	57	2.4
	Native Hawaiian/Pacific Islander	28	1.2
	More than 1 Race	144	6.1
	Missing/Declined	285	12.1
Reported Criminal Justice History (n, %)			
	Yes	1,598	67.9
	No	757	32.1
Homeless (n, %)			
	Yes*	544	23.1
	No	1,568	66.6
	Unknown/missing	243	10.4

Key: ETOH = alcohol; n = number; M = mean; SD = standard deviation

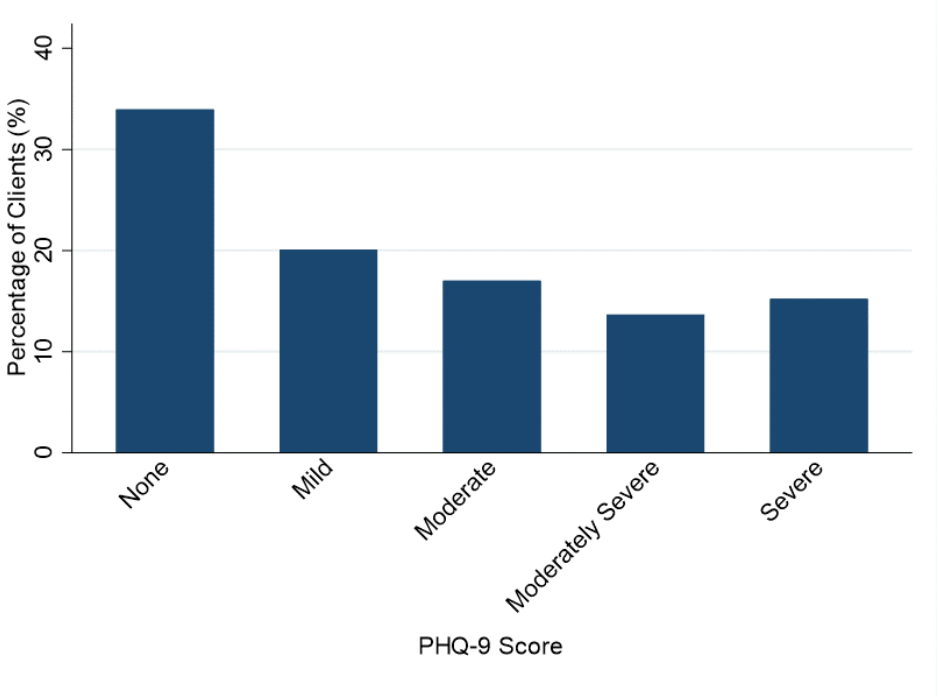
* Includes individuals in shelters, in transitional housing, and those doubling up. Unknown includes response of "other" when not specified.

Clinical Presentation of the Homeward Bound Initiative Sample

Depressive Symptoms

In total, the PHQ-9 was administered 19,719 times to a total of 2,022 Homeward Bound clients, with clients completing the scale a mean of 9.75 times each. At the baseline stage, clients reported a mean depression score of 9.73 (SD=7.98). The proportion of clients that report mild, moderate, or severe levels of depression is presented in Figure 10. In total, 45.95% (890 clients) of the sample reported at least moderate levels of depression at baseline, which is considered sufficient to meet DSM criteria for a depressive disorder. These findings highlight the high prevalence of depression in the population treated by the Homeward Bound Initiative, indicating its critical importance as a treatment target.

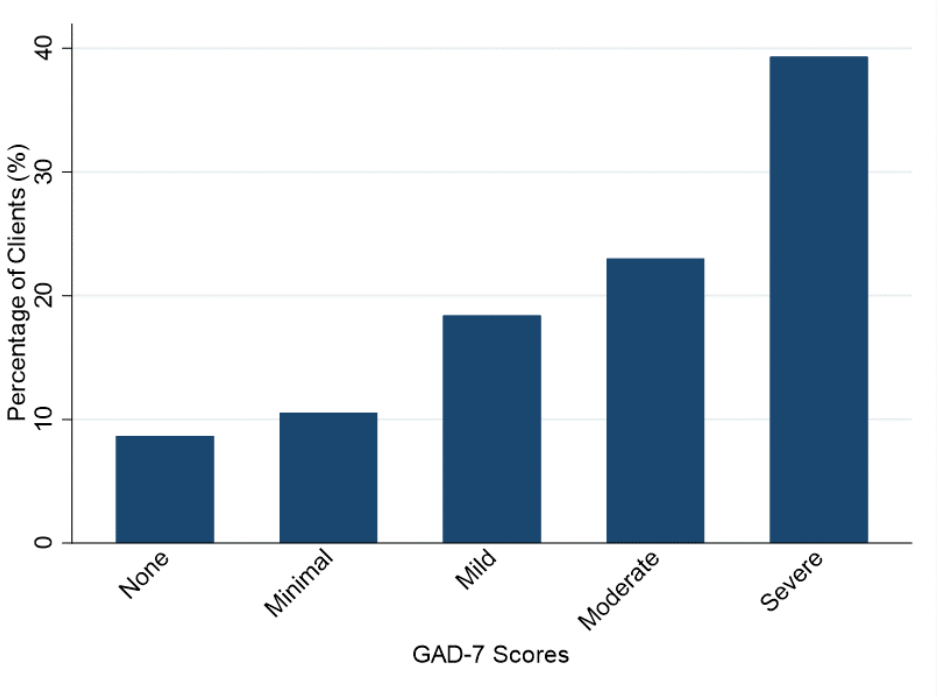
Figure 10: Proportion of Clients with Mild, Moderate, or Severe Depression at the Baseline Assessment Stage



Anxiety Symptoms

At the baseline assessment stage, when clients exhibited suspected symptoms of anxiety, they were asked to complete the GAD-7. The proportion of clients that report mild, moderate, or severe levels of anxiety is presented in Figure 11. This process led to a total of 959 Homeward Bound clients completing the GAD-7, representing 40.7% of the total sample. Of these, 62.3% (596 clients) reported experiencing at least moderate levels of anxiety, which is considered sufficient to meet DSM criteria for Generalized Anxiety Disorder. This represents 25.3% of the total Homeward Bound sample. Notably, of these, 39.3% of clients reported anxiety symptoms in the severe range. Overall, given the low prevalence of GAD-7 completions, it is difficult to determine the prevalence of anxiety in the Homeward Bound sample. However, amongst those that were assessed, a substantial proportion was found to report prominent anxiety symptoms, and of these many reported such symptoms in the severe range.

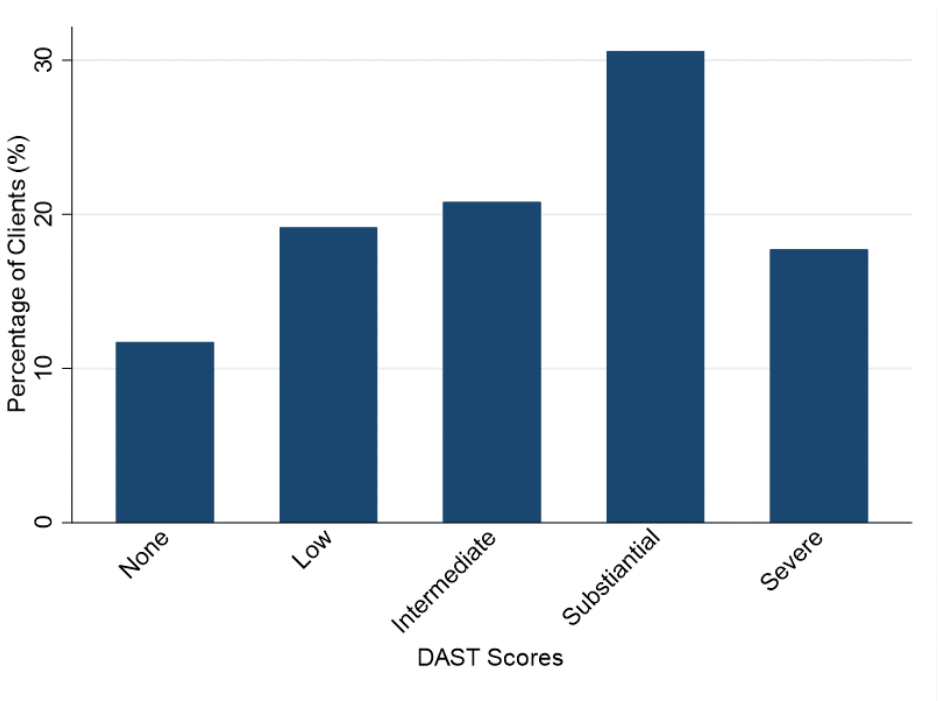
Figure 11: Proportion of Clients with Minimal, Mild, Moderate, or Severe Anxiety at the Baseline Assessment Stage



Degree of Problems Related to Drug Use

Complete DAST data was available for 1,331 clients, who include all individuals suspected of experiencing problems due to their substance use. At the baseline stage, clients reported a mean DAST-20 score of 9.31 (SD=5.88). The proportion of clients that report mild, moderate, or severe levels of issues related to substance use is presented in Figure 12. In total, 69.1% of clients scored at least 6 on the DAST-20, indicating at least intermediate levels of interference in daily functioning caused by substance use. At this level, clients are considered likely to meet DSM criteria for a SUD and meet ASAM placement criteria of Level I or II. Additionally, 30.6% of clients reported substantial interference, likely meeting ASAM criteria II or III, and 17.7% reported severe interference, likely meeting ASAM criteria III. Overall, these figures indicate that a large proportion of Homeward Bound clients experience significant interference in their daily living activities caused by substance use, in many cases rising to a level of substantial impairment.

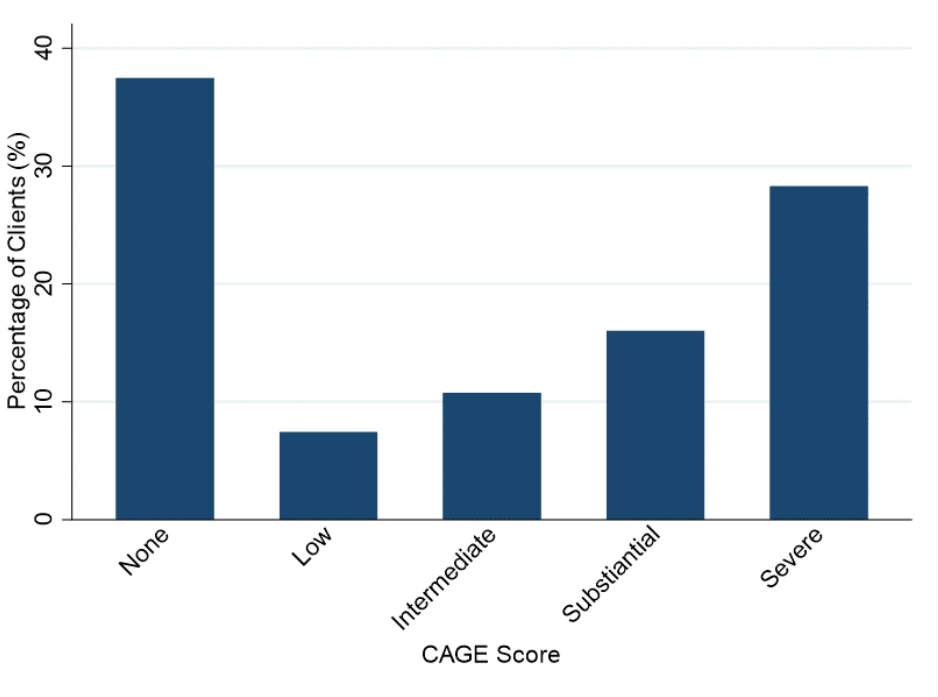
Figure 12: Proportion of Clients Experiencing Low, Intermediate, Substantial, and Severe Interference in Daily Functioning Caused by Drug Use



Degree of Problems Related to Alcohol Use

In total, 1199 clients completed the CAGE at the baseline assessment stage (50.9% of the total sample). Of these, 55.1% reported a score of intermediate or higher, which is a level considered to be clinically significant. The proportion of clients experiencing low, intermediate, substantial, or severe problems due to alcohol use is presented in Figure 13. Notably, of those that did report problems due to alcohol, a substantial proportion of clients reported the impact in the severe range (28.3%).

Figure 13: Proportion of Clients Experiencing Low, Intermediate, Substantial, and Severe Problems due to Alcohol Use



Summary of the Clinical Presentation of the Homeward Bound Sample

The assessment battery that Homeward Bound clients completed at the baseline stage indicates that many clients are experiencing significant and impairing symptoms of depression and anxiety, as well as significant impairments in daily functioning due to either alcohol or drug use. Alongside the relatively high degree of homelessness indicated in Table 2, these findings highlight the importance of the comprehensive integrated approach to care that the Homeward Bound Initiative delivers, incorporating case management, housing services, mental healthcare, and SUD counseling.

Across the different assessment tools, it is notable that over 86% of clients completed at least one PHQ-9 screen, and clients on average each completed 9.75 screens over the duration of their care. Given the availability of the data, allied with the high proportion of clients experiencing symptoms at a level that would be considered sufficient to meet DSM criteria for a depressive disorder (46.0%), tracking depressive symptoms over time was considered to represent one of the most effective ways to evaluate the impact of the Homeward Bound Initiative on outcomes.

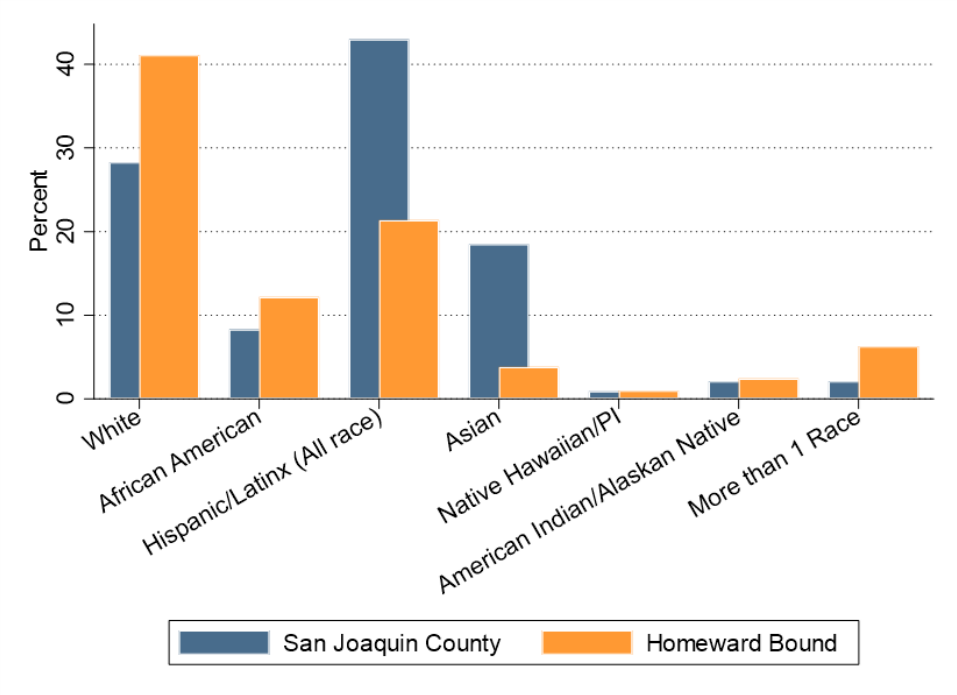
Outcomes Evaluation – Results

Improving Access and Engagement Amongst Historically Underserved Populations

One aim of the Homeward Bound project was to increase access and engagement to community behavioral health services in San Joaquin County amongst historically underserved groups, namely Black/African American and Hispanic/Latinx communities. Figure 14 below compares the racial and ethnic makeup of San Joaquin County, based on US Census data estimates (US Census, 2022) with that of Homeward Bound clients. It is important to note that conclusions based on analysis of race and ethnicity data are challenging, since race is a social construct, and given that assessments of race (including how people self-identify versus how race is assigned to people) are ambiguous and imprecise.

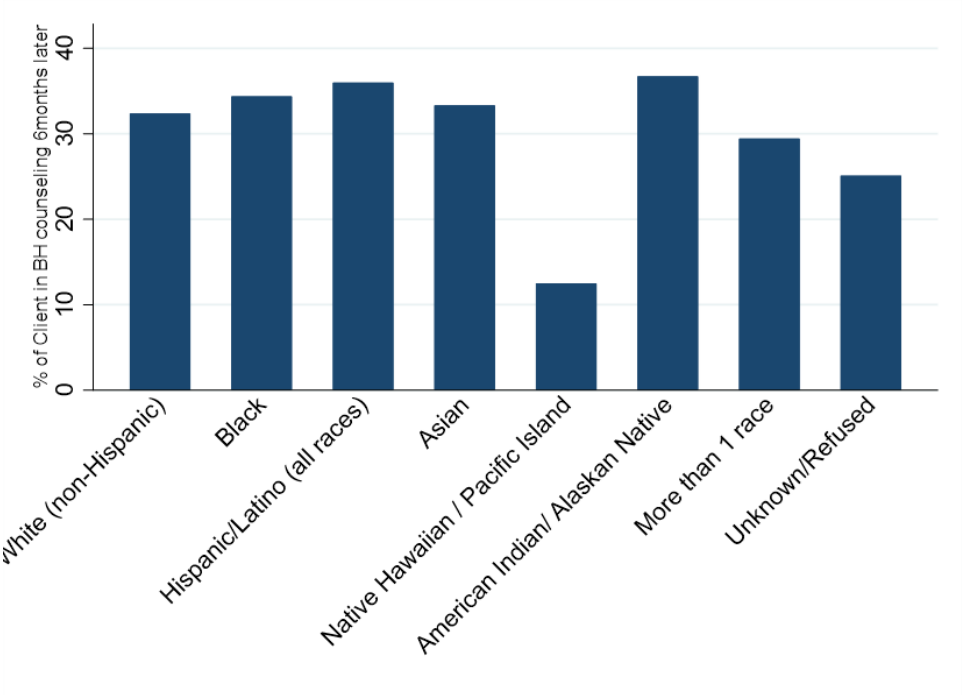
The population of San Joaquin County was 793,229 in 2022 according to the American Community Survey (U.S. Census Bureau, 2022), of which 43% identified as of Hispanic/Latinx ethnicity, 8.3% identified themselves as Black/African American, 28.3% as White (not including Hispanic/Lantix individuals), 18.5% as Asian, 2.1% as American Indian/Alaskan Native, 0.9% Native Hawaiian/other Pacific Islander, and 5.6% identified as being more than one race. As compared to the racial and ethnic breakdown of the census data, Non-Hispanic Whites were overrepresented in the Homeward Bound treatment sample by 12.6%, and Black and African American individuals were overrepresented by 3.9%. Hispanic/Latinx individuals across all races were found to be under-represented by 21.7%, Asian underrepresented by 14.6%, individuals from more than one race overrepresented by 0.5%. The Homeward Bound sample of Native Hawaiian/Pacific Islander and American Indian/Alaskan Natives were found to be broadly consistent with San Joaquin County population at approximately 1.1% and 2.4% respectively. Given the lack of data regarding treatment need by racial and ethnic groups within the San Joaquin County region, firm conclusions cannot be drawn from these findings. However, the figures overall suggest that the Initiative has been successful at engaging Black and African American, Native Hawaiian/Pacific Islander, and American Indian/Alaskan Native individuals in community behavioral healthcare, but continues to experience challenges in engaging Hispanic/Latinx and Asian individuals.

Figure 14: Race/Ethnicity of Clients who Received a Homeward Bound Assessment, as Compared to County Averages



As described previously, of the 1,780 consumers who received behavioral health services between August 2018 and August 2022, 575 (32.3%) were still receiving services at least six months later. Figure 15 depicts treatment retention in behavioral health counseling at the six-month follow-up stage across race and ethnicity. In total, 32.4% of white non-Hispanic consumers, 34.4% of Black and African Americans, 36.0% of Hispanic/Latinx consumers, 33.3% of Asian consumers, and 36.7% of American Indian/Alaskan Native consumers remained in behavioral health counseling six months after starting. While treatment retention amongst Native Hawaiian and Pacific Islanders was substantially lower at 12.5%, due to the very small sample size (n=16) caution should be exercised when interpreting this finding. Consistent with this, no significant difference was detected in treatment retention rates across race/ethnicity (X^2=11.54, p=.117). This finding therefore supports the conclusion that retention rates amongst Black/African American and Hispanic/Latinx consumers are at least equivalent with other racial and ethnic groups. This suggests the project is successfully delivering services to these historically underserved populations once connected with care.

Figure 15: Proportion of Clients that remain in Behavioral Health Counseling after Six Months, across Race/Ethnicity



As indicated previously, 34.0% (n=801) of the total population that has engaged in Homeward Bound Services has gone on to receive MAT. This proportion of clients that engage in such care across race/ethnicity is presented in Figure 16. In total, 38.5% of all white non-Hispanic Homeward Bound consumers have initiated MAT, 24.7% of Black and African American consumers, 35.6% of all Hispanic/Latinx consumers, 28.3% of all Asian consumers, 25.0% of all Native Hawaiian/Pacific Islanders, 33.3% of all American Indian/Alaskan Native consumers, and 29.5% of all consumers who identify as being more than one race. The differences in MAT engagement between racial and ethnic groups were found to be significant (X^2= 25.315, p=.001). That Black and African American consumers are significantly less likely to receive MAT is consistent with the literature that has found that Black/African American individuals are significantly less likely to be offered MAT due to structural and provider-level biases (i.e., Hansen et al., 2013).

Figure 16: Proportion of Homeward Bound Consumers who engage in MAT, by Race/Ethnicity

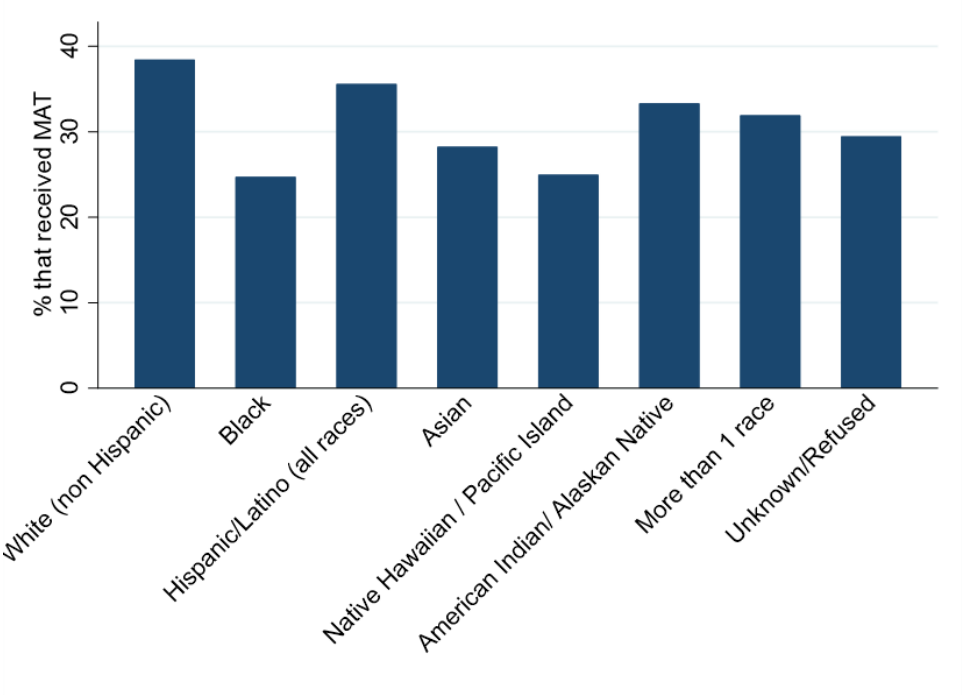
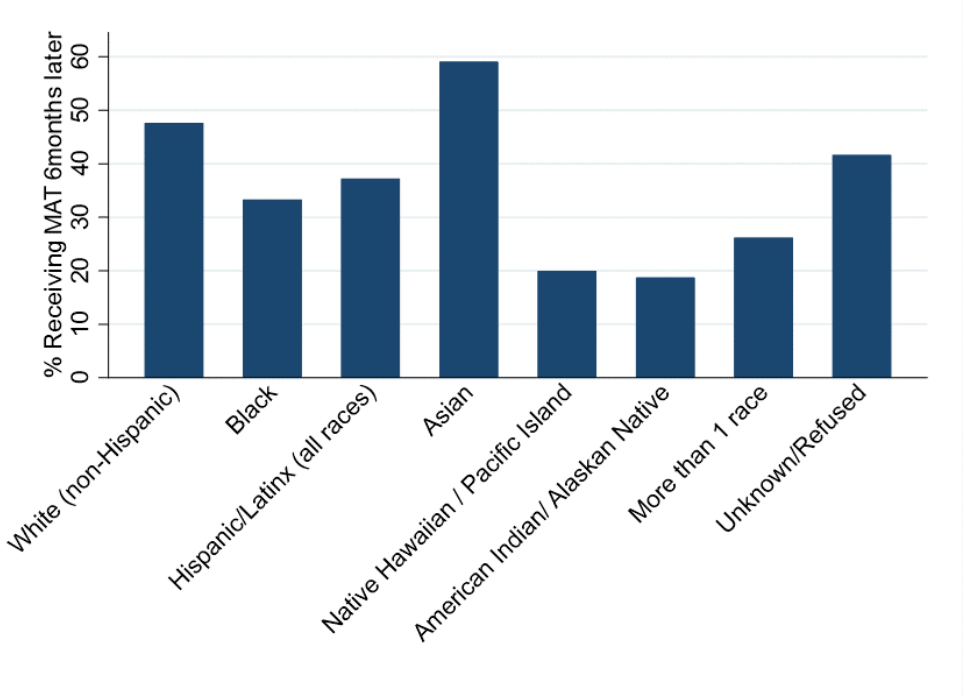


Figure 17 indicates treatment retention in MAT at the six-month follow-up stage across race and ethnicity. In contrast with the retention in behavioral health counseling, significant differences in treatment retention across race and ethnicity was evident (X^2= 19.137, p=.008). While the sample size was small (n=22), it was notable that consumers that identify as Asian were substantially more likely to remain in MAT relative to all other racial/ethnic groups (59.1%). Additionally, individuals who identify as Native Hawaiian/Pacific Islander and American Indian/Alaskan Native were found to be least likely to continue MAT, with only 18.8% and 20.0% of consumers still receiving the medication six months after treatment initiation.

Figure 17 Proportion of Clients that remain in MAT after Six Months, across Race/Ethnicity



Access and retention in Community Behavioral Health Treatment across Individuals that Identify as Homeless

In addition to improving access and retention in community behavioral health services amongst Hispanic/Latinx and Black and African American individuals, a key group historically underserved include individuals who identify as homeless. As indicated in Table 2, 23.1% of the sample identified as homeless. Those that reported being homeless at baseline were equally likely to go on to attend at least one behavioral health counseling session, relative to those who reported being housed X^2=.218, p=.897). Additionally, between August 2018 and August 2022, homeless consumers were equally likely to remain in behavioral health counseling after six months, relative to those who were housed, with retention rates of 30.55% and 27.27% respectively (X^2= .703, p=726). Regarding MAT, 28.2% of homeless Homeward Bound consumers were received MAT, relative to 36.6% of individuals who were housed, a difference that was statistically significant (X^2=21.657, p<.001). Between August 2018 and August 2022, 35.3% of homeless consumers that engaged in MAT treatment were still engaged in that treatment 6 months later, relative to 44.5% of consumers who were not homeless at baseline, a statistically significant difference (X^2=6.359, p=.042).

Improving Access and Retention Amongst Historically Underserved Groups Summary

The findings indicate that the Homeward Bound Initiative to date has been successful in engaging Black and African American individuals in community behavioral health services, but there is still progress to be made in engaging individuals from the Hispanic/Latinx community. These findings are consistent with previous annual reports that have shown consistently high levels of engagement amongst individuals that identify as Black and African American, but lower levels of engagement amongst Hispanic/Latinx individuals, in addition to those that identify as Asian. Once clients enter the Homeward Bound system of care, treatment retention in behavioral health counseling appears to be broadly equivalent across most racial and ethnic groups, including those that identify as Hispanic/Latinx and Black and African American. The notable exception to this is Native Hawaiian/Pacific Islander consumers, although this may be a feature of the small sample size (n=16). Importantly, this difference was not found to be statistically significant, meaning more data is needed before any firm conclusions can be drawn.

While engagement in behavioral health counseling appears broadly consistent across race and ethnicity, greater differences were evident with regards to MAT engagement and treatment retention. Notably, 38.5% of all white non-Hispanic consumers have received at least one session of MAT, while only 24.7% of Black and African American and 25.0% of Native Hawaiian/Pacific Islanders consumers have received MAT. This finding is consistent with the literature that has found that Black/African American individuals are significantly less likely to be offered MAT due to structural and provider-level biases (i.e., Hansen et al., 2013), and suggests that greater efforts to engage Black and African American consumers in MAT may be warranted. With regards to MAT retention at 6-months follow-up, there is a surprisingly high retention rate in care amongst Asian consumers relative to all other racial/ethnic groups, with 59.1% of Asian consumers till receiving MAT after 6 months. The reasons for this are unclear.

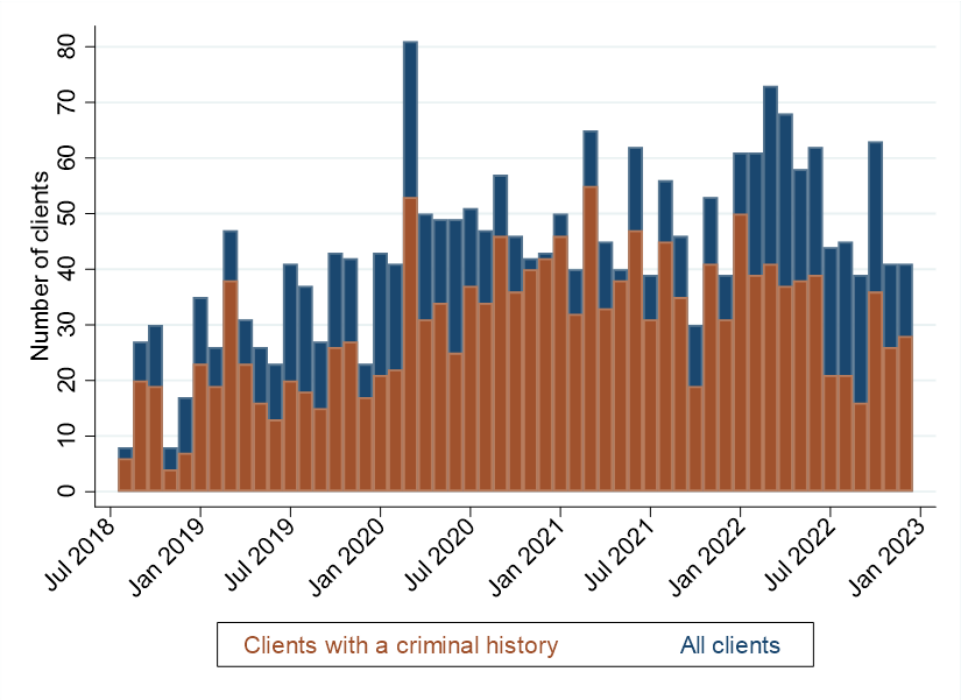
In the 2019 San Joaquin Point-in-Time Survey, 2,629 homeless individuals were identified as living in San Joaquin County, representing 0.3% of the county population. As this is a measure of point prevalence, as opposed to incidence, direct comparisons with the number of homeless individuals engaged in Homeward Bound care cannot be made. However, with 544 clients identifying as homeless (23.1% of total sample), this suggests the program has been very successful at engaging this chronically underserved, high-need group. Additionally, once in care, homeless individuals were found to be equally likely to remain in behavioral health counseling and MAT programs at six-months follow-up, despite the substantial additional barriers to care this population may face. The reasons for this higher rate of retention are unclear but may relate to the volume of additional services the Homeward Bound program can provide, including respite care, case management, and housing services. If so, these findings highlighted the importance of providing wrap-around care that programs such as the Homeward Bound Initiative can provide to individuals with significant unmet needs.

Reducing Criminal Justice Convictions

Proportion of Consumers who receive Homeward Bound Services that Report having a Criminal Justice History

One of aim the Homeward Bound Initiative is to reduce incarceration and recidivism amongst San Joaquin County residents who have a mild-to-moderate behavioral health concern and SUD. Of the 2,355 consumers that received Homeward Bound services, between August 2018 – January 2023, 1,577 (67.0%) reported having a criminal justice history. Figure 18 below presents the proportion of new Homeward Bound consumers who reported having a criminal justice history during their intake interview.

Figure 18: Proportion of New Consumers that Report a Criminal Justice History During the Intake Assessment over Time



Exploration of Recidivism Outcomes

To explore recidivism outcomes amongst Homeward Bound consumers, all consumers who reported having a prior conviction who presented for services between January 2019 and December 2020 were included in a subgroup analysis. This cohort was selected to enable recidivism outcomes to be examined for 24 months post-engagement in the Homeward Bound initiative. However, increased data access restriction to San Joaquin County Superior County records meant data collection related to recidivism outcomes was halted in September 2021. Between this period, data was collected for a total of 457 clients. Of these, 12-month

reconviction data from the point of treatment initiation was available for all 457 consumers, while 24-month recidivism data was available for 162.

In this analysis, the 12-month reconviction was found to be 8.1%. The 24-month reconviction rate was found to be 15.4%. Due to differences in the case-mix of individuals and the period of time between release from prison/placement on supervision and treatment initiation, direct comparisons with published state figures cannot be drawn. That said, these estimates should still be considered low given 50.1% of San Joaquin County residents with a prior conviction are found to be reconvicted of another office within three years (California Department of Corrections and Rehabilitation Office of Research, 2022). These estimates are also low relative to published recidivism rates amongst consumers who are released from prison with a SUD (i.e., Zgoba et al., 2020).

Reducing Criminal Justice Convictions Summary

In total, 66.96% of the consumers who received Homeward Bound services reported having a criminal justice history prior to the initiation of services. This high proportion indicates the success of the project at engaging individuals with a criminal justice history. Notably, the proportion of consumers served that reported a criminal justice history was found to increase over time and escalated during the height of the COVID-19 pandemic. The reasons for this are unclear but are likely attributable to the significant change in the case-mix of consumers served during the pandemic, and improved collaboration with local law enforcement during this period as detailed in the qualitative interview summary with the CMC Program Lead.

The 12-month and 24-month recidivism rate from the point of initiation of Homeward Bound treatment was found to be 8.1% and 15.4% respectively. These figures are low relative to both statewide recidivism calculations and those published in the literature (California Department of Corrections and Rehabilitation, 2020; Zgoba et al., 2020). However, as detailed in the findings these results come with a series of caveats, limiting the ability to make direct comparisons.

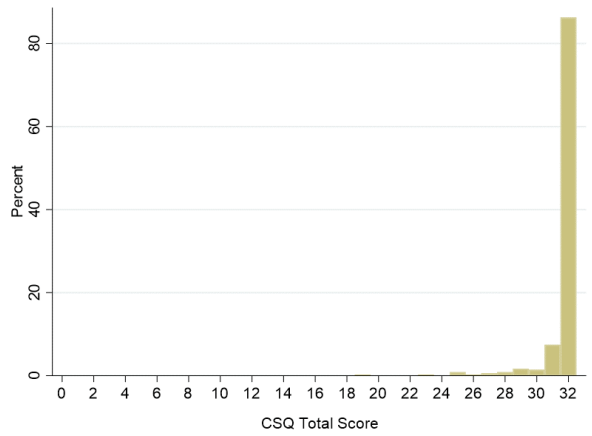
Client Satisfaction with Homeward Bound Services

In total, 349 clients completed the CSQ-8 between October 2019 and May 2021. The distribution of the total scores is presented in Figure 19.1. Overall, almost all clients who received services reported being highly satisfied with the level of care they received. In total, 86.3% of clients reported the highest level of satisfaction possible (i.e., a score of four out of four on all eight items). Additionally, 99.4% of clients reported a mean score of three or higher, indicating at least moderately high levels of satisfaction with services. Notably, no clients reported a mean satisfaction score below two, which would indicate any degree of dissatisfaction with services. The item-level CSQ-8 scores are presented in Figure 19.2. Across the eight different items, clients reported a mean satisfaction range of 3.93 (SD=.0.30) for Item

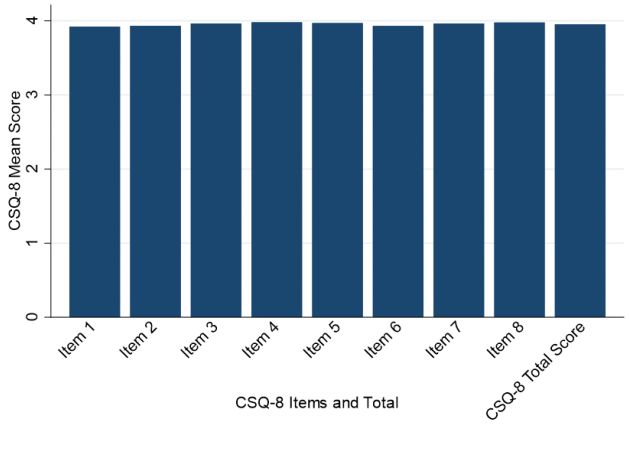
6 (“Have the services you received helped you to deal more effectively with your problems?”) to 3.97 (SD=0.32) for Item 3 (“To what extent has our program met your needs?”), indicating very high levels of satisfaction with care across all domains assessed.

Figure 19: Client Reported Satisfaction with Homeward Bound Services

19.1 Breakdown of Total Satisfaction Scores



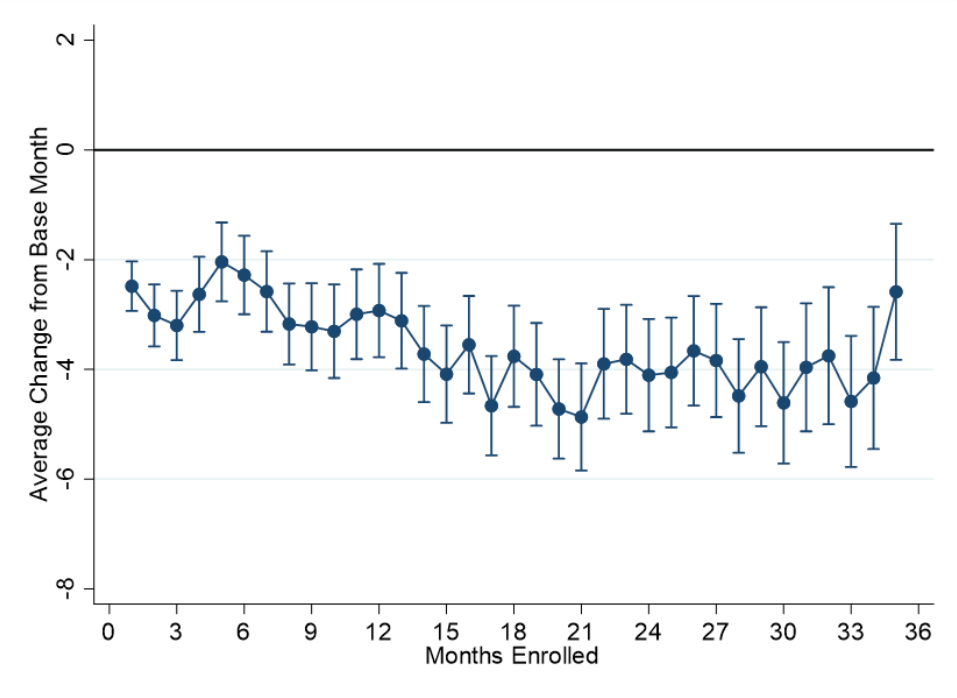
19.2 Item-Level Satisfaction Scores



Changes in Outcomes amongst Homeward Bound Clients over time

The longitudinal course of depressive symptoms amongst individuals that received Homeward Bound services is presented in Figure 20. After one month of receiving Homeward Bound services, clients reported PHQ-9 scores on average about three points lower compared to their baseline score. This reduction in PHQ-9 scores over was found to continue the longer the client remained in Homeward Bound services up until the 21-month point, where clients reported PHQ-9 scores on average approximately 5 points lower than their baseline values. Over the 36-month period assessed, reductions relative to client baseline values were found to be statistically significant throughout.

Figure 20: Mean Rate of Change of Depressive Symptoms over Time



Revenue Generated and Costs Incurred Through Delivering Homeward Bound Services.

To address Outcome 4.3 "Total revenue generated through the delivery of Homeward Bound behavioral health community services" a review of the total revenue generated, and expenses incurred by delivering Homeward Bound services was conducted. This analysis focused on the period between May 2021 and April 2022. This period was selected because it is the most recent full fiscal year for which data was available. This analysis was limited to the Waterloo Road Site, as this clinic served as the primary hub clinic where most of the services were delivered, and the Tracy Clinic, which was the most active spoke site. While the respite residential services represent a critical part of the Homeward Bound program, this was not incorporated into the current analysis to the unavailability of the data.

The revenue and expenses figures are presented in Table 3. Across these two sites, the Homeward Bound initiative generated approximately $626,000 worth of revenue for the financial year 2021-2022 through service billing. The total services delivered during this period cost approximately $2.1 million. This shortfall was fully covered by grants from the BSCC and the MHSOAC, but does indicate a potential shortfall of $1.49 million once the grants end. However, this figure comes with two notable caveats. First, this figure does not include any additional billable primary care and mental health services that may have been delivered to Homeward Bound clients by CMC because of engagement with the Homeward Bound system of

care. Additionally, this figure does not include revenue generated from the residential respite services, which is anticipated to represent a significant source of funding once fully operational.

Table 3: Homeward Bound Revenue and Expenses Between May 2021 – April 2022.

		Waterloo Road Hub Site	Tracy Spoke Site	Total
Yearly Figures				
	Total Yearly Gross Revenue	$2,320,720	$252,406	$2,573,126
	Total Year Gross Revenue Excluding Grant Funds	$499,535	$126,290	$625,825
	Total Yearly Expenses	$1,857,042	$255,882	$2,112,924
	Total Yearly Net Revenue	$463,678	-$3,476	$460,202
	Total Yearly Net Revenue Excluding Grant Funds	-$1,357,507	-$129,592	-$1,487,099
Monthly Figures				
	Monthly Gross Revenue	$193,393	$21,034	$214,427
	Monthly Gross Revenue Excluding Grant Funds	$41,628	$10,524	$52,152
	Monthly Expenses	$154,754	$21,324	$176,077
	Monthly Net Revenue	$38,640	-$290	$38,350
	Monthly Net Revenue Excluding Grant Funds	-$113,126	-$10,799	-$123,925

Discussion

The Homeward Bound Initiative was designed to improve access and engagement in behavioral healthcare across San Joaquin County, reduce disparities in utilization amongst underserved groups, reduce convictions and recidivism, and improve outcomes, all while delivering services with a high degree of client satisfaction. Across these different aims, the project has achieved some important milestones, despite the notable challenges to implementation that came with the pandemic and the subsequent shelter-in-place mandate.

With regards to increasing access and engagement in behavioral healthcare, 2,355 clients have received Homeward Bound services, including 1,780 receiving behavioral health services and 801 receiving MAT. Notably, 2,009 Homeward Bound clients also received physical health primary care serves at an average of 5 appointments each, suggesting the Homeward Bound Initiative may be an important facilitator to increased physical health utilization, in addition to behavioral healthcare. Part of this expansion of services comes from the extensive outreach and engagement Homeward Bound leadership has, alongside the successful implementation of the "hub and spoke" model, enabling a greater geographic spread across San Joaquin County.

Consistent with prior annual reports, the Homeward Bound Initiative appears to be successful at engaging individuals in care who identify as either homeless, and/or Black and African American. However, the under-representation of Asian and Hispanic/Latinx individuals engaging in services relative to population estimates is still evident. The fact that the under-representation in care amongst these racial and ethnic groups has not significantly changed is perhaps unsurprising, given the methods most likely used to address these discrepancies (i.e., extensive community outreach and engagement) had been seriously curtailed by the pandemic. Once clients enter the Homeward Bound system of care, when compared to other racial and ethnic groups Hispanic/Latinx and Black and African American clients were at least as likely to engage in behavioral health treatment and remain engaged in it at least six months later. Additionally, homeless individuals were found to be at least as likely to engage and remain in behavioral healthcare, relative to those reportedly not homeless. These findings point to the Homeward Bound Initiative being successful at engaging historically underserved groups in behavioral health counseling. However, while these findings were positive, it was notable that Black and African American clients were significantly less likely to receive MAT, which may reflect wider structural and provider-level biases that have been reported in the literature (i.e., Hansen et al., 2013). Additionally, MAT initiation and retention amongst individuals not in secure housing was also found to be significantly lower. These findings suggest that greater efforts to engage individuals from these historically marginalized groups in pharmacological treatments may be necessary to address this area of healthcare inequity.

A high proportion of the total sample served reported having a criminal history (67.0%), highlighting the success of the program at engaging this target population. Additionally, the conviction and recidivism rates amongst Homeward Bound clients appeared relatively low. However, without control group data it is not possible to determine what the impact of Homeward Bound services on these metrics may be.

One notable finding is the remarkably high degree of client satisfaction that clients report regarding the care they have received from Homeward Bound services. Over two thirds of clients reported the highest level of satisfaction possible on the CSQ-8, and 99.42% reported a mean score of 3 or higher, indicating at least moderately high levels of satisfaction with services. While these findings are encouraging, it is important to note that they come with one important caveat. During the study period when the CSQ-8 was available, only 14.8% of all clients completed the scale and as a result, it is unclear if these satisfaction values are representative of the whole sample. For example, it is unclear if a substantial proportion of the missing clients were missed due to random error, or if individuals who were less satisfied with care may have refused to complete the scale or dropped out leading to less opportunities to complete the questionnaire. However, it is also possible clients that are less satisfied with services be more likely to complete the questionnaire as a mechanism by which to be able to communicate their dissatisfaction with care. Regardless, the findings indicate that amongst those asked satisfaction with Homeward Bound services is incredibly high. This will be explored more, moving further, as more data becomes available.

With regards to the final project aim – an exploration of the impact of Homeward Bound services on outcomes – the longitudinal course of depressive symptoms amongst those enrolled in care were explored. Due to the absence of a control group, the lack of data amongst those who do not continue to receive services, and the likelihood of regression to the mean, one should be highly cautious when interpreting the data. However, following engagement in care with the Homeward Bound Initiative, clients reported a mean drop in the PHQ-9 scores by approximately three points by the first month, and client scores continued to trend downward to a five-point drop at the 21-month post-baseline stage. Notably, a 1-point change in an assessment using Clinical Global Impression – Severity scale (CGI-S) has been found to equate to a 3-point change in the PHQ-9 in patients with treatment-resistant depression (Turkoz et al., 2020). This therefore suggests that the reduction in PHQ-9 scores detected over time in this evaluation could be considered to be clinically meaningful.

Conclusion

Over the course of the implementation of the Homeward Bound Initiative, there have been some notable successes despite operating against the backdrop of the pandemic. There has been a significant expansion of mental health services for residents across San Joaquin County,

addressing an area that was previously identified as a substantial gap in the available continuum of care. While Asian and Hispanic/Latinx residents continue to be underserved, engagement in care amongst Black and African American and homelessness residents was high. Furthermore, once these historically underserved individuals engage in care, retention is relatively high. It is difficult to determine the impact of Homeward Bound services in conviction and recidivism outcomes, however these rates amongst clients appear low relative to figures typically published in the literature. Over time, clients report significant and clinically meaningful reductions in depressive symptoms. Finally, amongst those who responded, Homeward Bound clients report a very high level of satisfaction in the services that they have received. Overall, the findings of this evaluation point to the conclusion that Homeward Bound Initiative has made a substantial, positive contribution to supporting the behavioral health and wellness needs of San Joaquin County residents that have historically been either unserved and underserved.

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The San Joaquin County Homeward Bound Initiative

Deliverable 16: Final Evaluation Report

San Joaquin County Homeward Bound Final Evaluation Report
Submitted by the UC Davis Behavioral Health Center of Excellence on 6/29/2023

Executive Summary

Background

The main aims of the Homeward Bound Initiative included: 1) improving access and engagement in behavioral healthcare amongst residents of San Joaquin County, 2) increasing behavioral healthcare utilization amongst historically underserved groups, 3) reducing convictions and recidivism, 4) improving client outcomes, and 5) delivering services with a high degree of client satisfaction. The Initiative aimed to achieve these goals by delivering a host of services including residential and outpatient respite care, case management, psychotherapy, sobering services, substance use disorder (SUD) counseling, and medication-assisted treatment (MAT). These services were delivered by Community Medical Centers (CMC), a federally qualified health center (FQHC) with an established track record in providing health and social care to San Joaquin County residents in collaboration with San Joaquin County Behavioral Health Services (SJCBHS). These services were accessible via a multitude of pathways and were supported by extensive links with other community and governmental agencies. The provision of these additional services was expected to lead to improved functional and recovery outcomes for consumers, high levels of treatment satisfaction amongst clients, and reduced convictions and recidivism amongst those that receive care. The current report details the results of the Homeward Bound Initiative over the project duration.

Major Findings

Over the past five years, the Homeward Bound Initiative has achieved many of its stated goals and objectives. In total, 2,528 unique individuals have been enrolled in the Homeward Bound Initiative, 2,302 clients have received some form of behavioral health counseling, 828 have received MAT, 1,297 have received case management services, and 2,189 have received physical health services. Since the opening of the Respite Residential Care Program in October 2021, more than 101 clients have received respite residential services. In total, 12.3% of clients identified as Black or African American, which is an over-representation relative to San Joaquin County population estimates. However, Asian and Hispanic/Latinx clients were under-represented. Once engaged in care, individuals from these historically underserved groups engaged and remained in care at levels at least comparable to other racial and ethnic groups. Additionally, the program has been highly successful at engaging clients who identify as homeless (n=581, 23.0% of the sample).

In total, 67.8% of clients reported previously being convicted of crimes. Recidivism rates of individuals with a prior conviction were 8.1% at 12 months post-baseline, and 15.4% at 24 months. Due to the nature of the data, it is not possible to make direct comparisons to the published literature; however, these figures should be considered low. Homeward Bound

clients reported clinically and statistically significant reductions in depressive symptoms after one month of enrolling in Homeward Bound services, with further reductions evident the longer they remained in care. Finally, amongst the 349 clients that completed the Client Satisfaction Questionnaire (CSQ-8), satisfaction with the care delivered by the Homeward Bound Initiative was remarkably high, with 86.3% of clients reporting the highest level of satisfaction possible, and 99.4% reporting at least moderately high level of satisfaction. Across the Waterloo Road Site, the primary Waterloo Road Hub Clinic, and the Tracy Clinic spoke site, the Homeward Bound initiative generated approximately $626,000 worth of revenue for the financial year of 2021-2022 through service billing, not including revenue from the residential respite services.

The successes of the Homeward Bound Initiative are particularly notable given the backdrop of the coronavirus disease-2019 (COVID-19) and the subsequent shelter-in-place mandates that significantly impacted client needs, the delivery of services, and the effectiveness of collaborations with other community agencies.

Conclusions

Overall, the Homeward Bound Initiative is successfully delivering a broad range of behavioral healthcare services to individuals with mild-to-moderate behavioral health conditions, many of whom report having a history of interaction with the criminal justice system. These findings suggest that the Homeward Bound Initiative may represent an important step towards addressing a significant gap in the San Joaquin County Behavioral Health System-of-Care, delivering services in a manner that is successfully engaging historically underserved groups, improving outcomes, and providing services with a very high degree of client satisfaction.

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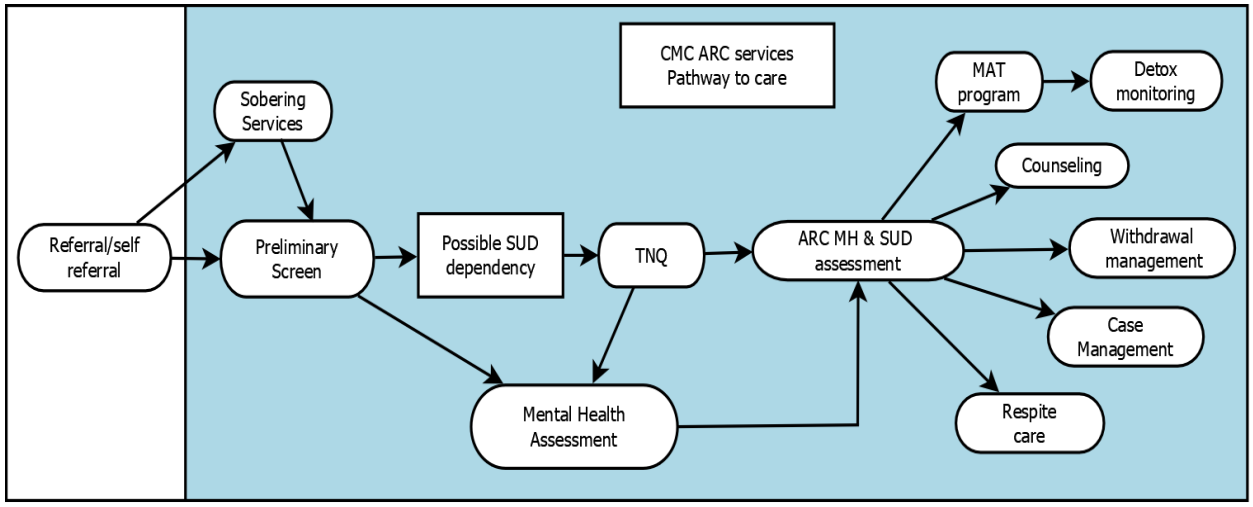
Project Description

The Homeward Bound Initiative represents a significant expansion of community-based behavioral health services, designed to improve population-level behavioral health outcomes for the residents of San Joaquin County. The overarching goal of the Homeward Bound Initiative is to improve access to substance use and mental health services for county residents with mild-to-moderate behavioral health concerns by expanding services and increasing low-barrier pathways to care. The program emphasizes supporting vulnerable and underserved populations, including 1) non-serious, non-violent offenders with trauma or other mental health concerns, 2) high-risk individuals with substance use disorders (SUD) who are homeless, and/or who have frequent contacts with law enforcement, and 3) Latinx, and Black and African American individuals who are underserved through traditional, existing behavioral health services.

The Homeward Bound Initiative focuses on 1) *service expansion* through the creation of the Assessment and Respite Center (ARC) with co-located withdrawal management services, 2) *system strengthening* through shared data use agreements and expedited referral pathways between providers, and 3) *service enhancement* by delivering wrap-around housing and case management services for those individuals that require intensive services to achieve recovery from behavioral health conditions. The ARC is a community-based treatment facility managed by Community Medical Centers (CMC), a not-for-profit healthcare network with an established track record of delivering health and social care services to individuals in the Stockton area for over 50 years. A conceptual model detailing the new system of care delivered by CMC via the Homeward Bound Initiative is presented below in Figure 1.

Figure 1: The Homeward Bound Initiative CMC/ARC Pathway to Care

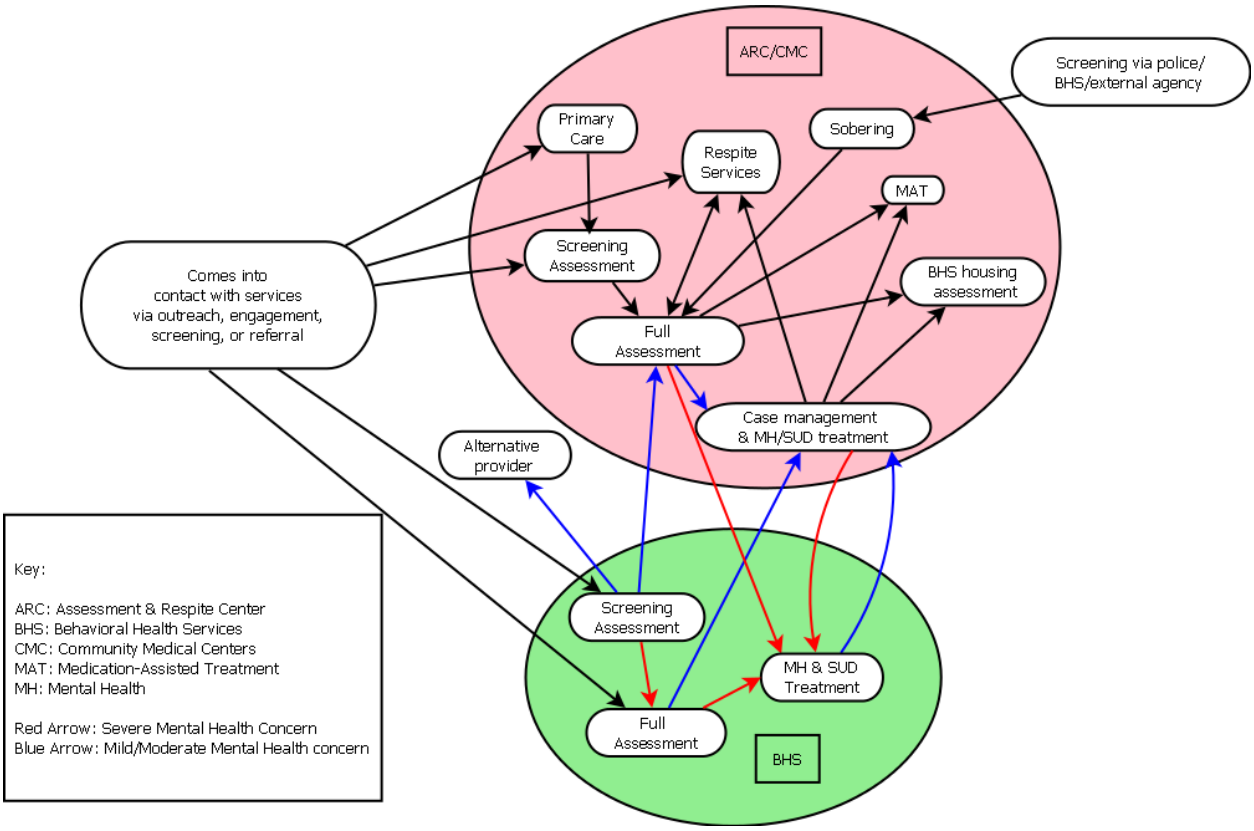


ARC = Assessment and Respite Center; CMC = Community Medical Centers; MAT = Medication Assisted Treatment; SUD = Substance Use Disorder; TNQ = Treatment Needs Questionnaire.

The Homeward Bound system of care allowed consumers to access services delivered by the ARC via a multitude of entry pathways. These include service referrals via community partners (e.g., Stockton Shelter for the Homeless, St. Mary's Dining Room, etc.), emergency services, San Joaquin County Behavioral Health Services (SJCBHS), law enforcement, the county court system, CMC primary care, and self-referral. If the individual accessed CMC services while intoxicated, they were offered sobering services, consisting of sobering beds available on the premises. Once sober, or if they accessed services when not intoxicated, they were offered a brief screening assessment to identify treatment needs, in addition to access to services that are designed to address immediate basic needs (e.g., thirst, hunger, hygiene). In the event of a positive screen, or based on the clinician's clinical judgment, the individual was offered a full behavioral health assessment, followed by services that could include MAT, withdrawal management, case management, and/or other forms of therapy, dependent upon need. In the final phase of the project, CMC respite residential care services were also available for individuals that require short-term residential care during periods of withdrawal. This service represents the first residential treatment services available in San Joaquin County designed for individuals with co-occurring mild-to-moderate mental health disorders. Individuals in receipt of services delivered under the Homeward Bound system of care were eligible for both behavioral health and physical healthcare, delivered by existing CMC co-located primary care services.

In addition to the expansion and enhancement of services offered by CMC, a second critical component of the Homeward Bound Initiative included the establishment of expedited referral pathways between CMC and SJCBHS. Figure 2 depicts how ARC services fit within the broader context of available care delivered under the Homeward Bound Initiative. If an individual with a severe mental health condition engaged with services at CMC, they were offered an expedited referral to SJCBHS including a "warm hand-off," with details from the CMC assessment passed on to SJCBHS to minimize any duplicate assessment. In cases where a screening or full assessment at SJCBHS took place, and the individual was deemed to be experiencing a mild-to-moderate behavioral health concern, the individual was referred directly to CMC with a "warm hand-off." Minimizing these barriers to appropriate care helped improve access to appropriate treatment, with the aim of leading to better outcomes overall.

Figure 2: The Homeward Bound Initiative Full System of Care

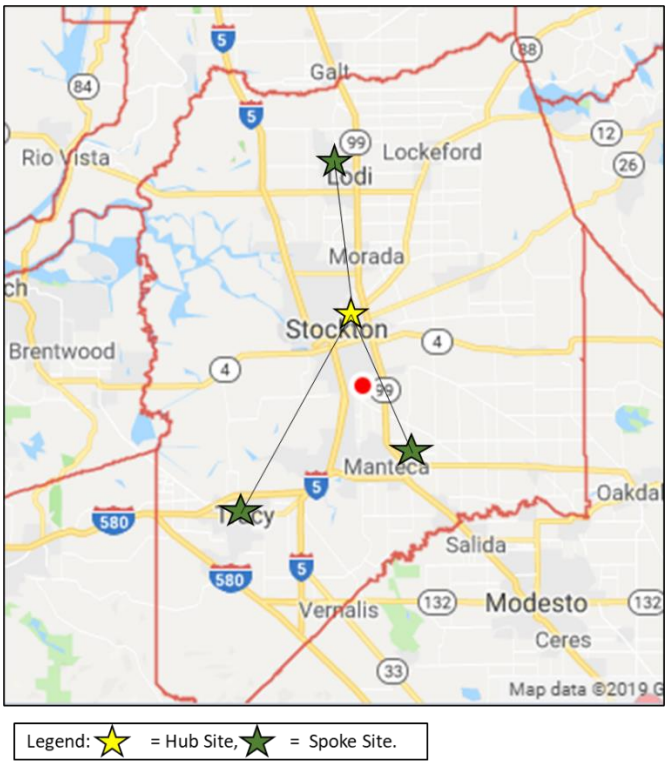


The Three-Phase Approach to the Implementation of the Homeward Bound Initiative

In the Homeward Bound proposal, the implementation of the project was designed to follow three discrete stages. In the first phase, CMC developed a primary "hub" site for Homeward Bound services situated in the county capital, Stockton. This site is co-located with the CMC Waterloo Road primary care site and included most of the services presented in Figure 2. Following the establishment of the hub clinic, the expansion of Homeward Bound services to cover the breadth of San Joaquin County was developed through a "hub and spoke" model of service delivery. A visual representation of this model is presented in Figure 3. This included the expansion services to satellite CMC clinics across San Joaquin County (the "spokes"), including Lodi, Tracy, and Manteca. Under this model, clients could either be initially seen at the hub site and then referred out to one of the satellite clinics at the convenience of the client, or else they could be referred into the system of care at the spoke site directly. The spoke site typically utilized the technical expertise and additional resources of the hub to best respond to the needs of the clients' treatment. In the third and final Phase of the proposal, CMC opened a

short-term residential care service to support clients experiencing significant symptoms of withdrawal in the city of Stockton, available to all clients that receive care within the hub and spoke system.

Figure 3: Visual Representation of the "Hub and Spoke" Model of Homeward Bound Service Delivery Across San Joaquin County



Defining Mild-to-Moderate and Severe Mental Health Concerns

One component of the Homeward Bound Initiative involved a direct referral pathway between CMC and SJCBHS to ensure each consumer receives the appropriate level of care for their behavioral health concern promptly. Individuals who were determined to have a mild-to-moderate mental health diagnosis, or have a primary diagnosis of SUD, received treatment at CMC. Individuals identified as having a severe mental health diagnosis typically received treatment at SJCBHS. Individuals were identified as meeting the criteria for a severe mental health concern based on the Beacon criteria, which are as follows:

The individual will be considered to have a severe mental health concern if:

1) The consumer has at least one mental health disorder diagnosis.

AND

2a) If the duration of illness is less than one year, then they must exhibit at least four moderate, two severe, or one extreme impairment in the following domains:

i. Feeling, mood, affect
ii. Thinking
iii. Family/living environment
iv. Interpersonal relationships
v. Performance of daily activities
vi. Social and legal
vii. Basic needs and self-care

OR

2b) If the consumer is identified as having a duration of mental illness of over one year, then they must exhibit at least two moderate, or one severe impairment in the domains listed above.

Indicators of Severe or Extreme Impairment

Indicators of severe or extreme impairment include mental health symptoms that substantially interfere with daily activities: these can include being highly disorganized, impulsive, or exhibiting aggressive behaviors with a decline in self-control; suicidal or self-harming behaviors; disruptions in self-care; and substantial disruptions in interpersonal relationships.

Indicators of Mild-to-Moderate Impairment

Indicators of mild-to-moderate impairments may include manageable mental health symptoms that are attributable to social stressors (i.e. loss of job, bereavement, management of a chronic medical condition); an expectation of a resolution of symptoms within six months; an ability to manage daily activities despite the presence of symptoms; no or minimal impact on interpersonal relationships; the absence of emergency psychiatric admissions in the past 12 months; and/or stable adherence to medication for over 12 months or medications no longer required.

Reducing Convictions amongst Clients with a Criminal Justice History

In addition to improving care access and the range of services available, one of the aims of the project was to reduce recidivism amongst individuals with behavioral health disorders. For this study, recidivism was defined in the following way:

> "The conviction of a new felony or misdemeanor committed within a specified period of the intake assessment of the Homeward Bound program."

Goals and Objectives

The Homeward Bound Initiative combines project goals as stated in the "Project Evaluation Plan" section of the Proposition 47 grant proposal (Proposition 47), submitted to the California Board of State and Community Corrections in February 2017, and the goals and objectives stated in the *Purpose of the Innovation* section of the Assessment and Respite Center Innovation Plan Document, submitted to the California Mental Health Services Oversight and Accountability Commission (MHSOAC). Where goals and objectives are closely related or overlap each other they have been combined and synthesized for clarity.

Goal 1. Reduce systemic gaps which lead to the underutilization of mental health services.
Objectives:

- To address structural limitations of the current model of care that leads to the underutilization of appropriate services in people with mental illnesses and co-morbid SUDs.
- To provide stabilization services, respite residential care, withdrawal management, housing, and case management, when necessary, to facilitate consumer engagement in mental health treatment.

Goal 2. Improve access to mental health services for underserved groups.
Objectives:

- To provide mental health services to non-violent offenders with trauma or other mental health concerns.
- To provide mental health services to high-risk individuals with SUD who are homeless, and/or have frequent law enforcement contact associated with their behavioral health concerns.
- To increase the number and proportion of Latinx and Black and African American individuals who utilize community behavioral health services.

Goal 3. Reduce gaps in the substance use disorder continuum of care.
Objectives:

- To provide effective SUD treatment services, ensuring that providers are trained in effective treatment practices, and are assigned to deliver services.
- To provide effective SUD treatment services, allowing former offenders to receive diversion programming and/or direct their own recovery efforts.

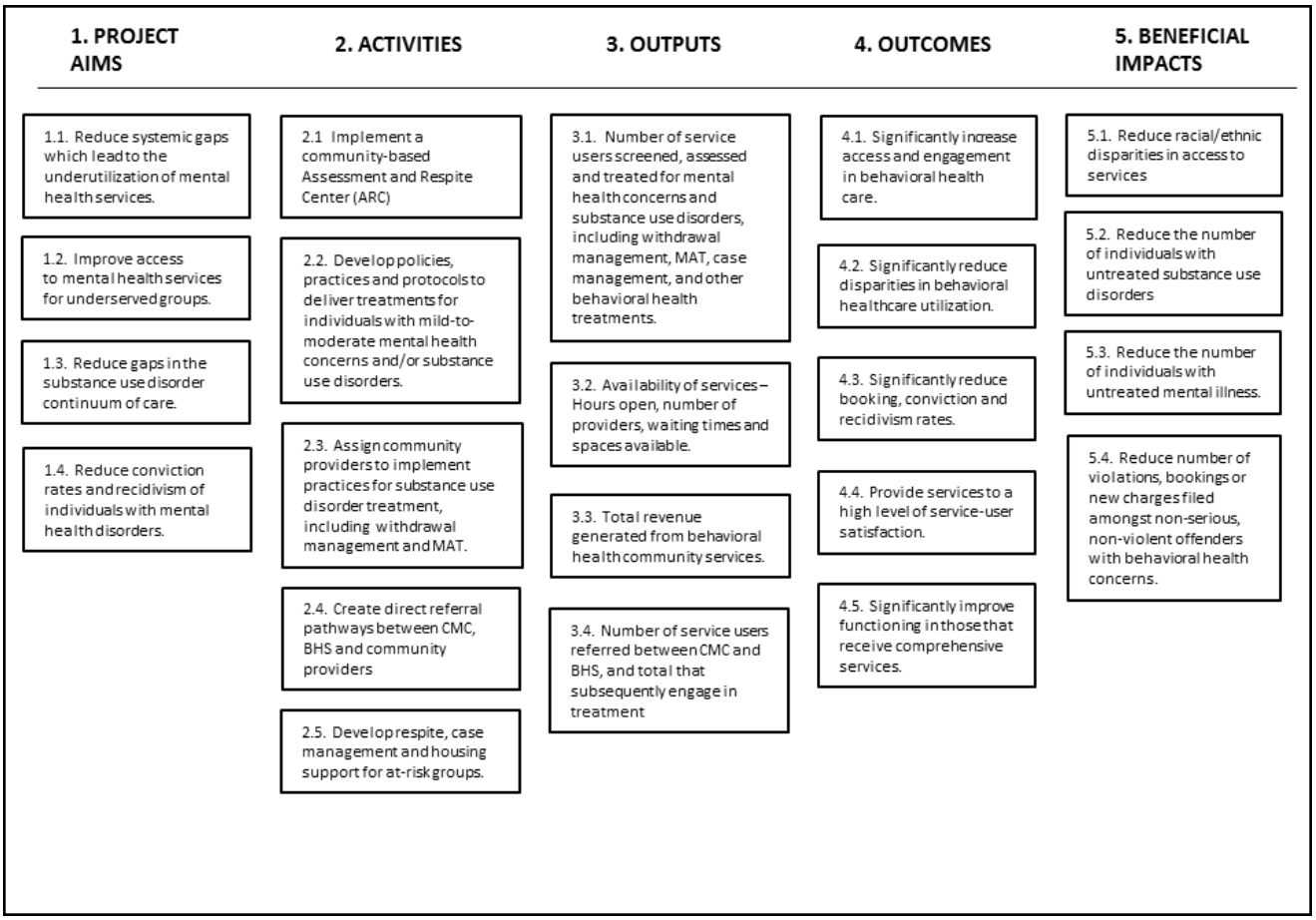
Goal 4. Reduce conviction rates and recidivism of individuals with mental health disorders.
Objectives:

- Improve the quality of life of non-violent consumers with prior convictions; individuals with SUD; those that are homeless or at risk of homelessness; and any other populations that have frequent contact with law enforcement associated with their behavioral health concerns.
- Reduce the number of incarcerations among non-violent offenders with untreated mental health and/or SUD and reduce the rate of recidivism in this population.

Logic Model

The logic model for the formative and summative evaluation of the Homeward Bound Initiative is detailed in Figure 4. The figure details the original aims of the project, the proposed activities designed to meet those aims, a measure of how successful the project is at producing those activities ("outputs"), and the impact of the activities delivered (the "outcomes"). The "beneficial impacts" column lists the wider, system-level changes one may hope or expect to see based on the success of the previous components of the logic model as outlined.

Figure 4: Logic Model of the Homeward Bound Initiative



Key: ARC, Assessment and Respite Center; BHS, Behavioral Health Service; CMC, Community Medical Centers; MAT, Medication-Assisted Treatment.

Modifications to the Delivery of Homeward Bound Services because of the COVID-19 Pandemic

At the beginning of the COVID-19 pandemic, states began to implement shelter-in-place orders to reduce the rate of transmission. By mid-March 2020, CMC had implemented a significant restructuring of its services to safeguard the health of providers and consumers, and to comply with shelter-in-place mandates. To understand the scope of these amendments, and their impact on the evaluation, members of the evaluation team interviewed the CMC project lead on two separate occasions. The first took place on April 21, 2020, not long after the protocol changes had been implemented.

In this meeting, the focus was on understanding the immediate changes that had taken place, and the potential short-term impact of the pandemic on the project. The second interview took place on October 1, 2020, to better understand the medium-to-long-term impacts of the pandemic and the service changes, including the period from July to August 2020, when COVID-

19 reported cases were at their first peak in San Joaquin County. The findings of these interviews are detailed in the results section.

Methods/Data Collection

Study Design

This report represents a formative and summative evaluation of the Homeward Bound Initiative. The outputs evaluate the staged implementation and expansion of the proposed activities. The outcomes evaluated in this report follow directly from the goals outlined in the *Goals and Objectives* section of this document and were outlined in detail in Section 4 of the *San Joaquin County Homeward Bound Initiative Evaluation Plan,* beginning on page 25. Those outcomes are listed below:

Outcome 1: Improvements in Access and Engagement in Care
Outcome 2: Reducing Disparities in Behavioral Healthcare Services Utilization
Outcome 3: Reducing Criminal Justice Bookings, Convictions, and Recidivism
Outcome 4: Delivering High Levels of Consumer and Provider Satisfaction with New Models of Care
Outcome 5: Functional Improvements Following Treatment

Target Population

All adults who accessed services delivered through the Homeward Bound Initiative were potentially eligible for inclusion in the analysis. The analysis includes all service data collected between the point when the Homeward Bound program's data was incorporated into the CMC electronic medical record (EMR), from 08/01/2018 until 04/30/2023. The clients included in this evaluation include everyone who was either referred or self-referred to one of the Homeward Bound program's hub or spoke sites to receive care, or utilized Homeward Bound sobering facilities during a period of intoxication.

Services Delivered by the Homeward Bound Initiative

The original components delivered as part of the Homeward Bound Initiative included MAT, withdrawal management, sobering services, case management, outpatient respite services, and behavioral health counseling. The services delivered were consistent with the American Society of Addiction Medicine (ASAM) guidelines at both Level 1 and Level 2 degrees of intensity ("ambulatory withdrawal management with and without extended on-site monitoring") (Mee-Lee et al., 2013). In the third and final implementation stage of the project, service delivery was

extended to include residential withdrawal management, enabling care consistent with ASAM Level 3.1 and 3.2 services (i.e., “clinically managed low-intensity residential services”). In conjunction with these additional services, consumers were eligible, based on need, to receive ongoing co-located physical and mental health care as part of CMC’s existing services.

MAT is the use of medications in combination with supportive therapies to treat SUD. The ARC primarily administered two medications: suboxone (buprenorphine and naloxone) for the treatment of opioid use disorders, and naltrexone for the treatment of alcohol use disorders. Buprenorphine suppresses the physical signs and symptoms associated with opioid withdrawal and is an effective intervention in the maintenance treatment of opioid dependence (Mattick et al., 2014). Naltrexone blocks feelings of intoxication and euphoria and has been found to reduce self-reported cravings and alcohol use (Hendershot et al., 2017).

The recovery counseling component of care was delivered both in a group format and on a one-to-one basis. Both treatment formats were delivered by qualified recovery counselors, and the focus of these treatments was to support the individual in their recovery from SUD. If either during the assessment or ongoing SUD treatment the consumer was identified as having additional mental health needs, then they were referred to a CMC behavioral health clinician where they could receive additional services.

For those who presented to the ARC intoxicated either via a self-referral, or a referral from law enforcement or other community partners, they were offered a safe space to achieve sobriety. Once sober, an assessment and additional care services were offered, based on need.

In addition to mental health and SUD treatment, the Homeward Bound Initiative provided a range of additional supportive services delivered as part of case management and respite care. These services were not contingent on consumer engagement in other components of care. The services included addressing immediate basic needs (i.e., providing food, basic hygiene support, etc.) to providing long-term case management, housing support, and employment assistance. Depending upon the nature of the support required, services were delivered by ARC providers or referred out to community partners. One of the primary aims of this component of care was to establish early engagement with the consumer, develop rapport, address basic needs, and provide an additional pathway to treatment for SUD and/or mental health treatment. Major components of this work included housing, vocational, and transportation support to facilitate engagement in care, address homelessness and housing insecurity, and support recovery outcomes.

In the final stage of the project, a short-term residential facility was established in Stockton to support substance withdrawal care for consumers where 24-hour monitoring was assessed to be clinically necessary (i.e., ASAM Criteria Level 3.1 and 3.2). In this facility, trained medical and behavioral health staff were on hand to medically manage consumer withdrawal from services,

after which they could be triaged to Homeward Bound community services - including services detailed above - to support consumer recovery.

Data Collection Procedures

CMC Electronic Medical Record (EMR) Data Collection Procedures

CMC provided the evaluation team with a client-level, de-identified dataset pulled directly from the service's medical record, covering the study period from August 2018, until April 2023. In this dataset, each client was assigned a unique study ID code enabling client-level linkage to other CMC-hosted datasets and includes an array of data, including service history, sociodemographic information, and a series of self-report measures. Consequently, these data represent the core component of the evaluation conducted.

In line with current practices, if the consumer does not already have an EMR at CMC, one is created at the first appointment. The EMR contains all of the consumer's demographic information and an ongoing record of their care. During their first appointment, the consumer completes the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder Scale (GAD-7). During this, or any subsequent appointments, if it becomes evident the consumer may be experiencing a SUD, they are encouraged to complete the Treatment Needs Questionnaire (TNQ). If this screening form identifies any intravenous drug use, prior receipt of MAT, use of cocaine or benzodiazepines, or alcohol misuse, then the consumer is referred to complete a full behavioral health assessment. During the assessment, the consumer is instructed to complete the Client Satisfaction Questionnaire (CSQ-8), the Drug Abuse Screening Test (DAST) for a more detailed exploration of their drug use history if they reported prior drug use, and the CAGE Substance Abuse Screening Tool (CAGE) if they report a history of alcohol problems. The individual is then referred to receive either withdrawal management, MAT, counseling, case management, and/or respite care, based on the outcome of the assessment. Individuals referred to receive MAT complete the Office-Based Opioid Treatment Stability Index (OBOT) at the initiation of treatment, and then at monthly intervals to review patient stability and recovery outcomes. As part of ongoing care, all consumers completed the PHQ-9 at the start of every appointment, and the GAD-7 either every six months or when considered clinically relevant. These data are used to both inform care, and track symptom progression over time. All the data were stored within the CMC EMR, and at each reporting stage, these data were extracted by CMC analysts and provided to the evaluation team for analysis.

Data Collection Procedures for Case Management and Respite Residential Services

While the CMC EMR dataset contained most elements relevant to reviewing the numbers of services delivered, notably this did not include the range of case management services delivered. These services include the provision of housing assistance to support clients either

homeless or at risk of homeless, other forms of financial aid, hygiene support, employment support, and assistance around transportation to and from treatment. These components of care represent a critical aspect of services delivered by the Homeward Bound program and are considered crucial to maintaining engagement in treatment. To incorporate these components of care into the evaluation, providers at CMC maintained a case management dataset that details the range of services provided.

Secondly, while the location of service delivery is available in the CMC EMR dataset, this is automatically updated as clients shift to different locations of care. Consequently, while it is possible to identify those either currently receiving respite residential services, or those that received such care and were discharged from CMC immediately afterward, the majority of clients are transferred to their community primary care sites, meaning the total figure would be a significant under-representation of the total number actually served. To address this, similarly to the Case Management Dataset, CMC staff have produced and maintained a spreadsheet detailing the date of admission and discharge from respite residential care. Data is available from all clients that have received services at this location since October 2021.

Data Collection Procedures for Recidivism Data

In the original proposal, convictions data was due to be sourced through the State of California Department of Justice records. However, due to state policy changes, Health Insurance Portability and Accountability Act (HIPAA) requirements, and significant barriers concerning release of information requests, this approach was not considered feasible for this project. Consequently, in January 2019 CMC and the evaluation team modified their data collection practices in the following ways. First, as part of the intake assessment in addition to asking consumers whether they had a criminal history, they were also asked for the most recent date of release from prison or placement on supervision. This data was then later extracted from the intake assessment form and added to a dedicated Excel sheet used to track convictions data. This approach was considered feasible, given the evidence supporting the validity of self-reported arrest data (i.e., Daylor et al., 2019).

To track subsequent convictions, CMC staff manually checked the Superior Court of San Joaquin County public court records for consumers every 12 months post the baseline assessment. These records were available at the following address: https://cms.sjcourts.org/fullcourtweb/mainMenu.do?&PageSize=0&Index=0. In cases where the consumer was convicted of a new felony or misdemeanor post-assessment, this information was added to the convictions data excel sheet. This check was completed twice over two years for each consumer.

To link both the recidivism and EMR datasets, an analyst based at CMC assigned all consumers a unique identification (ID) number. Once the evaluation team received the datasets, they were merged via the anonymized unique identifiers.

The CMC Financial Dataset

With the CMC Financial dataset, we aimed to address Output 3 of the logic model, concerning the total revenue generated from Homeward Bound-related activities. The dataset includes a monthly snapshot of the monthly revenue generated and the associated costs of care delivery from May 2021 to May 2022 at the primary Waterloo Road hub clinic and the Tracy recovery spoke site. This period was selected as it represents the project at the point of maturation, therefore providing the most accurate assessment of what ongoing costs and income could be expected to be going forwards. Total monthly revenue generated includes both the total funds generated, and the funds generated excluding grant funds. This allowed for an assessment of the current financial position of the project, in addition to an assessment of the possible shortfall that may exist once the grant expires.

Measures

In the current evaluation, the following client self-report and clinician-administered surveys were utilized:

Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) is a brief, nine-item instrument designed to diagnose depression and measure depression severity. Items concern different features of depression such as anhedonia, depressed mood, and loss of appetite, and depression is diagnosed by a PHQ-9 score of 10 or greater. As a severity measure, the scale ranges from 0-27, with a higher score indicating more severe depression. In this evaluation, all clients completed the PHQ-9 at the point of assessment, and then at each appointment until the point of discharge from Homeward Bound Services.

Generalized Anxiety Disorder Scale (GAD-7)

The Generalized Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006) is a seven-item questionnaire designed to both diagnose and measure the severity of anxiety the responder has experienced over the past two weeks. Items relate to symptoms such as uncontrollable worrying, irritability, and restlessness. Each item is rated on a scale of 0 (“not at all” bothered) to 3 (bothered “nearly every day”). A score of 1-4 is considered to indicate minimal anxiety, 5-9 mild, 10-14 moderate, and 15-21 severe. The authors suggest a score of 10 or higher as a reasonable cut-off point for identifying cases of GAD. The scale was administered by all clients at the point of assessment amongst those who presented with anxiety, as determined by the assessing clinician.

The Drug Abuse Screening Test (DAST)

The Drug Abuse Screening Test (DAST; Skinner 1982) is a 20-item self-report questionnaire designed to measure the degree of problems the client experiences as a consequence of their drug use. Each item requires a dichotomous yes/no response and includes items relating to

interpersonal conflicts, occupational problems, criminal activities, side effects, guilt, addiction, and treatment related to drug use. American Society of Addiction Medicine (ASAM) placement criteria suggest that a score ≤ 5 indicates a low-level impact of drug abuse, 6-10 indicates moderate, 11-15 indicates substantial, and ≥ 16 indicates a severe impact, with the individual likely requiring intensive treatment services. Clients completed the DAST at CMC at the intake assessment.

The CAGE Substance Abuse Screening Tool

The CAGE Substance Abuse Screening Tool (Ewing, 1984) is a four-item questionnaire used to identify responders who may potentially be misusing alcohol. Each item requires a dichotomous yes/no response and asks the responder whether they have ever felt that they should cut down on their drinking, if they get annoyed because people criticize their drinking, if they have felt guilty regarding drinking, or if they have ever had a drink first thing in the morning to alleviate symptoms of alcohol addiction or a hangover. The typical cutoff used for the CAGE is two positive answers. Clients completed the CAGE in CMC at the intake assessment.

Client Satisfaction Questionnaire (CSQ-8)

Clients' satisfaction will be assessed using the CSQ-8 (Larsen et al., 1979). The CSQ is an eight-item Likert questionnaire where responders rate each item from 1-4, with a higher score representing greater satisfaction with treatment. The CSQ-8 has been extensively used in various healthcare settings and has been validated for use in SUD populations (Wilde and Henriks, 2005). Clients receiving services at SJCBHS completed the CSQ-8 during their full assessment. Clients receiving care at CMC completed the CSQ-8 at the point of assessment.

Analysis Plan

The analysis detailed in the current report comprised two discrete sections, which include the formative and the outcomes evaluation. The formative evaluation focused on the following areas: summarizing the impact of COVID-19 on program implementation, detailing the number of and types of services delivered over time, and summarizing the sociodemographic and clinical presentation of the sample to ensure the program has been successful at engaging the intended target population.

The impact of COVID-19 on program delivery was explored utilizing semi-structured qualitative interviews with program leadership in a longitudinal design to capture both the short- and longer-term impacts. The interviews were recorded, with the main findings described in a brief narrative summary. Next, a review of the implementation and expansion of Homeward Bound services was conducted. This included utilizing basic summary statistics to detail the number of consumers enrolling in different components of care over time, and the expansion of services across the hub and spoke sites. Additionally, summary statistics detailing consumer engagement in different Homeward Bound services and 6-month retention rates were

examined, with retention calculated as the difference between the month of their first appointment, and the last appointment date recorded for that specific intervention in the consumers' EMR.

The sociodemographic details of the sample, including consumer age, race and ethnicity (combined as a single variable), gender, and housing status, were examined utilizing simple summary statistics, based on consumers' self-report at the baseline assessment stage. Finally, the clinical presentation of the sample at the baseline stage was examined using the PHQ-9 to capture depressive symptoms, the GAD-7 to measure symptoms of anxiety, the DAST to record the degree of problems experienced related to drug use, and the CAGE to record the degree of problems related to alcohol use.

The outcomes evaluation focused on the following areas: improve behavioral healthcare utilization amongst underserved groups, summarize the recidivism and reconviction rates of Homeward Bound consumers, provide services to a high degree of consumer satisfaction, and improve clinical outcomes amongst Homeward Bound consumers over time.

In the first part of the summative evaluation, referral, and engagement rates of consumers from historically underserved groups were compared to the total population. In the context of this evaluation, historically underserved groups included homeless individuals, Latinx, and Black and African American individuals. Engagement was defined as the consumer attending the first session of the program. To evaluate the efforts to engage underserved populations, the total proportion of individuals that identify as belonging to each of these groups was reported. With regards to race and ethnicity, this was compared to San Joaquin County census estimates, based on the assumption the behavioral health needs across the different racial and ethnic groups would be broadly consistent. To evaluate efforts to engage individuals from these underserved groups into different components of care, engagement rates of each sub-group were compared to the remaining population using Chi-square tests.

Analysis of behavioral healthcare service utilization among underserved populations was accomplished by examining the demographics of the consumer population, including the share of consumers in mental health treatment and SUD counseling for at least six months. We assessed the utilization of services by underserved groups by comparing the Homeward Bound Initiative's service utilization by race and ethnicity to their respective rates within the general population.

Analysis of reconviction among clients with a criminal justice history focuses on the share of persons with a criminal justice history among all clients over time, and the reconviction rate at 12 and 24 months from enrollment.

In the evaluation of consumer satisfaction, simple summary statistics were utilized to explore the degree of satisfaction consumers had with services, as measured using the CSQ-8. In this analysis satisfaction scores were analyzed as a single summary score, in addition to item-level

analysis. Additionally, the proportion of consumers that scored at least a mean score of '3' on the CSQ-8, indicating moderately high levels of satisfaction was reported.

In the assessment of treatment outcomes, we tracked symptoms of depression over time using the PHQ-9. These data were selected as the primary outcome given the fact these data were collected at every appointment, as opposed to when clinically indicated (such as the GAD-7), which could significantly impact the validity of the findings. In this analysis, we assessed the share of consumers receiving the PHQ-9 questionnaire in each month since their baseline month, where a consumer's baseline PHQ-9 is indexed as month one. We also estimate the mean month-to-month change in subsequent PHQ-9 scores relative to the mean baseline PHQ-9 score using fixed-effects panel regression to control for unobserved consumer characteristics that are constant in time and correlated with PHQ-9 scores.

Formative Evaluation - Results

Impact of COVID-19 on Homeward Bound Program Implementation

To detail both the short- and longer-term impact of COVID-19 on the implementation of the Homeward Bound Initiative two rounds of semi-structured qualitative interviews with CMC Leadership were conducted. The first took place on April 21, 2020, while the second took place on October 1, 2020. A summary of the findings from these interviews is detailed below.

April 21, 2020, Meeting Between the CMC Program Lead and the Evaluation Team

By the middle of March 2020, to minimize potential COVID-19 exposure to consumers and providers inside the ARC, CMC implemented an outdoor triaging service where consumers were screened before coming in for their appointments or assessments. In addition, many appointments that were previously conducted in-person, either on-site or in the community, were changed to be delivered over the phone. At the time, the program director suggested that this shift to telemedicine had been received well by consumers with minimal impact on service engagement.

Regarding services that were either reduced or canceled, CMC was no longer able to offer the "Shower of Love" service, which entails making showers available every Wednesday with the provision of fresh clothing. To minimize the impact of this, they started to provide "Health Kits" that included sanitary products and hand sanitizer as an alternative. Sobering services were restricted to one patient per room, which significantly reduced the service capacity. Additionally, the hours of operation were shortened from 24 hours a day to running from 8 a.m. to 5 p.m.

The CMC Program Lead reported a significant shift in the population served, and the reported needs of the consumers. This change was attributed primarily to four factors: 1) the reduced

hours of operation, 2) the closure of local liquor stores, 3) the change in referral pathways, and 4) the shift in need to housing and nutritional support due to increased unemployment/lack of work, the need to be off the streets during a pandemic, and other agencies either closing or reducing services.

As stated previously, due to staffing and sanitation needs, CMC changed the hours of operation of the ARC from 24 hours to 8 a.m. to 5 p.m. Anecdotally, the experience of the program lead was that these new hours limited access for people who normally scheduled evening appointments, or walked-in after 5 p.m. This was considered to represent a particular barrier to those employed during standard work hours, albeit with the impact mitigated to some extent through the expansion of telehealth services.

Additionally, CMC noticed a rise in the number of consumers seeking help with their alcohol use disorder and greater consistency in appointment attendance amongst those who had previously been inconsistent. Some of the factors that were attributed to this included the closure of local liquor stores reducing the accessibility of alcohol, the greater flexibility afforded by the availability of telemedicine, and a decline in other competing ways consumers were able to spend their time. In response, an additional provider was brought into the MAT program to manage the increased demand. CMC were also in the progress of hiring more SUD counselors to respond to the increased need.

The typical referral pathway into the Homeward Bound program experienced a significant shift because of the pandemic. The main changes included a greater number of referrals coming from emergency departments (ED) and the absence of consumers being referred by the county law courts after their closure in March. Regarding the changes in ED referrals, part of this change was attributed to the significant outreach that CMC had been conducting with local hospitals immediately prior to the start of the pandemic. However, another factor was ED personnel more actively referred housing-insecure consumers to Homeward Bound services who were either exposed to COVID-19 or were experiencing non-serious COVID-related symptoms to facilitate isolation. This was considered an important factor in the shift towards an increase in demand for housing services, relative to before the pandemic. Regarding the county court closures, not only did this mean a previous referral source was unavailable to the project, but it also reduced the proportion of the treated population that report having a criminal history, particularly those who are released from custody/placed on supervision within three years of treatment initiation.

One of the biggest changes was the shift from referrals for SUD needs to housing-related needs. Because CMC was one of the few programs still providing services to the community at the time, there was a higher demand for respite services and housing. Through the help of Proposition 47 and Mental Health Services Act (MHSA) Innovation grants, the county allowed them to use hotel vouchers to house consumers. CMC was also purchasing food, providing

laundry vouchers and soap, and providing pet food, which increased costs but expanded the scope of CMC's services.

October 1, 2020, Meeting Between the CMC Program Lead and the Evaluation Team

The evaluation team interviewed CMC leadership again on October 1, 2020, to get an update on how the pandemic continued to affect services and implementation. Notably, costs increased due to the need to buy equipment for staff to work from home long-term, such as laptops and cell phones. Referral pathways had also changed. The County courts opened in May 2020, resulting in a flux of court referrals beginning in September. In September 2020, police began to refer individuals again now that more knowledge about COVID-19 and preventative measures had been disseminated. Heightened police referrals led to an increase in sobering utilization.

CMC hired more staff, all of whom specialize in addiction. Even with the additional staff, there had been staffing shortages, and an increase in staff anxiety and burnout as the pandemic continued. Many staff had children and had balanced family responsibilities with children at home full-time, and remote working. CMC offered time off to help with burnout, but many staff declined the offer because there were no travel opportunities during the pandemic. Those who did take time off did so for family obligations and therefore were not resting, leading to further burnout. CMC opted to allow some staff to come back into the office while maintaining distance to alleviate the double burden of working while aiding in childcare.

Consumers were initially excited to have the service remain open, but over time it was noted that consumers found the situation increasingly challenging, resulting in a higher rate of relapse and increased demands upon staff. SUD patients that previously had consistent, regular appointments adjusted well to remote sessions. However, newer consumers had trouble engaging via phone. Moreover, there was an influx of consumers who were predominantly seeking housing, not treatment. Once assessments and treatment started, many of these consumers opted to leave, increasing dropout rates.

Staff also needed to educate consumers on confidentiality and finding a safe space to engage in remote sessions. Consumers sometimes called into sessions in public or near family, compromising the confidentiality of sessions. Staff encouraged consumers to find private locations, but when not available, staff documented the circumstances of the session (i.e., family in earshot, etc.). Another issue with remote sessions had been making sure consumers have enough minutes on their cell phones to last a full session.

For consumers who were going into CMC, there had been issues surrounding transportation. CMC used to utilize rideshare services for consumer transportation; however, during the pandemic, there had been a shortage of rideshare drivers. Furthermore, buses limited how many individuals could ride at a time, furthering transportation limitations.

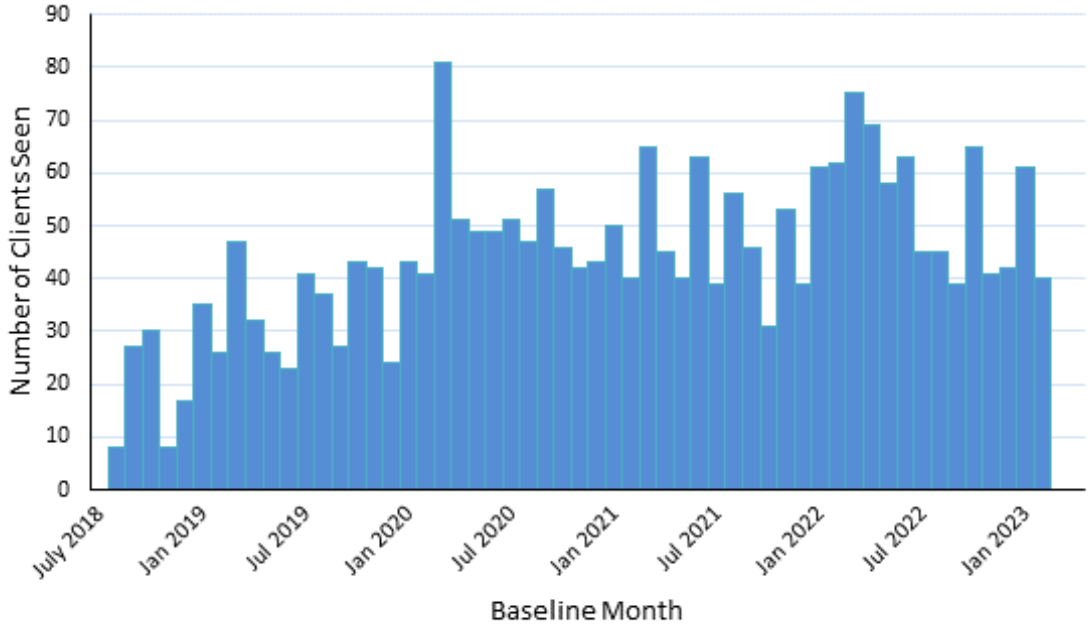
Impact of COVID-19 on Homeward Bound Implementation – Summary

The pandemic is likely to have impacted the evaluation findings in multiple important ways. First, the experiences reported by the Program Lead during both interviews indicate that a significant change in the case-mix of new consumers occurred. In the early stages of the pandemic, a larger proportion of consumers who were entering into the system had significantly more housing needs—and a greater focus on addressing their housing situation—as opposed to substance use disorder needs, relative to pre-COVID consumers. In addition, a greater number of referrals came from EDs, and none from the county court system. These changes in the case mix were suggested to lead to significant changes in the data in terms of how consumers engaged in treatment, modified treatment response trajectories, and reduced the proportion of people with a criminal history, which in turn impacted recidivism outcomes. In the October 2020 interview, the prolonged experience of working and living through a pandemic, and the subsequent shelter-in-place mandates, were found to lead to significant burnout among providers and increased frustration among consumers. In both cases, this could again negatively impact staff turnover, treatment engagement, and subsequent treatment outcomes. In addition, it is also important to consider the impact of the changes in services delivered both by Homeward Bound and community partners on the evaluation itself. For example, the switch from in-person appointments to telehealth may represent barriers to consumers who do not have phones, have limited minutes on their pre-paid phone plans, or frequently lose access to their phones. In addition, CMC reported that while existing consumers had managed to remain engaged in treatment, engaging new referrals via telemedicine was more challenging, suggesting that higher dropout rates during this period for new consumers were expected. Social distancing requirements had led to a significant reduction in the availability of sobering beds, which significantly reduced the number of consumers who both receive these services, and other services, as a consequence of coming in via this pathway. The closure and restriction of services delivered by other community agencies was also likely to have resulted in fewer additional needs of the consumers being met. Overall, consistent with the changes in the case mix of consumers, these changes are likely to have negatively impacted meeting consumer needs, treatment engagement, and treatment outcomes. Where appropriate, these factors were considered in the interpretation of the findings presented in this report.

Service Delivery and Expansion over Time

From August 2018 to April 2023, 2,528 unique individuals were enrolled in the Homeward Bound Initiative. The number of individuals enrolled over time over this period can be found in Figure 5. During the period depicted, there was a significant increase in enrollment over time until the start of the COVID-19 pandemic in April 2020, at which point a very slight downward trend began. As vaccine eligibility expanded and stay-at-home orders were lifted at the beginning of 2022, a slight increase in enrollments was evident.

Figure 5: Number of New Clients Enrolled into the Homeward Bound Initiative over Time



Development of the "Hub and Spoke" model of Homeward Bound Service Delivery

A review of the development of the "hub and spoke" model to Homeward Bound care delivery is presented in Table 1. While the first client to be entered into the updated EMR took place on August 1, 2018, the first Homeward Bound Initiative client was seen in January 2018 at the Waterloo Road hub site. Since then, services were first delivered at the Lodi site in August 2018 before the broader expansion in March 2019. At the Manteca site, the first Homeward Bound client was served in December 2018, and in Tracy, the first client received services in September 2019. In January 2020, clients from out-of-county who were originally seen at the Stockton hub site were referred to CMC sites in neighboring counties, including the cities of Dixon and Vacaville in Solano County. Despite these additional sites, it is notable that almost all clients involved in the program were served at the Hub Waterloo Road site. The Stockton Hub Site in Table 1 includes multiple sites within Stockton, but are reported as one.

Table 1: Expansion of the Homeward Bound Initiative Across Hub and Spoke Sites

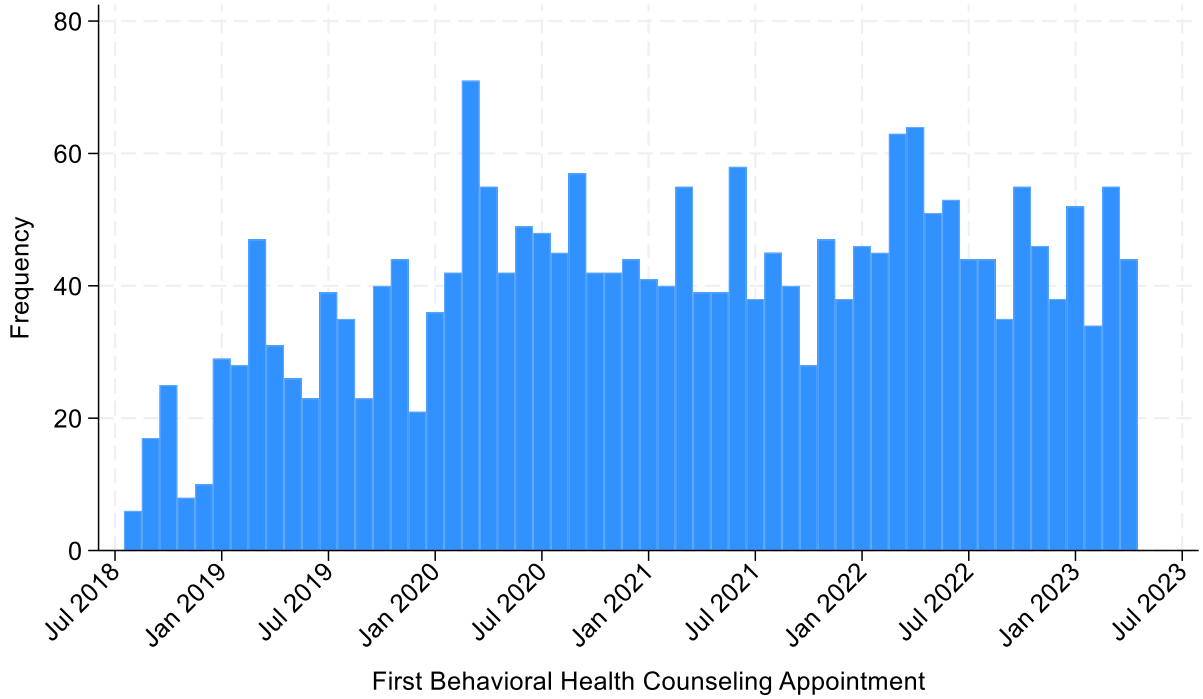
CMC Clinic Site	n	%	First Date of Service
Hub Site			
Stockton	2,149	85.0%	Jan-2018
San Joaquin Spoke Site			
Lodi	27	1.1%	Aug-2018
Manteca	10	0.4%	Dec-2018
Tracy	242	9.6%	Sep-2019
Out-of-County Spoke Site			
Dixon	21	0.8%	Jan-2020
Vacaville	79	3.1%	Jan-2020

Delivery of Behavioral Health Counseling

In total, 2,302 clients attended at least one mental health or substance abuse counseling session, representing 95.1% of the total population that engaged in Homeward Bound services. Of these, clients attended a median of 4 appointments (IQR 2-10).

The first appointment date was available for 1,976 clients (91.1% of all the clients that attended a behavioral health appointment). The rate of engagement in such services is presented in Figure 6. As expected, these trends are consistent with enrollment figures. Over time, there appears to be a gradual increase in clients seen each month until January 2020, after which approximately 40 clients attended a first appointment each month. Of those that were seen, 98.0% of clients had their first behavioral health appointment within one month of making contact with the service, suggesting that the program has been highly successful at funneling clients into behavioral health services from the point of contact.

Figure 6: Number of clients completing a Behavioral Health Assessment over Time

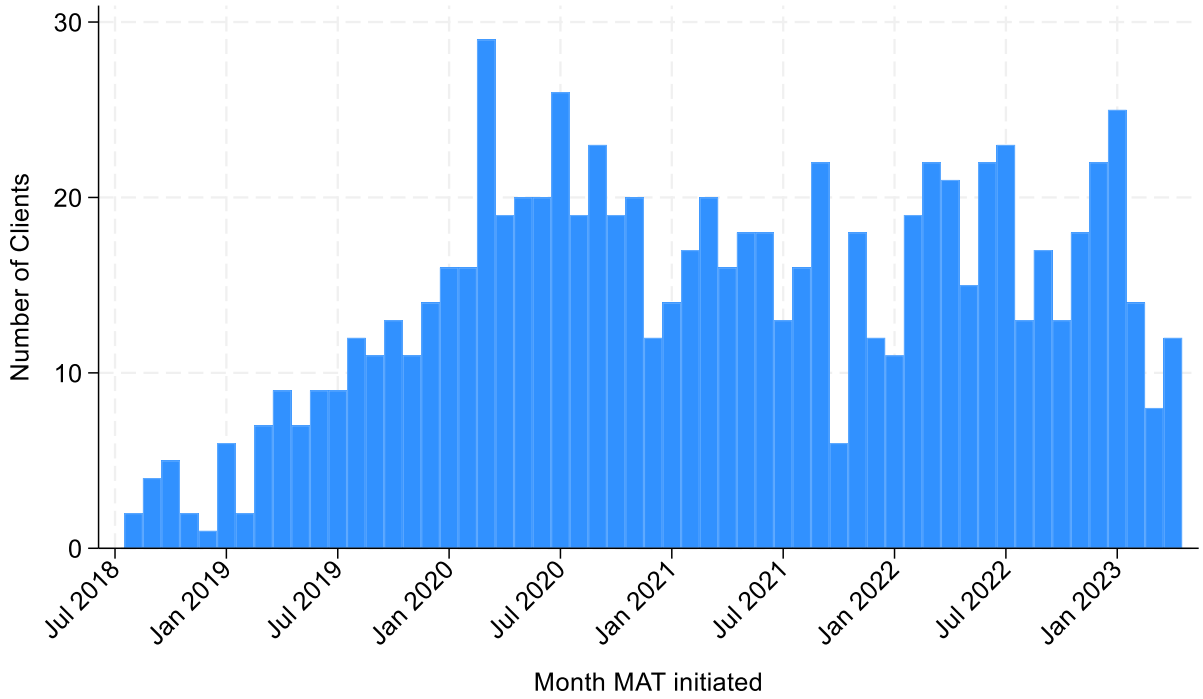


Delivery of Medication Assisted Treatment (MAT)

From August 2018 to April 2023, 828 clients enrolled in the Homeward Bound MAT program. Not including Homeward Bound clients that initiated MAT prior to the initiation of Homeward Bound, this represents 32.6% of the total sample. Of these, 429 clients (51.8%) were prescribed Suboxone, and 399 (48.2%) were prescribed Naltrexone. Clients initiating MAT attended a median of three appointments (IQR 1-8).

Enrollment into the MAT program over time is presented in Figure 7. Consistent with other metrics, the number of clients seen over time consistently increased until approximately January 2020, after which a median of 18 new clients were seen per month (IQR 14 – 21.5). Collectively, the data presented in Figures 5-7 appear to indicate that maturation of the project appeared to occur by January 2020, approximately 18 months after project initiation.

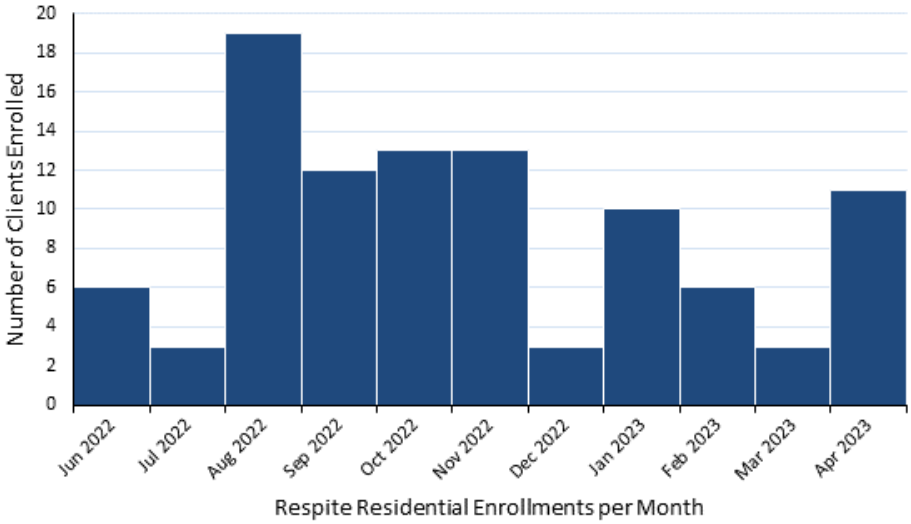
Figure 7: Number of Clients who Initiated Medication Assisted Treatment (MAT) over Time



Delivery of Respite Residential Care

At the end of October 2021, the Homeward Bound Initiative opened its Respite Residential Care Program, which represents the third and final implementation phase of the Homeward Bound Initiative. Data has been manually collected by providers at the respite residential service since its opening in October 2021. However, limitations in how this data was initially recorded meant that between October 2021 to May 2022, it was not possible to consistently determine what proportion of individuals referred went on to receive residential care, and which ones either disengaged, did not meet criteria, or received outpatient services. Therefore, the following data represents only a subgroup analysis of care delivery following a period of 11 months, from June 2022 until April 2023. During these 11 months, 101 unique clients enrolled in respite residential services. The rate of enrollment over time is presented in Figure 8. Since June 2022, the program saw approximately 9 unique clients per month.

Figure 8: Number of Enrollments into the Respite Residential Service Over Time



Delivery of Case Management Services

The delivery of case management services was manually collected by case managers from program initiation until April 2023. In total, case managers reported that 1,297 Homeward Bound consumers received some form of case management services. Of these, at least some information regarding what was provided was available for 417 consumers (32.2% of the total). The most frequently reported service provision included the delivery of some form of housing services (n=311 consumers), which included referrals to local housing organizations such as the Central Valley Low Income Housing Cooperation (CVLIC), supporting clients to access local shelters, providing vouchers for people to stay in motels, and rental assistance. The next most frequently provided service included help with transportation (n=220 consumers), and supporting people to access healthcare appointments and remain engaged in Homeward Bound services. Finally, case managers recorded providing some form of employment support to 172 consumers, which included conducting career assessments, helping consumers craft resumes, supporting consumers to enroll in vocational training, assisting in job searches, and helping consumers complete applications and prepare for interviews. In the last thirteen months of the evaluation (April 2022 – April 2023). additional information regarding case managers supporting consumers with documentation assistance, including helping individuals get copies of their birth certificates, other forms of ID, and social security cards was collected. During this period, the available documentation indicates that case managers supported at least 84 consumers in this domain.

Overall, given the challenges in systematic data collection and the substantial amount of missing data, these figures are likely to represent a significant underreporting of the range of case management services delivered. Despite this important caveat, these data are helping in

highlighting the volume and range of critical case management services provided to Homeward Bound consumers.

CMC Primary Care Services Received by Participants of the Homeward Bound Initiative

In addition to the various behavioral health appointments Homeward Bound consumers attended, 2,189 (86.6%) also attended primary care visits at CMC. Individuals that attended primary care visits attend a median of 6 appointments (IQR = 2 - 12) each. Due to the nature of the data, we were unable to determine what proportion of consumers were existing CMC primary care consumers, and what proportion were new consumers that were enrolled in CMC primary care via the ARC. Regardless, engagement in CMC care via either pathway should be considered important. Amongst Homeward Bound clients who were new CMC consumers engaging in primary care via the ARC, the subsequent increase in billable primary care services represents an important component of the sustainability plan for the ARC. For those Homeward Bound clients who were already receiving primary care services at CMC, given the previous gaps in the SUD continuum of care across San Joaquin County, this may represent a low-barrier pathway addressing an important, previously unmet need amongst many CMC consumers.

Client Retention in the Homeward Bound Initiative

The six-month retention rates of consumers served between August 2018 and October 2022 across different intervention types are presented in Figure 9. Of the 2,029 consumers who received behavioral health services during this period, 716 (35.3%) were still receiving services at least six months later. Of the 729 Homeward Bound clients who initiated MAT services between August 2018 and October 2022, 43.8% were still receiving services six months later. This degree of retention in MAT is comparable to retention rates reported in the literature (Timko et al., 2016), and is important given a longer duration of receiving MAT has been associated with improved outcomes (World Health Organization, 2009).

Figure 9: Six-Month Retention for Behavioral Health, and MAT Treatment

Figure 9.1 BH Six-Month Retention

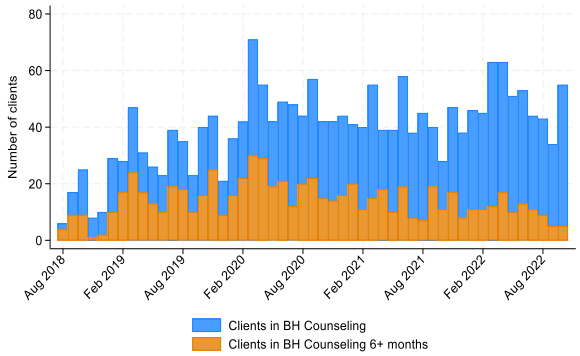
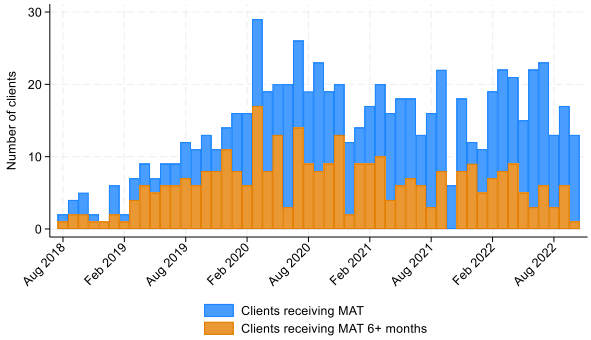


Figure 9.3 MAT Six-Month Retention



Service Delivery and Expansion of Services over Time Summary

Throughout the Homeward Bound Initiative, a substantial increase in the number of unique consumers entering the program each month was evident up until the start of the pandemic at the beginning of 2020. At this point, only a slight decrease in consumers seen was evident, despite the substantial upheaval in healthcare delivery caused by the pandemic. The high degree of engagement with consumers over much of the duration of the project is likely to be attributable to the expansion of service availability, the successful implementation of the 'hub and spoke' model expanding program outreach, and the extensive outreach and engagement efforts implemented by staff at CMC. Notably, the relatively high level of enrollment throughout 2020 suggested the program was able to adapt quickly to the associated challenges of the COVID-19 pandemic. Many other services in the area were shut down during the shelter-in-place mandate, likely increasing engagement in Homeward Bound via some pathways during this period (i.e., the local EDs).

Secondly, the wait times for services across the whole duration of the project were relatively short. These findings indicate that the pathways through care within the Homeward Bound Initiative were efficient and that the program had sufficient capacity to meet the needs of the population referred. Importantly, these transitions into care did not appear to have been substantially impacted by COVID-19, or the subsequent shift to telehealth due to the shelter-in-place mandates.

Overall, engagement in psychological and pharmacological services designed to support clients experiencing behavioral health concerns appeared high. Only 35.3% of consumers continued to receive behavioral health services 6 months later. However, due to limitations in the data, it is unclear if this is attributable to clients terminating treatment prematurely, or successfully graduating from the treatment programs within the assessed period. In addition, 43.8% of

consumers who started MAT remained engaged in treatment for at least 6 months, which compares positively with the literature which has shown a high degree of variability in treatment retention (Timko et al., 2016). This finding suggests that CMC has been relatively successful at identifying and engaging consumers in MAT at the appropriate stage in their recovery. Anecdotally, the extensive array of Homeward Bound services available including case management, housing support, and respite care was also considered to be an important factor in MAT treatment retention (based on anecdotal reports from providers).

Finally, despite notable challenges regarding data collection of case management services, the available data suggests the program was successful at providing critical services related to consumer basic needs, housing assistance, assistance with securing documentation, vocational support, and assistance with transport. Additionally, the respite residential data indicated that the project was successful at implementing the third phase of the project – delivering residential care services for individuals in need of higher levels of care during substance withdrawal.

Sociodemographic Breakdown of Homeward Bound Clients

The sociodemographic details of all individuals that received Homeward Bound services are presented in Table 3. The mean age of the sample was 39.9 years old (SD=13.3). Across race and ethnicity, 40.9% of individuals identified as white non-Hispanic, 20.4% as Hispanic/Latinx, 12.3% as Black and African American, 3.8% identified as Asian, 2.2% as Alaskan Native or Native American, 1.1% identified as Native Hawaiian or other Pacific Islander, and 6.3% as having more than one race. In total, 62.7% of clients identified as male and 37.3% as female. At the point of the assessment, 67.8% reported having a history of criminal justice involvement, and 23.0% identified as homeless.

Table 3: Sociodemographic Details of all Clients Enrolled in the Homeward Bound Program

Variable			
Sex (n, %)			
	Male	1,584	62.7
	Female	944	37.3
	Other	0	0
Age (M, SD)		39.9	13.3
Race/Ethnicity (n, %)			
	White	1035	40.9
	Hispanic/Latinx (all races)	542	20.4
	Black/African American	311	12.3
	Asian	96	3.8
	Native American/Alaskan Native	56	2.2
	Native Hawaiian/Pacific Islander	27	1.1
	More than 1 Race	158	6.3
	Missing/Declined	303	12.0
Reported Criminal Justice History (n, %)			
	Yes	1,713	67.8
	No	815	32.2
Homeless (n, %)			
	Yes*	581	23.0
	No	1685	66.7
	Unknown/missing	262	10.4

Key: ETOH = alcohol; n = number; M = mean; SD = standard deviation

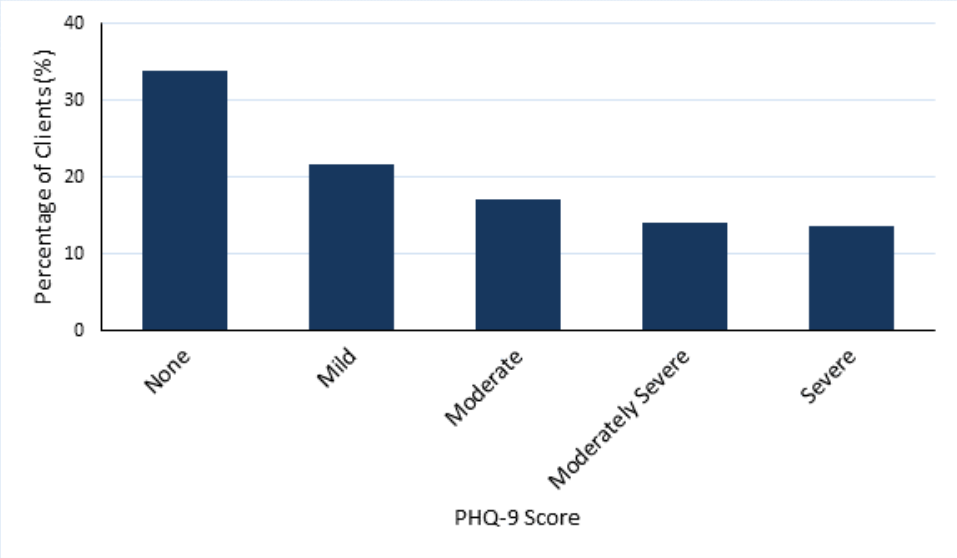
* Includes individuals in shelters, in transitional housing, and those doubling up. Unknown includes response of "other" when not specified.

Clinical Presentation of the Homeward Bound Initiative Sample

Depressive Symptoms

In total, between August 2018 and April 2023, the PHQ-9 was administered 25,029 times to a total of 2,493 Homeward Bound clients, with clients completing the scale a mean of 10.0 times each. At the baseline stage, clients reported a mean depression score of 8.49 (SD=6.83). The proportion of clients that report mild, moderate, moderately severe, or severe levels of depression is presented in Figure 10. In total, 44.7% (1,114 clients) of the sample reported at least moderate levels of depression at baseline, which is considered sufficient to meet DSM criteria for a depressive disorder. These findings highlight the high prevalence of depression in the population treated by the Homeward Bound Initiative, indicating its critical importance as a treatment target.

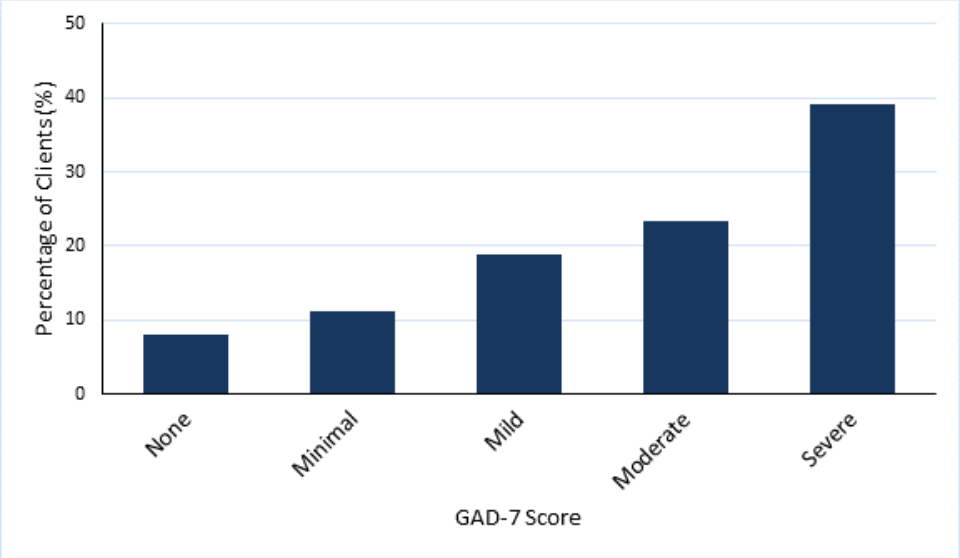
Figure 10: Proportion of Clients with Mild, Moderate, or Severe Depression at the Baseline Assessment Stage



Anxiety Symptoms

At the baseline assessment stage, when clients exhibited suspected symptoms of anxiety, they were asked to complete the GAD-7. The proportion of clients that report mild, moderate, or severe levels of anxiety is presented in Figure 11. This process led to a total of 1126 Homeward Bound clients completing the GAD-7, representing 44.5% of the total sample. Of these, 62.1% (699 clients) reported experiencing at least moderate levels of anxiety, which is considered sufficient to meet DSM criteria for Generalized Anxiety Disorder. This represents 27.7% of the total Homeward Bound sample. Notably, 38.9% of clients completing the GAD-7 reported anxiety symptoms in the severe range. Overall, given the low prevalence of GAD-7 completions, it is difficult to determine the prevalence of anxiety in the Homeward Bound sample. However, amongst those that were assessed, a substantial proportion was found to report prominent anxiety symptoms, and of these many reported such symptoms in the severe range.

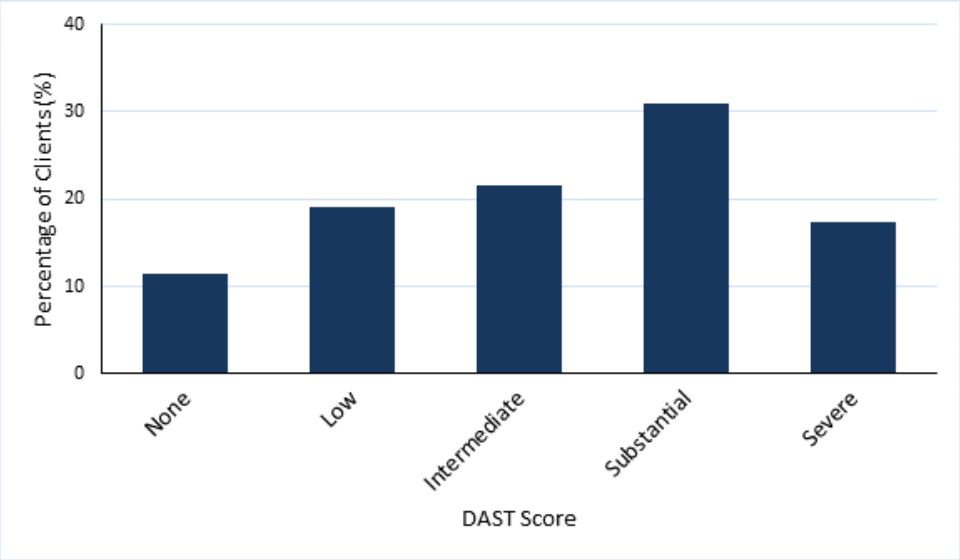
Figure 11: Proportion of Clients with Minimal, Mild, Moderate, or Severe Anxiety at the Baseline Assessment Stage



Degree of Problems Related to Drug Use

Complete DAST data was available for 1,423 clients, who include all individuals suspected of experiencing problems due to their substance use. At the baseline stage, clients reported a mean DAST-20 score of 9.32 (SD=5.83). The proportion of clients that report mild, moderate, or severe levels of depression is presented in Figure 12. In total, 69.6% of clients scored at least 6 on the DAST-20, indicating at least moderate levels of interference in daily functioning caused by substance use. At this level, clients are considered likely to meet DSM criteria for a SUD and meet ASAM placement criteria of Level I or II. Additionally, 30.9% of clients reported substantial interference, likely meeting ASAM criteria II or III, and 17.3% reported severe interference, likely meeting ASAM criteria III. Overall, these figures indicate that a large proportion of Homeward Bound clients experience significant interference in their daily living activities caused by substance use, in many cases rising to a level of substantial impairment.

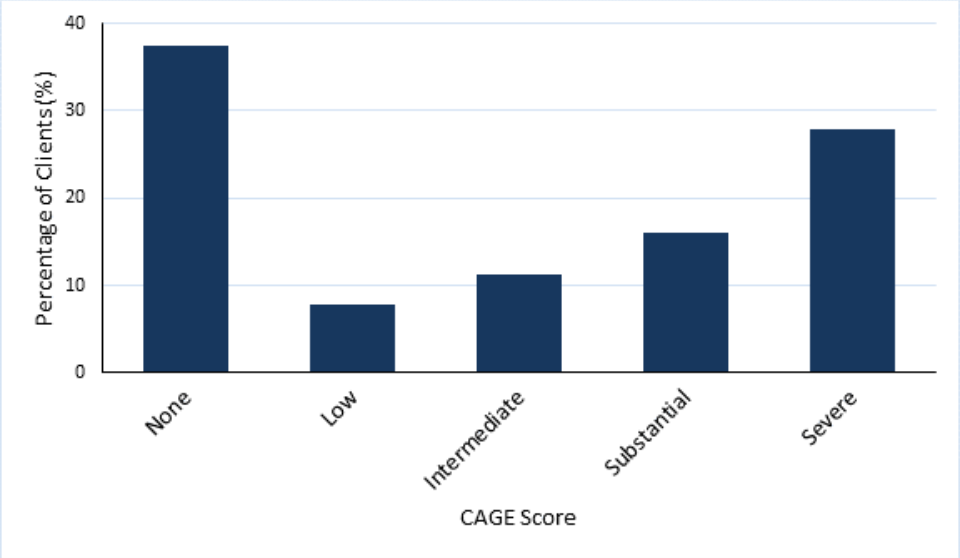
Figure 12: Proportion of Clients Experiencing Low, Intermediate, Substantial, and Severe Interference in Daily Functioning Caused by Drug Use



Degree of Problems Related to Alcohol Use

In total, 1447 clients completed the CAGE at the baseline assessment stage (57.2% of the total sample). Of these, 55.0% reported a score of intermediate or higher, which is a level considered to be clinically significant. The proportion of clients experiencing low, intermediate, substantial, or severe problems due to alcohol use is presented in Figure 13. Notably, a substantial proportion of clients reported the impact in the severe range (27.8%).

Figure 13: Proportion of Clients Experiencing Low, Intermediate, Substantial, and Severe Problems due to Alcohol Use



Summary of the Clinical Presentation of the Homeward Bound Sample

The assessment battery that Homeward Bound clients completed at the baseline stage indicates that many clients are experiencing significant and impairing symptoms of depression and anxiety, as well as significant impairments in daily functioning due to either alcohol or drug use. Alongside the relatively high degree of homelessness indicated in Table 3, these findings highlight the importance of the comprehensive integrated approach to care that the Homeward Bound Initiative delivers, incorporating case management, housing services, mental healthcare, and SUD counseling.

Across the different assessment tools, it is notable that over 98.6% of clients completed at least one PHQ-9 screen, and clients on average each completed 10.0 screens over the duration of their care. Given the availability of the data, allied with the high proportion of clients experiencing symptoms at a level that would be considered sufficient to meet DSM criteria for a depressive disorder (44.7%), tracking depressive symptoms over time was considered to represent one of the most effective ways to evaluate the impact of the Homeward Bound Initiative on outcomes.

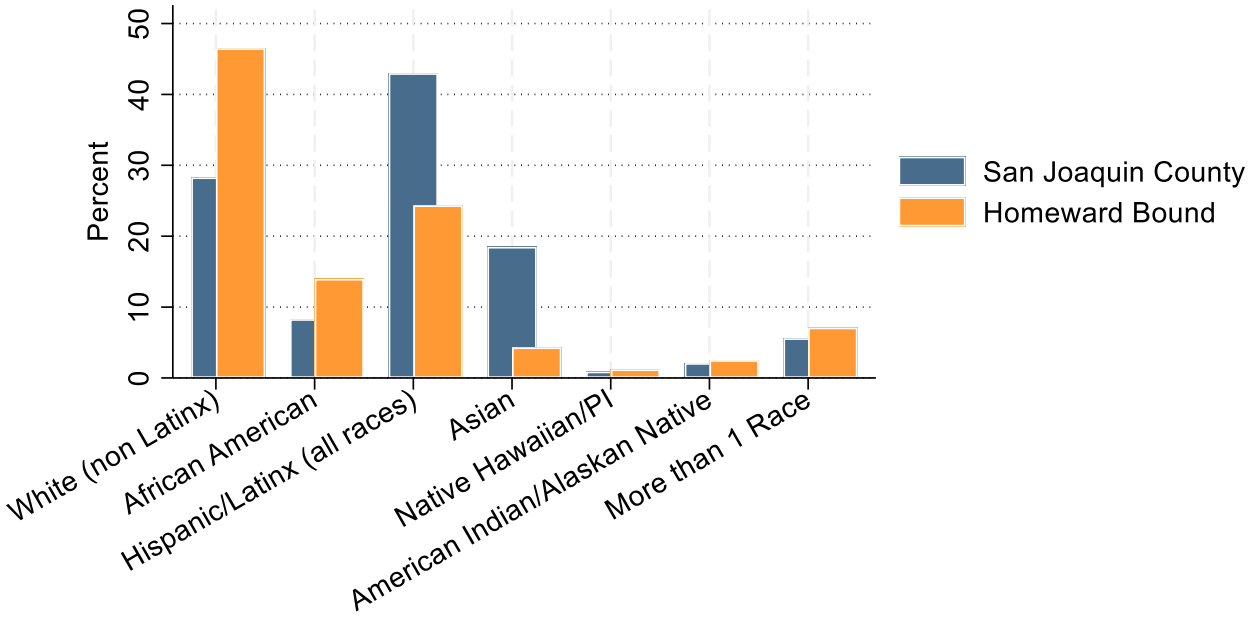
Outcomes Evaluation – Results

Improving Access and Engagement Amongst Historically Underserved Populations

One aim of the Homeward Bound project was to increase access and engagement to community behavioral health services in San Joaquin County amongst historically underserved groups, namely Black and African American and Hispanic/Latinx communities. Figure 14 below compares the racial and ethnic makeup of San Joaquin County, based on US Census data estimates (US Census, 2022), with that of Homeward Bound clients. It is important to note that conclusions based on analysis of race and ethnicity data are challenging as race is a social construct, and given that assessments of race (including how people self-identify versus how race is assigned to people) are ambiguous and imprecise.

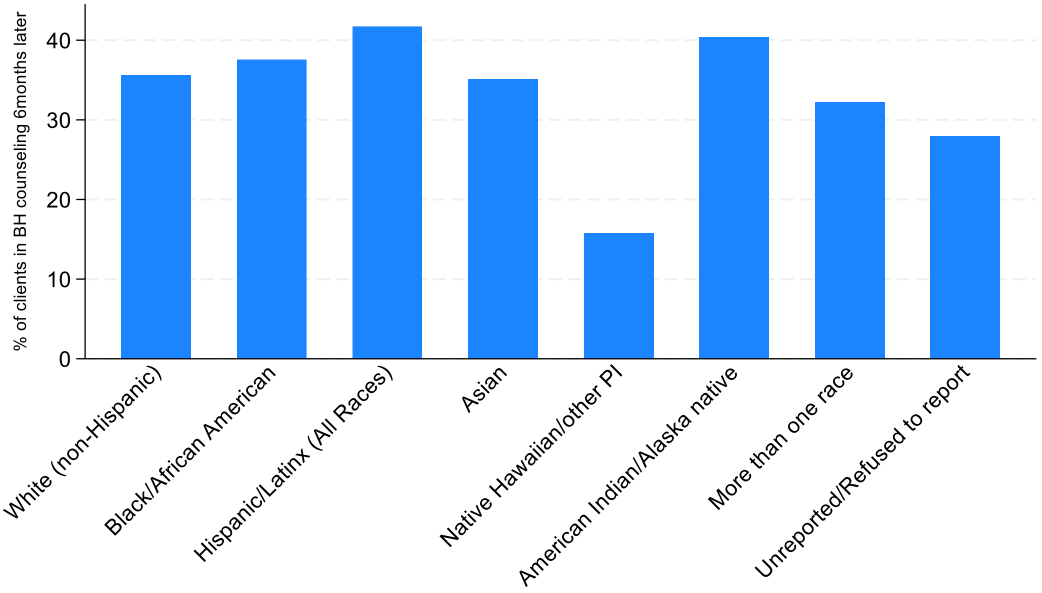
The population of San Joaquin County was 793,229 in 2022 according to the American Community Survey (U.S. Census Bureau, 2022), of which 43% identified as of Hispanic/Latinx ethnicity, 8.3% identified themselves as African American, 28.3% as White (not including Hispanic/Latinx individuals), 18.5% as Asian, 2.1% as American Indian/Alaskan Native, 0.9% Native Hawaiian/other Pacific Islander, and 5.6% identified as being more than one race. As compared to the racial and ethnic breakdown of the census data, after removing missing data, Non-Hispanic Whites were overrepresented in the Homeward Bound treatment sample by 18.2%, and Black and African American individuals were overrepresented by 5.7%. Hispanic/Latinx individuals across all races were found to be under-represented by 18.6%, Asian underrepresented by 14.2%, and individuals from more than one race overrepresented by 1.5%. The Homeward Bound sample of Native Hawaiian/Pacific Islander and American Indian/Alaskan Natives were found to be broadly consistent with San Joaquin County population at approximately 0.3% and 0.4% respectively. Given the lack of data regarding treatment need by racial and ethnic groups within the San Joaquin County region, firm conclusions cannot be drawn from these findings. However, the figures overall suggest that the Initiative has been successful at engaging Black and African American, Native Hawaiian/Pacific Islander, and American Indian/Alaskan Native individuals in community behavioral healthcare, but continues to experience challenges in engaging Hispanic/Latinx and Asian individuals.

Figure 14: Race/Ethnicity of Clients who Engage in Homeward Bound Services, as Compared to County Averages



As described previously, Of the 2,029 consumers who received behavioral health services between August 2018 and October 2022, 716 (35.3%) were still receiving services at least six months later. Figure 15 below depicts treatment retention in behavioral health counseling at the six-month follow-up stage across race and ethnicity. In total, 35.5% of white non-Hispanic consumers, 37.6% of Black and African Americans, 41.7% of Hispanic/Latinx consumers, 35.1% of Asian consumers, and 40.4% of American Indian/Alaskan Native consumers remained in behavioral health counseling six months after starting. While treatment retention amongst Native Hawaiian and Pacific Islanders was substantially lower at 15.8%, due to the very small sample size (n=19) some caution should be exercised when interpreting this finding. Regardless, a significant difference in treatment retention was identified across race and ethnicity (X^2= 17.319, p=.015), likely due to these lower retention rates amongst native Hawaiian/other PI clients. Notably, no difference was detected in retention rates between white non-Hispanic, Black and African American, and Hispanic/Latinx participants (X^2= 4.530, p=.104). Therefore, consistent with original aims of the project, the Homeward Bound initiative as been at least as successful as retaining Black and African American and Hispanic/Latinx consumers in care, relative to white non-Hispanic participants.

Figure 16: Proportion of Clients that remain in Behavioral Health Counseling after Six Months, across Race and Ethnicity



As indicated previously, 32.6% (n=828) of the total population that engaged in Homeward Bound Services between August 2018 and April 2023 went on to receive MAT. This proportion of clients that engage in such care across race and ethnicity is presented in Figure 16. In total, 36.7% of all white non-Hispanic Homeward Bound consumers have initiated MAT, 24.3% of Black and African American consumers, 32.8% of all Hispanic/Latinx consumers, 30.5% of all Asian consumers, 31.8% of all Native Hawaiian/Pacific Islanders, 33.0% of all American Indian/Alaskan Native consumers, and 31.5% of all consumers who identify as being more than one race. The differences in MAT engagement between racial and ethnic groups were found to be significant (X^2= 21.384, p=.006). That Black and African American consumers are significantly less likely to receive MAT is consistent with the literature that has found that Black and African American individuals are significantly less likely to be offered MAT due to structural and provider-level biases (i.e., Hansen et al., 2013).

Figure 16: Proportion of Homeward Bound Consumers who engage in MAT, by Race and Ethnicity

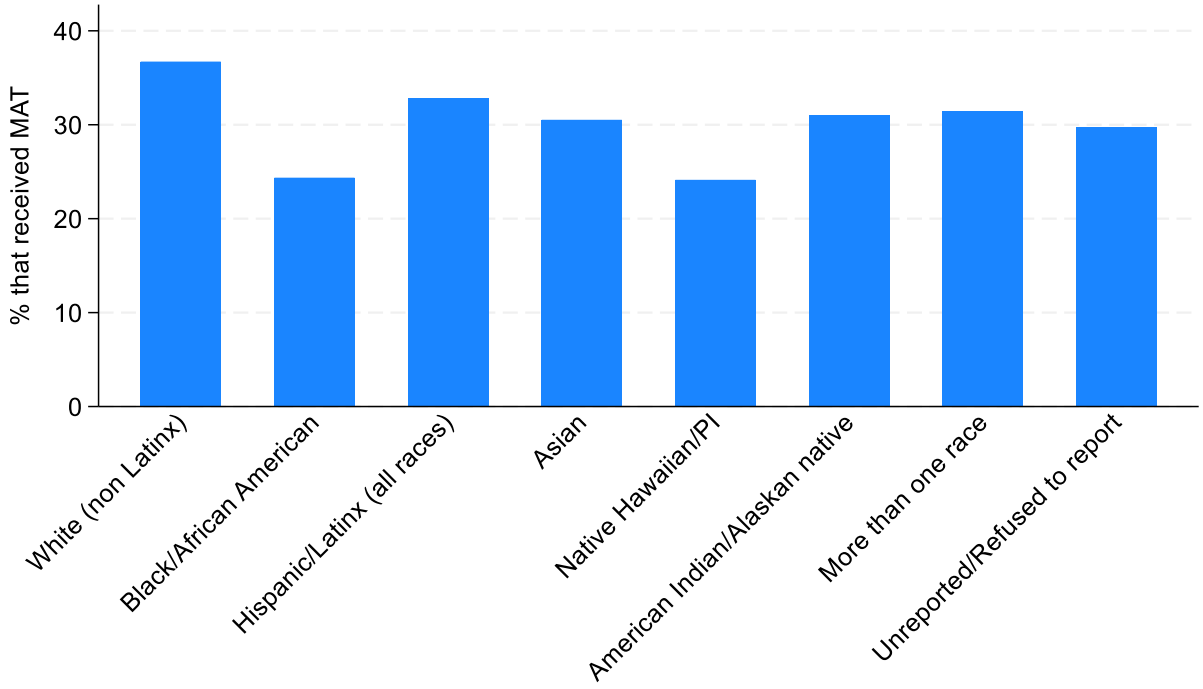
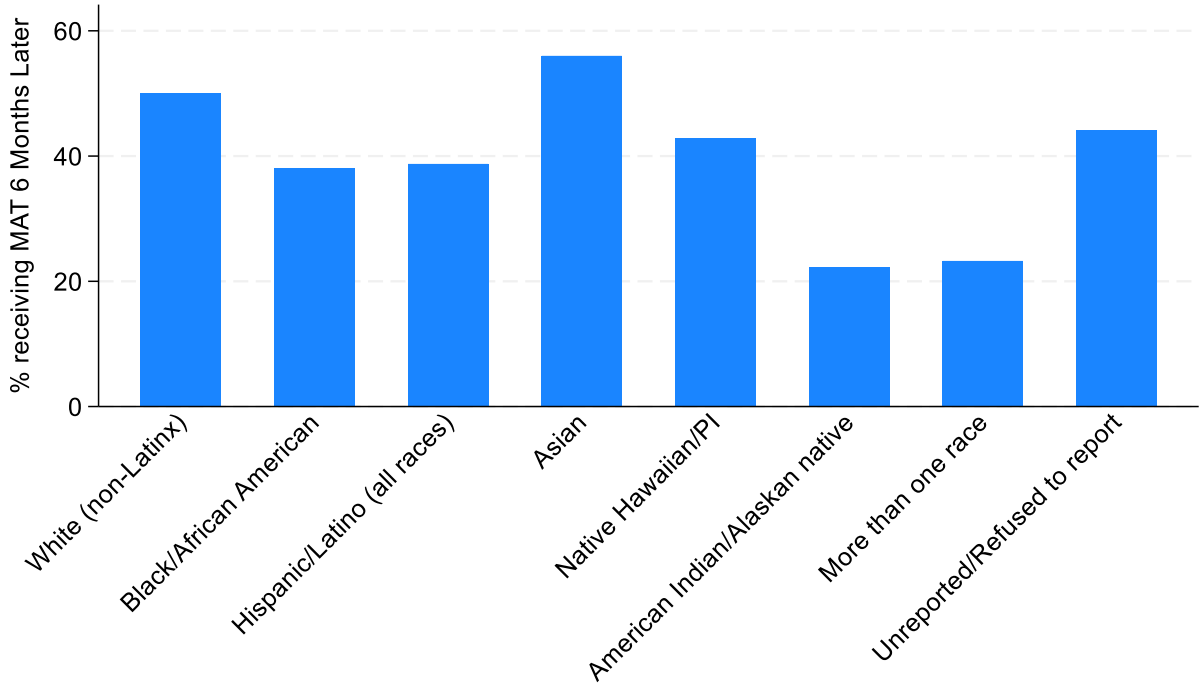


Figure 17 indicates treatment retention in MAT at the six-month follow-up stage across race and ethnicity. In contrast with the retention in behavioral health counseling, significant differences in treatment retention across race and ethnicity were evident (X^2= 20.037, p=.005). While the sample size was small (n=25), it was notable that consumers that identify as Asian were more likely to remain in MAT relative to all other racial and ethnic groups (56%). Additionally, individuals who identify as being more than one race, or American Indian/Alaskan Native, were found to be least likely to continue MAT, with only 23.3% and 22.2% of consumers still receiving the medication six months after treatment initiation.

Figure 17 Proportion of Clients that remain in MAT after Six Months, across Race and Ethnicity



Access and Retention in Community Behavioral Health Treatment across Individuals that Identify as Homeless

In addition to improving access and retention in community behavioral health services amongst Hispanic/Latinx and Black and African American individuals, a key group historically underserved include individuals who identify as homeless. As indicated in Table 3 (p. 33), 23% of the sample identified as homeless. Those that reported being homeless at baseline were equally likely to go on to attend at least one behavioral health counseling session, relative to those who reported being housed (X^2=1.893, P=.169). Homeless clients were slightly less likely to remain in BH counseling after 6 months relative to housed individuals (32.6% relative to 37.0%), a figure that approached significance (X^2=3.055, p=.081). Regarding MAT, 27.8% of homeless Homeward Bound consumers received MAT relative to 36.2% of individuals who were housed, a statistically significant difference (X^2=22.429, p<.001). Between August 2018 and October 2022, 35.7% of homeless consumers that engaged in MAT treatment were still engaged in that treatment 6 months later, relative to 46.3% of consumers who were not homeless at baseline, a difference that approached statistical significance (X^2=5.021, p=.064).

Improving Access and Retention Amongst Historically Underserved Groups Summary

The findings indicate that the Homeward Bound Initiative to date has been successful in engaging Black and African American individuals in community behavioral health services, but there is still progress to be made in engaging individuals from the Hispanic/Latinx community. These findings are consistent with previous annual reports that have shown consistently high levels of engagement amongst individuals that identify as Black and African American, but lower levels of engagement amongst Hispanic/Latinx individuals, in addition to those that identify as Asian. Once clients enter into the Homeward Bound system of care treatment retention in behavioral health counseling appears to be broadly equivalent across most racial and ethnic groups, including those that identify as Hispanic/Latinx and Black and African American. The notable exception to this is Native Hawaiian/Pacific Islander consumers, although this may be a feature of the small sample size (n=19).

While engagement in behavioral health counseling appears broadly consistent across race and ethnicity, greater differences were evident with regard to MAT engagement and treatment retention. Notably, 36.7% of all white non-Hispanic consumers received at least one session of MAT, while only 24.3% of Black and African American and 30.5% of Asian consumers received MAT. This finding is consistent with the literature that has found that Black and African American individuals are significantly less likely to be offered MAT due to structural and provider-level bias and discrimination (i.e., Hansen et al., 2013), and suggests that greater efforts to engage Black and African American consumers in MAT may be warranted. With regards to MAT retention at 6-month follow-up, there is a surprisingly high retention rate in care amongst Asian consumers relative to all other racial and ethnic groups, with 56.0% of Asian consumers still receiving MAT after 6 months. The reasons for this are unclear.

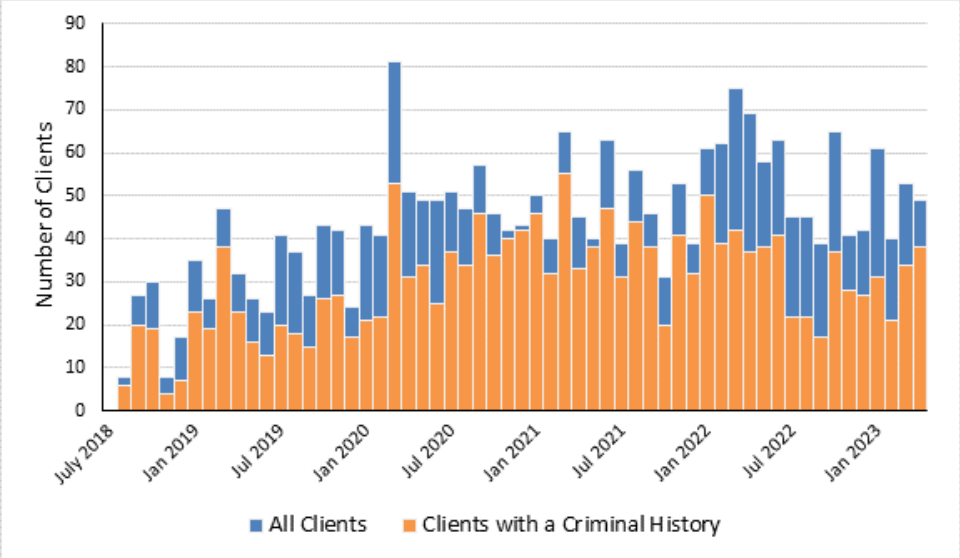
In the 2019 San Joaquin Point-in-Time Survey, 2,629 homeless individuals were identified as living in San Joaquin County, representing 0.3% of the county population. As this is a measure of point prevalence, as opposed to incidence, direct comparisons with the number of homeless individuals engaged in Homeward Bound care cannot be made. However, with 581 clients identifying as homeless (23.0% of the total sample), this suggests the program has been very successful at engaging this chronically underserved, high-need group, although it was notable that homeless individuals were significantly less likely to receive MAT. Once in care, homeless individuals were found to be only marginally less likely to remain in behavioral health counseling and MAT programs at six-month follow-up, despite the substantial additional barriers to care this population may face. The reasons for this are unclear, the relatively high retention levels but may relate to the volume of additional services the Homeward Bound program can provide, including respite care, case management, and housing services. If so, these findings highlighted the importance of providing wrap-around care that programs such as the Homeward Bound Initiative can provide to individuals with significant unmet needs.

Reducing Criminal Justice Convictions

Proportion of Consumers who receive Homeward Bound Services that Report having a Criminal Justice History

One aim of the Homeward Bound Initiative is to reduce incarceration and recidivism amongst San Joaquin County residents who have mild-to-moderate behavioral health concerns and SUD. Of the 2,528 consumers that received Homeward Bound services, between August 2018 and April 2023, 1,713 (67.8%) reported having a criminal justice history. Figure 18 below presents the proportion of new Homeward Bound consumers who reported having a criminal justice history during their intake interview.

Figure 18: Proportion of New Consumers that Report a Criminal Justice History During the Intake Assessment over Time



Exploration of Recidivism Outcomes

To explore recidivism outcomes amongst Homeward Bound consumers, all consumers who reported having a prior conviction and who presented for services between January 2019 and December 2020 were included in a subgroup analysis. This cohort was selected to enable recidivism outcomes to be examined for 24 months post-engagement in the Homeward Bound initiative. However, increased data access restriction to San Joaquin County Superior County records meant data collection related to recidivism outcomes was halted in September 2021. During this period, data was collected for a total of 457 clients. Of these, 12-month reconviction data from the point of treatment initiation was available for all 457 consumers, while 24-month recidivism data was available for 162.

In this analysis, the 12-month reconviction rate was found to be 8.1%. The 24-month reconviction rate was found to be 15.4%. Due to differences in the case mix of individuals and the time between release from prison/placement on supervision and treatment initiation,

direct comparisons with published state figures cannot be drawn. That said, these estimates should still be considered low relative to the 2019 California recidivism rate (California Department of Corrections and Rehabilitation, 2020), and amongst consumers who are released from prison with a SUD (Zgoba et al., 2020).

Reducing Criminal Justice Convictions Summary

In total, 67.8% of the consumers who received Homeward Bound services reported having a criminal justice history prior to the initiation of services. This high proportion indicates the success of the project at engaging individuals with a criminal justice history. Notably, the proportion of consumers served that reported a criminal justice history was found to increase over time and escalated during the COVID-19 pandemic. The reasons for this are unclear but are likely to be attributable to the significant change in the case mix of consumers served during the pandemic, and improved collaboration with local law enforcement during this period as detailed in the qualitative interview summary with the CMC program lead.

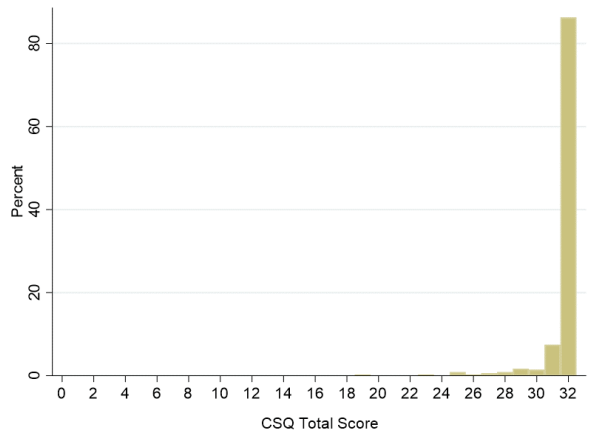
The 12-month and 24-month recidivism rate from the point of initiation of Homeward Bound treatment was found to be 8.1% and 15.4% respectively. These figures are low relative to both statewide recidivism calculations and those published in the literature (California Department of Corrections and Rehabilitation, 2020; Zgoba et al., 2020). However, as detailed in the findings these results come with a series of caveats, limiting the ability to make direct comparisons.

Client Satisfaction with Homeward Bound Services

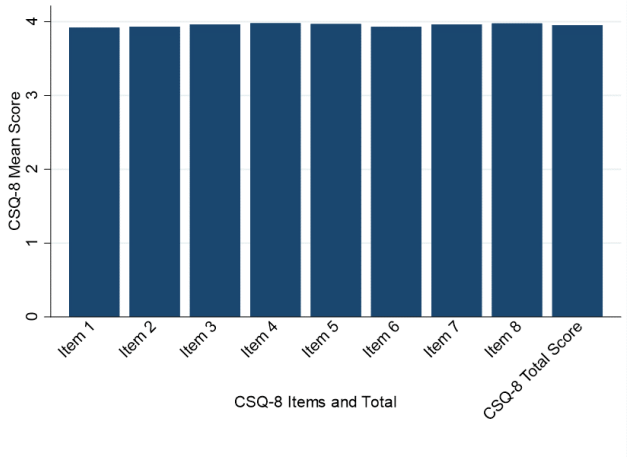
In total, 349 clients fully completed the CSQ-8 between October 2019 and May 2021. The distribution of the total scores is presented in Figure 19.1. Overall, almost all clients who received services reported being highly satisfied with the level of care they received. In total, 86.3% of clients reported the highest level of satisfaction possible (i.e., a score of four out of four on all eight items). Additionally, 99.4% of clients reported a mean score of three or higher, indicating at least moderately high levels of satisfaction with services. Notably, no clients reported a mean satisfaction score below two, which would indicate any degree of dissatisfaction with services. The item-level CSQ-8 scores are presented in Figure 19.2. Across the eight different items, clients reported a mean satisfaction range of 3.93 (SD=.0.30) for Item 6 (“Have the services you received helped you to deal more effectively with your problems?”) to 3.97 (SD=0.32) for Item 3 (“To what extent has our program met your needs?”), indicating very high levels of satisfaction with care across all domains assessed.

Figure 19: Client Reported Satisfaction with Homeward Bound Services

19.1 Breakdown of Total Satisfaction Scores



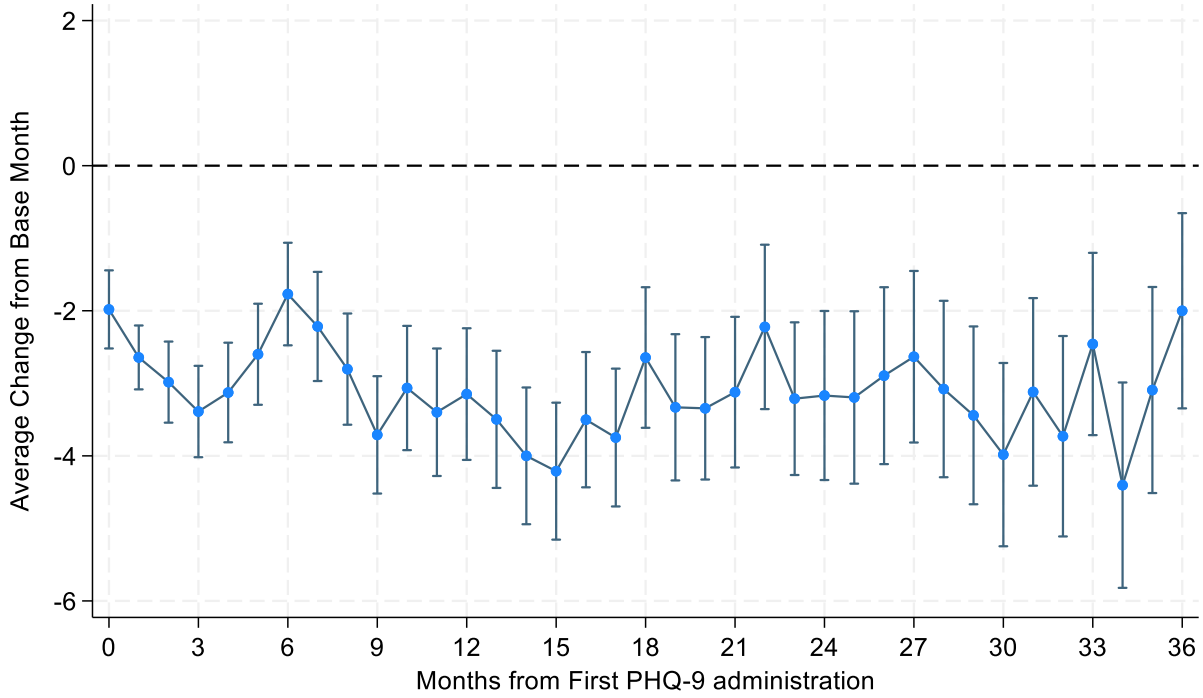
19.2 Item-Level Satisfaction Scores



Changes in Outcomes amongst Homeward Bound Clients over Time

The longitudinal course of depressive symptoms amongst individuals that received Homeward Bound services is presented in Figure 20. After one month of receiving Homeward Bound services, clients consistently reported a mean reduction of between 2 to 4 points in their PHQ-9 scores, relative to their baseline score. Throughout a period of 36 months, these reductions in PHQ-9 scores were found to be statistically different. Given the nature of the data, it is not possible to determine whether these changes are attributable to any possible treatment effect related to Homeward Bound services, external factors, or a regression to the mean. However, from this data, we can conclude that Homeward Bound clients do report experiencing significantly lower levels of depression following engagement in services for at least one month.

Figure 20: Mean Rate of Change of Depressive Symptoms over Time



Revenue Generated and Costs Incurred Through Delivering Homeward Bound Services.

To address Outcome 4.3 "Total revenue generated through the delivery of Homeward Bound behavioral health community services" a review of the total revenue generated, and expenses incurred by delivering Homeward Bound services was conducted. This analysis focused on the period between May 2021 to April 2022 and was limited to activities delivered at the Waterloo Road and Tracy clinical sites. This period was selected given it is the most recent full fiscal year where data were available. This analysis was limited to the Waterloo Road site given this clinic represented the primary hub clinic where most of the services were delivered, and the Tracy clinic was the most active spoke site. While the respite residential services represent a critical part of the Homeward Bound program, this was not incorporated into the current analysis. The respite residential program only opened in October 2021 and gradually expanded service delivery over multiple months. As a result, the available data would not be able to provide an accurate representation of the program at full capacity, and as a result, would only be able to provide limited information regarding the ongoing sustainability of the program.

The revenue and expenses figures are presented in Table 5. Across these two sites, the Homeward Bound initiative generated approximately $626,000 worth of revenue for the financial year of 2021-2022 through service billing. The total services delivered during this period cost approximately $2.1 million. This shortfall was fully covered by grants from the BSCC and the MHSOAC but does indicate a potential shortfall of $1.49 million once the grant funding ends. However, this figure comes with two notable caveats. First, this figure does not include any additional billable primary care and mental health services

that may have been delivered to Homeward Bound clients by CMC as a consequence of engaging with the Homeward Bound system of care. Additionally, this figure does not include revenue generated from the residential respite services, which is anticipated to represent a significant source of funding once fully operational.

Table 5: Homeward Bound Revenue and Expenses Between May 2021 – April 2022.

		Waterloo Road Hub Site	Tracy Spoke Site	Total
Yearly Figures				
	Total Yearly Gross Revenue	$2,320,720	$252,406	$2,573,126
	Total Year Gross Revenue Excluding Grant Funds	$499,535	$126,290	$625,825
	Total Yearly Expenses	$1,857,042	$255,882	$2,112,924
	Total Yearly Net Revenue	$463,678	-$3,476	$460,202
	Total Yearly Net Revenue Excluding Grant Funds	-$1,357,507	-$129,592	-$1,487,099
Monthly Figures				
	Monthly Gross Revenue	$193,393	$21,034	$214,427
	Monthly Gross Revenue Excluding Grant Funds	$41,628	$10,524	$52,152
	Monthly Expenses	$154,754	$21,324	$176,077
	Monthly Net Revenue	$38,640	-$290	$38,350
	Monthly Net Revenue Excluding Grant Funds	-$113,126	-$10,799	-$123,925

Discussion

The Homeward Bound Initiative was designed to improve access and engagement in behavioral healthcare across San Joaquin County, reduce disparities in utilization amongst underserved groups, reduce convictions and recidivism, and improve outcomes, all while delivering services with a high degree of client satisfaction. Across these different aims, the project has achieved some important milestones, despite the notable challenges to implementation that came with the pandemic and the subsequent shelter-in-place mandate.

With regards to increasing access and engagement in behavioral healthcare, 2,528 clients have received Homeward Bound services, including 2,302 receiving some form of behavioral health counseling, 828 receiving MAT, 101 clients receiving respite residential care, and 1,297 clients receiving case management services. Notably, 2,189 Homeward Bound clients also received CMC-delivered physical health primary care services at a median of 6 appointments each, suggesting the Homeward Bound Initiative may be an important facilitator to increased physical health utilization, in addition to behavioral healthcare. Part of this expansion of services comes from the extensive outreach and engagement conducted by Homeward Bound leadership, alongside the successful implementation of the "hub and spoke" model, enabling a greater geographic spread across San Joaquin County.

Consistent with prior annual reports, the Homeward Bound Initiative appears to be successful at engaging individuals in care who identify as either homeless and/or Black and African American. However, the under-representation of Asian and Hispanic/Latinx individuals engaging in services relative to population estimates is still evident. The fact that the under-representation in care amongst these racial and ethnic groups has not significantly changed is perhaps unsurprising, given some of the efforts planned to address these discrepancies (i.e., extensive community outreach and engagement) were seriously curtailed by the pandemic. Once clients enter the Homeward Bound system of care, when compared to other racial and ethnic groups Hispanic/Latinx and Black and African American clients were at least as likely to engage in behavioral health treatment and remain engaged in it at least six months later. Additionally, homeless individuals were found to be at least as likely to engage in behavioral healthcare, relative to those reportedly not homeless. These findings point to the Homeward Bound Initiative being successful at engaging historically underserved groups in behavioral health counseling. However, while these findings were positive, it was notable that Black and African American clients were significantly less likely to receive MAT, which may reflect wider structural and provider-level biases that have been reported in the literature (i.e., Hansen et al., 2013). Additionally, MAT initiation and retention amongst individuals not in secure housing was also found to be significantly lower. These findings suggest that greater efforts to engage individuals from these historically marginalized groups in pharmacological treatments may be necessary to address this area of healthcare inequity.

A high proportion of the total sample served reported having a criminal history (67.9%), highlighting the success of the program at engaging this target population. Additionally, the conviction and recidivism rates amongst Homeward Bound clients appeared relatively low. However, without control group data it is not possible to determine what the impact of Homeward Bound services on these metrics may be.

One notable finding is the remarkably high degree of client satisfaction that clients report regarding the care they have received from Homeward Bound services. Over two-thirds of clients reported the highest level of satisfaction possible on the CSQ-8, and 99.42% reported a mean score of 3 or higher, indicating at least moderately high levels of satisfaction with services. While these findings are encouraging, it is important to note that they come with one significant caveat. During the study period when the CSQ-8 was available, only 14.8% of all clients completed the scale and as a result, it is unclear if these satisfaction values are representative of the whole sample. For example, it is unclear if a substantial proportion of the missing clients were missed due to random error, or if individuals who were less satisfied with care may have refused to complete the scale or dropped out leading to fewer opportunities to complete the questionnaire. However, it is also possible clients who are less satisfied with services may be more likely to complete the questionnaire as a mechanism by which to be able to communicate their dissatisfaction with care. Regardless, the findings indicate that amongst those asked satisfaction with Homeward Bound services is incredibly high and serves to highlight the high regard clients appear to have for the services provided by CMC as part of the Homeward Bound initiative.

With regards to the final project aim – an exploration of the impact of Homeward Bound services on outcomes – the longitudinal course of depressive symptoms amongst those enrolled in care was explored. Due to the absence of a control group, the lack of data amongst those who do not continue to receive services, and the likelihood of regression to the mean, one should be highly cautious when interpreting the data. However, following engagement in Homeward Bound clients reported a mean drop in PHQ-9 scores of between three and four points over their duration in the initiative. Notably, a 1-point change in an assessment using Clinical Global Impression – Severity scale (CGI-S) has been found to equate to a 3-point change in the PHQ-9 in patients with treatment-resistant depression (Turkoz et al., 2020). Therefore, this suggests that the reduction in PHQ-9 scores detected over time in this evaluation could be considered to be clinically meaningful.

Conclusion

Throughout the implementation of the Homeward Bound Initiative, there have been some notable successes despite operating against the backdrop of the pandemic. There has been a significant expansion of mental health services for residents across San Joaquin County, addressing an area that was previously identified as a substantial gap in the available continuum of care. While Asian and Hispanic/Latinx residents continue to be underserved,

engagement in care amongst Black and African American and homeless residents was high. Furthermore, once these historically underserved individuals engage in care, retention is relatively high. It is difficult to determine the impact of Homeward Bound services on conviction and recidivism outcomes, however, these rates amongst clients appear low relative to figures typically published in the literature. Over time, clients report significant and clinically meaningful reductions in depressive symptoms. Finally, amongst those who responded, Homeward Bound clients report a very high level of satisfaction with the services that they have received. Overall, the findings of this evaluation point to the conclusion that the Homeward Bound Initiative has made a substantial, positive contribution to supporting the behavioral health and wellness needs of San Joaquin County residents that have historically been either unserved or underserved.

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San Joaquin Behavioral Health Services
Progressive Housing Initiative

Final Report
December 2022

Executive Summary

Background

The Progressive Housing Initiative is an innovative, shared-housing approach to addressing homelessness, drawing from Housing First principles. The program has been delivered through a collaboration between Stockton Self-Help Housing (SSHH) and San Joaquin County Behavioral Health Services (SJCBHS). Progressive Housing adopts a low barrier-to-entry model; abstinence from substances is not a requirement to receive housing. By utilizing such an approach, the primary aim of the Progressive Housing Initiative is to provide stable housing to individuals at high-risk or experiencing homelessness who experience serious mental illness (SMI). Once housed, guests/residents are offered a range of recovery-oriented behavioral health services, tailored to their readiness to engage in such care. To support recovery, as guests/residents engage in services, they progress through the system and are moved into homes with other guests/residents at a similar stage in their own recovery, until the point of graduation where they are ready to transition into private housing. Overall, the initiative aims to provide services to highly vulnerable unserved or underserved individuals in the San Joaquin County area and help to address the urgent unmet needs of those experiencing homelessness in Stockton and the surrounding areas.

Major Findings

The project has expanded to include 16 homes (with two more in preparation), which is at the top end of the original project target of 12-18 homes to be available by the end of the project. Recruitment has been well above original projections, which is likely to be attributable to the rapid expansion of the program, the successful referral pathway into the system, and the higher-than-expected guest/resident turnover. However, COVID-19 and the subsequent shelter-in-place mandate has had a significant impact on service delivery, leading to reduced housing capacity, greater restrictions around entry and exits from homes, and significant disruption to behavioral health treatment availability. This includes therapy groups, skills training classes, and home visits either being halted, substantially reduced, or shifted to remote delivery. These challenges are likely to have contributed to the high guest/resident dropout rate and impacted guest/resident recovery trajectories.

More positively, the demographic profile of the guests/residents served appears highly representative of the homeless population of San Joaquin County, indicating the program has been successful at engaging historically underserved groups. Additionally, many of the clients reported experiencing chronic homelessness over multiple episodes, complex mental health and substance use disorder needs, and high levels of functional impairment spanning multiple domains, indicating the project is successfully engaging individuals the program was originally

designed to serve. Client satisfaction with care explored both qualitatively and quantitatively was found to be high, despite the impact of COVID-19 on care delivery. Finally, while there is limited data available to draw strong conclusions, there is some evidence to suggest that engagement in the Progressive Housing initiative leads to less severe impairments related to the guests'/residents' living situation and housing instability, and potentially less severe impairment related to substance use.

Relative to other housing projects completed in San Joaquin County, Progressive Housing initiative homes were made available to guests/residents at a much faster rate and a lower initial cost, although ongoing costs may be higher. Therefore, some version of the Progressive Housing initiative may represent a model to help address some of the large unmet needs amongst homeless individuals with mental health concerns across San Joaquin County over a shorter time.

Conclusions

The Progressive Housing project, delivered as part of a collaboration between SSHH and SJCBHS has been successful at implementing a housing program for individuals following Housing First principles. The project has successfully engaged individuals historically underserved in community behavioral health settings, consumers report feeling highly satisfied with the care they received, and there is tentative evidence to suggest the program may lead to improvements in key outcomes. Additionally, the Progressive Housing model is capable of delivering homes at a lower initial cost and over a quicker timeframe than other approaches previously adopted by San Joaquin County. Future work is necessary to conclusively determine how effective the model is at improving recovery outcomes amongst those served, and how to most effectively deliver appropriate behavioral health services to individuals with SMI in a shared home environment during a pandemic.

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Project Description

San Joaquin County is experiencing an extreme housing shortage, contributing to high rates of homelessness. The 2022 Point-in-Time survey found 2,319 homeless individuals residing in San Joaquin County, and of those, 1,355 of those individuals were unsheltered (San Joaquin Continuum of Care, 2022). Additionally, 33% of the unsheltered population in San Joaquin County self-reported having a mental health issue and 33% reported substance use. This is problematic, given that many existing programs available in San Joaquin County adopt a high barrier-to-entry model, meaning individuals are required to be sober before obtaining housing, and can face eviction for relapsing. These zero-tolerance policies for drug and alcohol use can make finding and maintaining housing a difficult task for individuals with co-occurring mental health and substance use disorders (SUD). In recognition of this, in the 2022 Point in Time survey it was noted that "profound physical and mental health challenges, and struggles with substance use" were identified as significant individual barriers to obtaining stable housing (San Joaquin Continuum of Care, 2022. p.4)

In response to the growing need for affordable, low-barrier housing for individuals with serious mental illness (SMI) who may also have SUD, San Joaquin County Behavioral Health Services (SJCBHS) developed the Progressive Housing Innovation project. This new housing service is being delivered in a partnership between SJCBHS and Stockton Self-Help Housing (SSHH). SSHH is a subsidiary of Sacramento Self-Help Housing that assists persons who are homeless or at risk of becoming homeless to find and retain stable and affordable housing, and operates in the Stockton, San Joaquin County area.

The Progressive Housing Initiative is an adaptation of the Housing First model. Housing First is a validated clinical and housing intervention that focuses on non-contingent permanent housing, autonomy, and community-based support (Tsemberis, 2012; Stefancic & Tsemberis, 2007). This model does not require abstinence upon entry, considering that drug rehabilitation should be a part of an individual's treatment rather than a precursor to other interventions (Pearson, et al., 2009; Stefancic & Tsemberis, 2007; Tsemberis, Gulcur, Nakae, 2004).

Literature on how to implement Housing First programs is scarce. Nelson and colleagues (2014) noted that having partnerships with government agencies, landlord associations, and different services was pivotal to implementing a Housing First program in Canada. However, they still faced barriers with a lack of available, affordable housing. This is an issue particularly acute in California with some of the highest housing prices in the US, and with rental vacancy rates well below the US average (United States Census Bureau, 2022). The Progressive Housing Initiative intends to address this significant issue by adapting the traditional single-occupancy Housing First model and implementing it in single-family homes where multiple individuals can be housed together.

Housing First approaches have robust evidence supporting their effectiveness at securing long-term housing (Brown, et al., 2017; Aubry, et al., 2016; Stefancic & Tsemberis, 2007), however, there are mixed results on their effectiveness in recovery from SUD (Groton, 2013; Padgett et al., 2011; Gulcur, et al., 2003). The Progressive Housing Initiative intends to remedy the mixed results in recovery by implementing a hierarchical structure of housing levels based on guests'/residents' recovery status. Guests/Residents enrolled in program services will be placed in a group house that corresponds with their recovery level. Each house is staffed by a resident house manager, called the "House Leader," who has lived experience of recovery. The program is designed to stabilize a person's living situation, while also providing supportive services on-site within a shared housing environment.

In the original model, clients initially completed a housing assessment with SJCBHS and if they were deemed eligible, they were invited to participate as a guest in a Level 1 Progressive Housing home. While at this stage they complete the assessment process, determine eligibility, and decide if they are ready to participate in treatment. At this stage, guests undergo a clinical psychosocial assessment to determine diagnosis, develop care plans, and initiate referrals to appropriate treatment for approximately 90 days. Additionally, they receive frequent site visits by an outreach worker to encourage participation in the program. At the end of this 90-day period, if the guest is found not to meet criteria for a moderate to severe mental illness, they are connected to a SSHH case manager and linked to alternative services. If the guest meets criteria and is willing to engage in the program, they are transferred to a Level 2 home, with a higher level of independence and expectations. In the Level 2 homes, guests are expected to take their own medications, perform household chores, attend house meetings, and create/abide by house rules. A SJCBHS clinician attends house meetings once a month to listen to any emerging issues and help the house leader brainstorm response strategies. At this level, guests are assigned a housing case manager to help them create a pathway to permanent housing. SJCBHS also provides weekly home visits by a clinician to conduct medication support services, run treatment groups, conduct outreach, and provide transportation to various other support centers. At Level 3, clients enter a lease, and are re-categorized as residents. Residents contribute a portion of their income to monthly household expenses and are expected to develop a plan to obtain permanent housing. At this stage, SJCBHS provides weekly home visits from recovery coaches, facilitates independent living skills classes, and provides transportation to other centers. Finally, at Level 4, the residents live in independent housing without a house leader. The residents' goals at this stage are to maintain housing for over a year, attend 90% of routine scheduled appointments, be medication adherent, and have 0-1 crisis visits per year. The guest/resident characteristics, housing services offered, and the range of treatments available at each level of the Progressive Housing Initiative are presented in Table 1.

Table 1: Chart of Progressive Housing Program Services

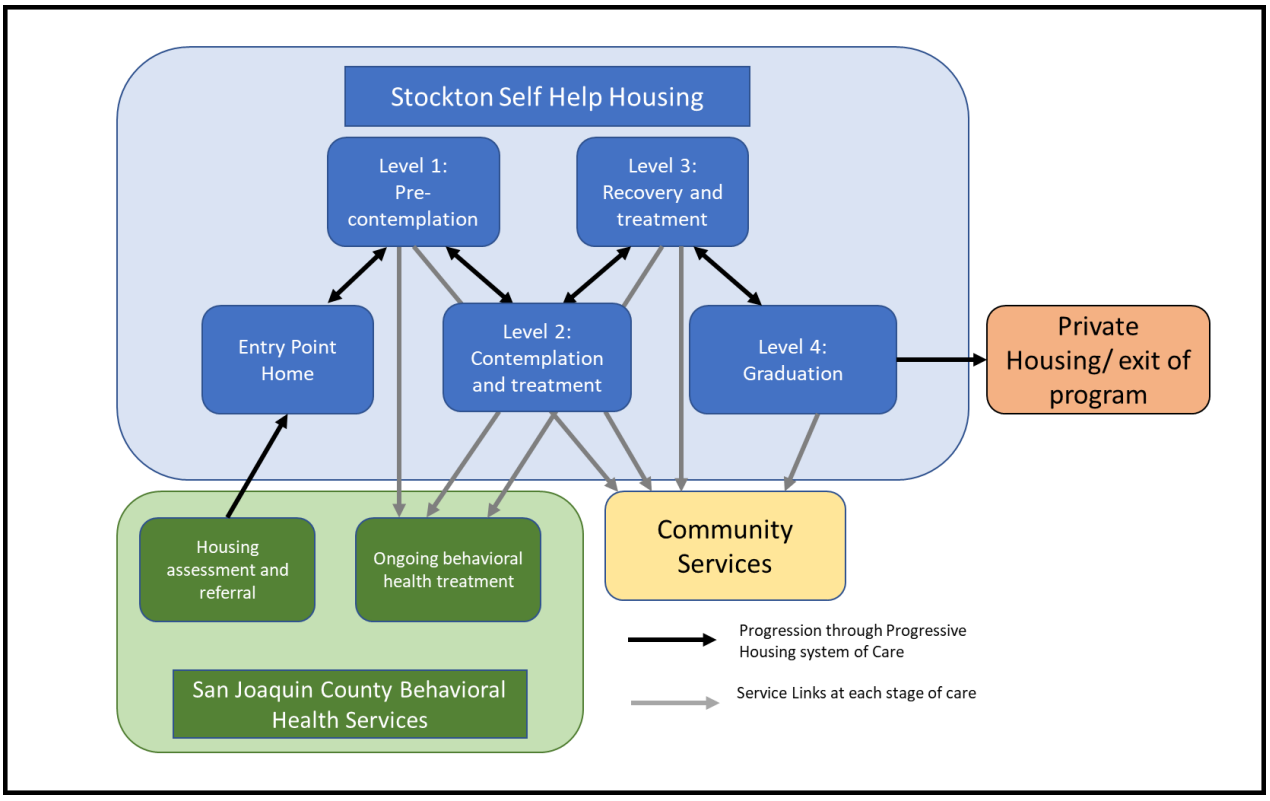
	Guest/Resident Characteristics	Housing Services	Treatment Services
Level 1: ***Precontemplation*** Pre/Post Assessment Process	The guest is suspected of having a mental health concern, and has been referred by a health navigator, outreach worker, or service provider for assessment	Guests are provided with a place to stay as a guest while they complete the assessment process and determine if they are ready to participate in treatment interventions Residents are assigned a housing case manager to help them create a pathway to permanent housing plan	Regular engagement by outreach workers to encourage program participation. A clinical psychosocial assessment is made to determine diagnosis, initial case plan, and referrals to treatment
Level 2: ***Contemplation and Treatment*** Engagement and Linkage to Routine Mental Health Services	guests have been assessed as having SMI and have been referred for treatment interventions guests may be moved from one type of house to another depending on progress, and resident needs guests enroll in Medi-Cal and begin the application process for Supplemental Security Income (SSI) guests will have a goal of exiting level 2 within 12-18 months	guests are placed in a shared housing environment, staffed by a house leader guests are expected to take their own medications, perform household chores, attend house meetings, and create/abide by house rules SJCBHS Clinician will attend a house meeting monthly to listen to any emerging issues and help house leader brainstorm responses strategies, as needed	SJCBHS will provide weekly home visits to conduct clinical assessments and provide linkage to community, substance abuse or mental health services. Assist clients with problem solving with house leaders and other residents. Problem solve issues in collaboration with SSHH SJCBHS will provide home visits 2-3 times/week by Mental Health Specialists and outreach workers to meet individually with Residents SJCBHS will provide transportation services for household members to behavioral health services on

			regular days and times at least 2 times/week SJCBHS staff will conduct regular home visits to meet individually with Residents and/or conduct treatment groups
Level 3: ***Recovery and Treatment*** Stabilization and Recovery Support Services	The client enters a lease and is redefined as a resident resident is stabilized and participating successfully in routine mental health treatment services resident is utilizing extant community resources and has more independent living skills	residents elect to participate in a shared housing environment, with a portion of income contributing to monthly household expenses residents have a plan to obtain permanent housing and are working to establish the appropriate documentation for housing vouchers and rental applications	SJCBHS will provide transportation services for household members to Wellness Center, BHS, and the Gibson Center* transportation is provided as needed, but at Level 3, clients are encouraged to provide their own transportation SJCBHS will refer Residents to Independent Living Skills classes in preparation for graduation to independent living
Level 4: ***Graduation*** Independent, permanent housing	resident is stable in routine treatment services resident assumes responsibility for paying a portion of the rent through SSI resident obtains resident rights and responsibilities	resident obtains independent housing Goals: House is no longer supported by a house leader resident pays rent from SSI or other income. resident maintains residence for at least 1 year	resident is stable in treatment Goals: resident attends 90% of routine scheduled appointments, is adherent to medication and treatment resident has no more than one crisis visit in a year

*drop-in socialization center providing health and wellness classes, online zoom classes, consumer empowerment groups, job readiness and vocational services, and local transportation services to SJCBHS

Since the implementation of the original model, a series of modifications have taken place to better meeting the needs of the clients, and to ensure the program could be implemented safely during the pandemic. The current Progressive Housing model is presented in Figure 1.

Figure 1. Current Conceptual Model of Current Progressive Housing Services



One of the most significant modifications to the model included the addition of entry point homes, which serve as a brief assessment home prior to clients entering the program at Level 1. This component of the model was added in January 2021 during the shelter-in-place mandate, where there were concerns that new people coming into the homes could potentially lead to the spread of COVID-19. Additionally, this component served to address the concerns of some clients that were identified in the qualitative study. During the interviews, multiple guests detailed the challenge of new people who needed a higher level of care coming into the homes and causing a notable level of disruption to the other guests. During a resident's stay in the entry home all individuals received an orientation to the PH model, review expectations and protocols, receive new clothes and hygiene resources, and are screened for COVID-19. After this 10-day period, residents were then transferred to a Level 1 home as previously executed.

Towards the end of the project, the challenge of recruiting, training, and retaining House Leaders was becoming increasingly apparent. In recognition of this, the Progressive Housing initiative expanded the support services available to House Leaders, and initiated Leadership Group Training for guests/residents from Level 2 onwards who were considering the possibility of transitioning to a House Leader role. This was considered important to increase employment opportunities to guests/tenants and help improve a potential pathway from guest/resident to House Leader as described in the initial proposal.

The third notable modification of the Progressive Housing model included the expansion of behavioral health services available to Level 1 and 2 guests. During the pandemic, services were substantially reduced, and this was considered to have a detrimental impact on retention and recovery outcomes. To address this, additional treatment services were made available at Level 1, and at Level 2 clients were now required to engage in some form of behavioral intervention as a condition of housing services. Options included attending vocational programs, independent living skills courses, substance use disorder treatment, and/or other behavioral health treatments. What program the client enrolls in is at their discretion, with the focus on trying to meet their own recovery-oriented goal. Notably, while substance use treatment was an option, in keeping with the Housing First model this was not a mandated requirement for those with a substance use disorder issue.

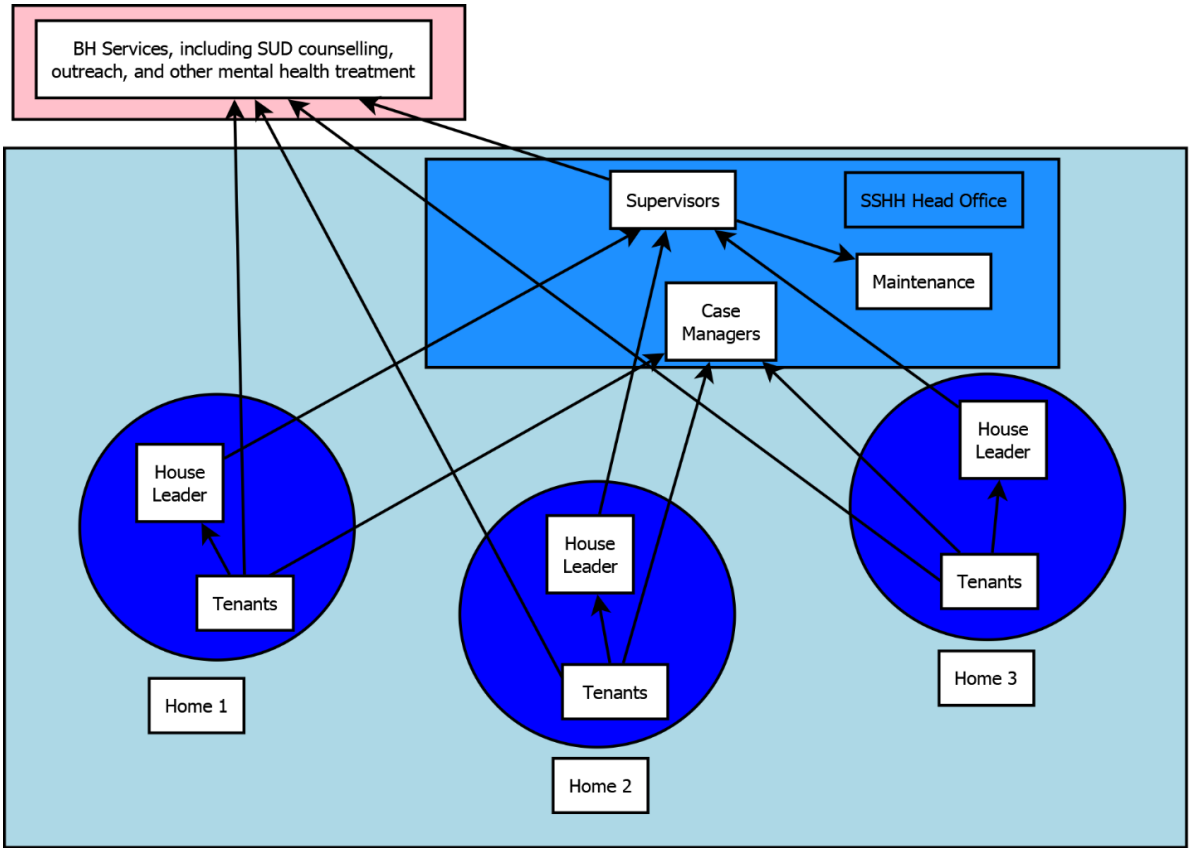
Summary of the Progressive Housing Model of Care

The Progressive Housing modifications to the Housing First model aimed to improve recovery outcomes by focusing one's status in the program on their recovery goals and providing more manageable sub-goals to reach over time. Additionally, the proposed modifications address some of the inherent challenges in implementing Housing First programs. For example, one major challenge of implementing the Housing First model is the limited access to privately owned apartment complexes to integrate homeless individuals into, and the willingness of other community members to share the complex with these programs (Stefancic & Tsemberis, 2007). The Progressive Housing Initiative provides single-family homes for guests/residents to live in that accomplish Housing First's goal of integrating guests/residents into the community. This therefore may represent a viable alternative model in more suburban areas where appropriate housing complexes may be scarcer. However, the Progressive Housing model also presents additional implementation challenges that currently remained unanswered. For example, the acceptability, opportunities, and challenges of delivering a Housing First model in a shared home with house leaders and other guests/residents all experiencing complex needs are unknown, as are the experiences of guests/residents as they navigate different levels within the system. These challenges and opportunities were explored throughout this evaluation and are detailed in this report.

Progressive Housing Organizational Structure

The Progressive Housing program has been delivered through a collaboration between SSHH and SJCBHS. The organizational structure of the initiative is presented in Figure 2. Under this model, all housing is provided within single-family homes. Pre-pandemic, each home was designed to house approximately 6 guests/residents and one House Leader. However, during the COVID-19 pandemic, in some cases this was reduced by one space to accommodate isolation rooms in case of any of the guests/residents contracted COVID. Within each of the homes, the House Leaders are responsible for enforcing house rules and submitting daily reports of any events in the homes to their supervisors, who are based at SSHH head office. Outside of the implementation of basic house rules, each client has access to a SSHH case manager to provide additional support. Finally, depending upon what stage in their recovery the guest/resident is at, they are eligible to access various behavioral health services either delivered or arranged by SJCBHS, including SUD counseling, skills training, and other behavioral health treatments, as detailed in Table 1.

Figure 2: Organizational Structure of the Progressive Housing Initiative



Blue areas: Components implemented by Stockton Self Help Housing (SSHH).
Pink areas: Components implemented by San Joaquin County Behavioral Health Services (SJCBHS).

Project Aims and Objectives

The Progressive Housing Innovation Project is anticipated to have two major outcomes: 1) increased access to mental health services amongst unserved and underserved populations, and 2) improved recovery outcomes for program residents.

The aims and objectives for the project are based on the original Mental Health Services Oversight and Accountability Commission (MHSOAC) innovation proposal. These include:

Project Aim 1. Improve outcomes related to housing retention, engagement in treatment, and functional outcomes.

- Increase access to housing and housing retention for homeless and housing-insecure individuals that experience co-occurring mental illnesses and SUD.
- Increase engagement in behavioral health services for individuals who experience co-occurring housing insecurity and/or homelessness and ongoing behavioral health concerns.
- Increase functional and recovery outcomes for individuals who experience co-occurring housing insecurity and/or homelessness and ongoing behavioral health concerns.

Project Aim 2. Determine costs associated with implementing housing for individuals with severe mental illnesses and substance use disorders.

- Determine the costs associated with opening Progressive Housing homes
- Deliver Progressive Housing homes at a lower cost to alternative housing solutions for equivalent populations.

Project Aim 3. Deliver housing over a shorter timescale than other housing solutions for individuals with equivalent needs.

- Determine the mean startup time of Progressive Housing homes from site identification to opening.
- Deliver Progressive Housing homes over a shorter timescale than alternative housing solutions for equivalent populations.

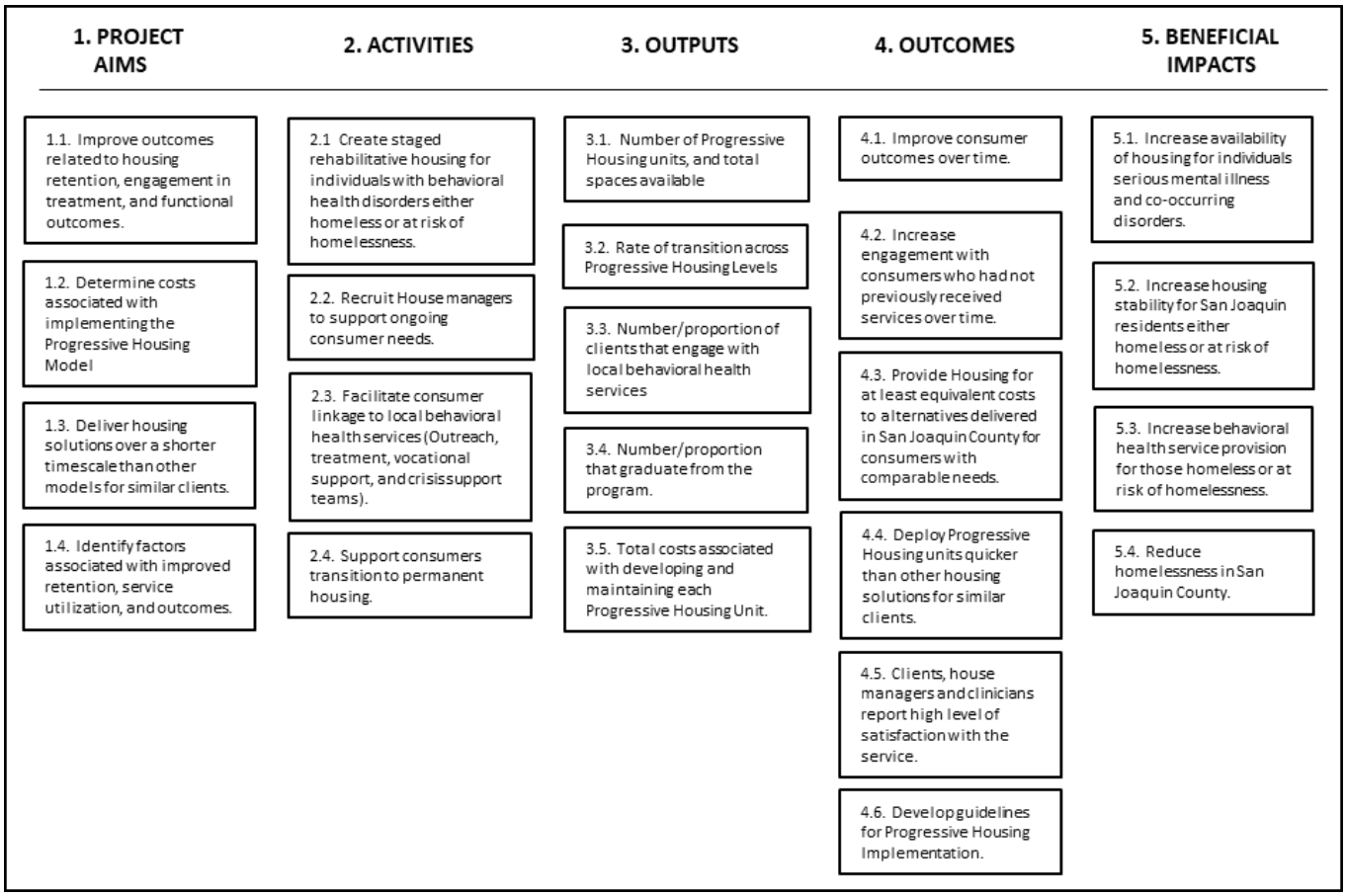
Project Aim 4. Identify factors associated with improved retention, service utilization, and outcomes.

- Identify barriers and facilitators to successful project implementation
- Explore guest/resident, house leader, and provider experiences of delivering and receiving care as part of the Progressive Housing Initiative
- Explore consumer-level factors associated with improved outcomes.

Logic Model

Prior to the initiation the evaluation, a logic model was developed, as presented in Figure 3. The logic model details the main project aims as specified in the original MHSOAC application, the activities that will be conducted to address those aims, a series of outputs that quantify the delivery of the proposed activities, and the measured outcomes of conducting these activities. Beneficial impacts detail some of the broader system-level changes that the project – if successful – could result in over time. This report provides an in-depth description of the activities, outputs, and outcomes of the project.

Figure 3: Logic Model of the Progressive Housing Initiative



Methods

Target Population for Progressive Housing Services

The target population for the Progressive Housing Initiative includes adults (18 years and older) who have SMI and who are experiencing housing insecurity in San Joaquin County. Notably, actively using substances was not considered an exclusion criterion for program eligibility, contrary to many housing programs in the area. SJCBHS has identified the target population for services as the following:

- Underserved Individuals: Identified consumers with moderate-to-severe mental health concerns who do not have a stable place to live or cannot maintain successfully in available housing options due to recovery challenges (e.g., emotional dysregulation, substance use disorders). As a result, these individuals are typically poorly served and at grave risk of becoming chronically homeless.

- Unserved Individuals: Homeless individuals with moderate-to-severe mental health concerns who remain undiagnosed or are not successfully engaged by SJCBHS. Accurate statistics on the proportion of homeless individuals with SMI in San Joaquin County are unavailable. However, an estimated 33% of the homeless individuals in San Joaquin County report experiencing some form of mental health concern in the most recent Point-in-Time Count (San Joaquin Continuum of Care, 2022).

For this study, SMI typically included at least one of the following diagnoses:

i. Psychotic disorder
ii. Major depressive disorder
iii. Bipolar disorder
iv. Paranoid personality disorder
v. Borderline personality disorder
vi. Co-occurring disorders (mental illness and substance abuse or mental illness and a developmental disability)
vii. Other diagnoses or criteria established in the future by SJCBHS as allowed by the MHSA and following the priorities identified in the SJCBHS annual update

In addition, homelessness and housing insecurity was typically defined as the following:

1. Homelessness – an individual or eligible household that:

    i. Lacks fixed, regular, and adequate nighttime residence,

ii. Has a nighttime residence that is a publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for people with mental illnesses),
iii. Has a nighttime residence that is an institution that provides a temporary residence for individuals intended to be hospitalized,
iv. Has a nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

2. People identified as at high-risk for homelessness typically met one of the following criteria:

i. Is a transition-age youth exiting the child welfare or juvenile justice systems,
ii. Is an individual discharged from an institutional setting, which includes hospitals and acute psychiatric hospitals/health facilities,
iii. Is an individual being discharged from a skilled nursing facility with a certified special treatment program (STP) for people with mental illnesses,
iv. Is an individual currently residing in a crisis and transitional residential setting,
v. Is an individual being released from County jail,
vi. Is an individual temporarily living in a Board and Care facility following discharge from one of the institutional settings cited above, or
vii. Meets the local standard designated by the San Joaquin County Mental Health Director, which has been established as being an individual or eligible household who is enrolled in a San Joaquin County MHSA full-service program (FSP) and is at imminent risk for homelessness. Imminent risk is defined as individuals or families becoming homeless within 14 days and verified by the San Joaquin County MHSA Housing Program.

In the evaluation of the Progressive Housing Initiative, all guests/residents who have received services under this program from July 2018 to October 2022 were included in the analysis, unless otherwise stated.

Program Evaluation Design

To conduct the full evaluation of the Progressive Housing initiative multiple research methods were utilized. A summary of each is presented below.

Evaluating the implementation of Progressive Housing as it relates to Housing First principles

The Housing First Fidelity Assessment Scale

To assess the structure of the Progressive Housing system of care as it relates to Housing First principles (Stefancic & Tsemberis, 2007), midway through the project the SSHH program director responsible for the implementation of the project completed a Housing First fidelity self-assessment survey. The tool used was an adapted version of the Housing First Fidelity Scale (Gilmer et al., 2013). In this adapted version, 16 items are presented in a two-factor model: one covering the program's approach to housing, separation of housing and services, and service philosophy, and the other related to service array and team structure. Items include questions such as “What is the program’s approach to substance use among clients?” and “How often do program staff meet to plan and review services for clients?” The scale is presented in Appendix I.

Exploring the Impact of COVID-19 on Progressive Housing Implementation Procedures

To explore the impact of COVID-19 on Progressive Housing implementation and outcomes, Progressive Housing senior management at both SSHH and SJCBHS were interviewed utilizing a longitudinal qualitative interview approach. The first interviews took place on June 5, 2020. The purpose of these interviews was to understand the initial impacts of COVID-19 and the subsequent shelter-in-place mandates. The second round of interviews took place April 27-30, 2021. For these, the aim was to understand some of the longer-term impacts on Progressive Housing procedures, and possible impacts on outcomes. For each study, an unstructured qualitative interview was conducted. For this deliverable, a narrative summary of each interview is presented.

Qualitative Interview Data Collection Procedures

Qualitative semi-structured interviews with Progressive Housing guests/residents and House Leaders were conducted to explore participant satisfaction with services and explore possible barriers and facilitators to effective implementation of the program.

Participants

Participants included current and previous guests/residents and House Leaders. All participants were recruited via a voluntary response sampling method. The inclusion criteria for

participation included: 1) fluency in English at a level sufficient to complete the interview, and 2) confirmation by SJCBHS or SSHH staff members of their status as a current or former guest/resident or House Leader.

To be eligible to receive Progressive Housing Services as a guest/resident, the individual must have previously experienced housing insecurity, have a severe mental illness diagnosis, and reside in San Joaquin County. This assessment of eligibility was completed by providers at SJCBHS.

House Leaders are individuals employed by SSHH who live in the shared housing units and report directly to the Housing Operations Specialist. Their primary responsibilities include monitoring the houses and reporting safety concerns, submitting written reports of participant house rule violations, and submitting maintenance requests to the Housing Operations Specialist. House Leaders are typically employees with lived experiences of homelessness and behavioral health conditions who are further along in their recovery.

Development of the Interview Guide

Prior to recruitment, two semi-structured interview guides were created: one for guests/residents and one for House Leaders (see Appendix II*)*. The interview guides were developed by the research team, and were reviewed by SJCBHS and SSHH staff, including a House Leader with lived experience of homelessness. Questions covered in the guides focused on the participant's experiences of receiving Progressive Housing services, their past housing experiences, and their perspective on different components of the housing model (i.e., house leader roles, progression through levels, etc.).

Study Recruitment and Implementation

Guest/Resident participants were recruited through a multi-step process. With the permission of the individual house leaders, a flyer providing study details was attached to each home's notice board*.* This flyer included the telephone contact details of the study coordinator to receive more information about the study. In addition, SJCBHS providers already involved in the potential participants' care provided individuals with a study flyer and asked if they would be interested in speaking to a member of the research team to hear more about the study. House Leaders were informed about the study via their SSHH program manager.

Following an expression of interest from the potential participant, one of three scenarios occurred, at the discretion of each potential participant: 1) the potential participant was given the contact details of the study coordinator who they contacted for more information about the study; 2) the potential participant gave the provider permission to pass on their contact details to the study coordinator who then contacted the potential participant to provide more information; or 3) the SJCBHS or SSHH provider arranged a time with the potential participant

to meet a member of the research team when they were due to be on location either at SSHH head office or the SJCBHS clinical site.

Upon the agreement of the potential participant, a meeting was scheduled with a member of the evaluation team on SJCBHS or SSHH premises. Participants that were interviewed at SJCBHS checked in with the front desk staff upon arrival and were introduced to research staff. Research staff then led participants to a private office space where the interviews were conducted. House Leader participants that were interviewed at SSHH arrived before or after their staff meeting to participate in interviews. For all interviews, the researcher went through the full consent process before conducting the interview. Each interview took approximately 60 minutes. All interviews were audio-recorded. Upon completion of each interview, the audio recording was submitted to Rev.com for transcription. Prior to analysis, any identifying information was removed from the transcripts.

In an iterative process, the two interviewers regularly met to discuss the completed interviews, refine the interview guides based on the emergence of possible preliminary categories, and then conduct additional interviews utilizing the amended guides. This process was repeated until saturation of the main topic areas was reached.

Qualitative Analysis Plan

In the analysis of the qualitative transcripts, a conventional approach to content analysis was adopted (Hsieh and Shannon, 2005). Conventional content analysis is a method of describing a phenomenon (i.e., experiences of guests/residents living within the Progressive Housing system of care), which is commonly adopted when existing knowledge about the phenomenon is limited. These analyses were conducted utilizing the qualitative software NVivo 12 (QSR International, 1999).

The analysis of the transcripts was completed by three individuals, one supervisor and two coders. The supervisor is a researcher with a PhD in Social Psychiatry, with expertise in utilizing qualitative methods to evaluate the implementation of novel approaches in community behavioral health services. One coder is a researcher with a MA in psychological sciences, whose research has focused on utilizing qualitative methods to study interventions for homelessness and mental health issues. The other coder is a researcher with a BA in psychology, whose research has focused on the implementation of evidence-based interventions for SMI from community providers and prodromal interventions for psychosis.

The coding supervisor and one of the coders conducted the interviews, and regularly met to discuss preliminary categories during the interview period, giving them an initial familiarization with the data. After the interviews were transcribed, the supervisor and coder read through a sample of transcripts and identified potential codes. The supervisor and coder then met to discuss initial codes and develop a preliminary coding framework. Next, the full coding team

coded 10% of the same transcripts to refine the preliminary coding framework, and to ensure the coding framework could be consistently applied across the different coders. Once this consistency was achieved, the two coders each completed half of the remaining transcripts. Each week, the coding team met together to review their analysis, discuss anomalies, and further refine the framework. This process was completed until all the transcripts had been coded and reviewed. In the last three meetings, there were no further amendments to the coding framework, indicating that saturation of the main categories had been reached. Once all the transcripts had been coded, the team met to review the coding framework and combine the codes into overarching categories.

In the quotes detailed in this deliverable, some were amended by the authors to anonymize responses, remove crosstalk, and elucidate pronouns. In these instances, the edits were denoted through the use of square brackets ("[ ]").

Comparison Between Progressive Housing and Alternative Approaches Procedures

To examine deployment times and cost comparisons of the Progressive Housing initiative relative to similar projects completed in the region, data regarding the timeline of deployment for each Progressive Housing unit was collected throughout the implementation of the program. In addition, the costs associated with the deployment of each unit were collected from project financial records. These data were compared to deployment times and costs detailed in published reports of other local housing projects supported by SJCBHS since 2008, 10 years before the approval of the Progressive Housing project in 2018. These local projects were identified through a review of reports published by SJCBHS detailing any housing program they were associated with, and through review with senior SJCBHS leadership.

House- and Guest/Resident-Level Survey Data Collection Procedures

The quantitative survey data collected both by SSHH and SJCBHS represented the bulk of the Progressive Housing evaluation dataset.

The data collected by SSHH included both housing-level and guest/resident-level data. With regards to the housing-level data, the SSHH Program Manager collected information regarding the identification, leasing, capacity, and opening date of each home, enabling the evaluation team to track the expansion of the program over time. SSHH-held guest/resident-level data were collected via the Homeless Management Information System (HMIS) intake assessment. At the point of intake into the Progressive Housing program, each potential guest/resident completed an assessment with a SSHH staff member. During this assessment, the full HMIS

assessment is completed. Upon completion of the intake assessment, a SSHH case manager uses the assessment form to enter data into a Progressive Housing Evaluation data collection sheet. These data include demographic information, details about past episodes of homelessness, prior service utilization, government assistance, health needs, and vocational information.

The data sourced by SJCBHS providers was collected at the intake stage, each time the guest/resident moved homes, annually from the point of intake, and at discharge. All data collected at the program intake stage was collected via the Progressive Housing program data collection tool (See Appendix III). This tool was used to collect basic demographic information, prior service utilization, clinical diagnosis, information around benefits and documentation, an assessment of guest/resident needs and strength using the Adult Needs and Strengths Assessment (ANSA), and guest/resident satisfaction with services using the Client Satisfaction Questionnaire (CSQ-8). Once the assessment was completed, these data were added to the SJCBHS Progressive Housing Data Log. Next, longitudinal data including subsequent changes in benefits/documentation, annual ANSA assessments, and CSQ-8 scores, in addition to any changes in housing status across the duration of the program are then added to the log by SJCBHS staff as more data was collected.

In order to link the two datasets, providers at SSHH assigned guests/residents a unique ID number following completion of the intake assessment, which was then communicated to their SJCBHS partners. This number was then added to the appropriate case within the SJCBHS Progressive Housing Data Log. These datasets were periodically sent to the evaluation team, who could link cases through the shared unique ID.

Measures

The Adult Needs and Strengths Assessment (ANSA)

The Adult Needs and Strengths Assessment (ANSA; Lyons, 2013) is an assessment tool designed to support clinical decision-making and monitor outcomes in behavioral health. The ANSA is validated for use in SUD populations (Allen and Olson, 2015). Across four core domains (life functioning, strengths, behavioral health needs, and risk behaviors), providers rate various dimensions based on a 4-point scale, with a higher score indicating greater severity of need. For this project, senior leadership at SJCBHS determined that nine items of the ANSA in particular represented domains most relevant to the Progressive Housing intervention. The nine domains include impairments related to the guest's/resident's residential stability, their living situation, substance use, social functioning, self-care, sleep, transport needs related to care, physical health, and criminal behavior. These nine domains were captured at both the intake assessment, and then annually, until the point of discharge from the program. At each time point, a trained SJCBHS clinician conducted the assessment.

One limitation of the tool as an outcome measure relates to the fact that a score of '1' can relate to both a current and historical need, limiting the ability of the tool to capture change

over time. To address this, in the current evaluation, all guest/resident responses were dichotomized to indicate whether at the point of assessment the individual does or does not present with at least a moderate degree of need, as indicated by a score of '2' or higher.

Client Satisfaction Questionnaire (CSQ-8)

The Client Satisfaction Questionnaire-8 (CSQ-8; Larsen et al., 1979) is an 8-item Likert questionnaire where responders rate each item from 1-4, with a higher score representing greater satisfaction with treatment. Items include questions such as "Have the services you received helped you to deal more effectively with your problems?" and "How would you rate the quality of service you have received?" The full scale is presented in Appendix IV. The CSQ-8 has been extensively used in various healthcare settings and has been validated for use in SUD populations (Wilde and Henriks, 2005).

Longitudinal Survey Analysis Plan

To explore service expansion and recruitment, the first part of the analysis utilized program-level data collected by SSHH that detailed the date the lease of each home was signed, and the date each home was opened for guests/residents. Simple summary statistics were used to explore the expansion of services over time, and the rate of expansion. The total number of clients served to date, along with the rate of recruitment over time was explored using summary statistics utilizing guest/resident-level data collected by SSHH.

To explore guest/resident characteristics, a detailed summary was conducted using quantitative data collected by SSHH at the baseline assessment stage. The areas of interest included guest/resident sociodemographic information, prior housing status and behavioral health service utilization, baseline sources of income, clinical presentation, educational and vocational health needs, and physical and behavioral health needs. Sociodemographic information was compared to the sociodemographic data of the sheltered and unsheltered homeless population of San Joaquin County, as detailed in the 2019 Point-In-Time survey (San Joaquin County Continuum of Care, 2019). This survey was selected given it represented the closest mid-point of program implementation.

An evaluation of program retention and transition through the program levels was conducted using the longitudinal survey data collected by SJCBHS. Summary statistics were used to calculate the proportion of clients that either progressed or regressed across the different housing levels, and the mean number of moves that guests/residents experience during their time in the Progressive Housing Initiative.

Changes in functional impairment were evaluated utilizing the ANSA baseline and follow-up assessment scores, conducted by SJCBHS staff. At each time point, the proportion of clients that scored above and below a score of '2 - moderate impairment' for each item was examined. Pre-post comparisons were conducted utilizing the McNemar test.

To evaluate the impact of Progressive Housing on vocational and educational outcomes, the proportion of clients that returned to either work or school/college was reported over each timepoint. Finally, to explore client satisfaction with services, item-level and CSQ-total mean scores were examined both at the baseline stage, and at one-year follow-up.

All quantitative analysis was conducted utilizing either STATA 14 (StataCorp, 2015), or SPSS version 28 (IBM Corp, 2021).

Results

Structure of Progressive Housing as it relates to Housing First Principles

The Progressive Housing Initiative is a novel intervention based on the principles of the Housing First approach (Tsemberis, 2012). The overlap between the two is important because Housing First is a validated intervention for individuals with co-occurring SMI and SUD. To determine the extent to which the Progressive Housing Initiative adheres to Housing First principles, a Housing First Fidelity Survey (Gilmer et al., 2013) was completed by the Progressive Housing Program Director on June 3, 2021.

The Housing First Fidelity Survey originally encompasses 46 items across five domains: housing process and structure, separation of housing and services, service philosophy, service array, and team structure. In the current study, a reduced, 16-item version of the tool was used, comprising two factors.

Factor one encompasses three domains: housing process and structure, separation of housing and services, and service philosophy. The Progressive Housing model deviated from the Housing First model most noticeably under housing process and structure. In Housing First, under ideal conditions participants reside in individual, affordable, permanent, scattered-site housing, where participants take up around 15% of a standard apartment complex (Gilmer, et al., 2013). In the Progressive Housing Initiative, guests/residents are housed in single-occupancy homes with a group of other guests/residents and a house leader in each home. They do align, however, in the fact that both the Progressive Housing Initiative and Housing First house individuals in standard residential spaces, as opposed to supported housing environments.

Both the Housing First and the Progressive Housing models are low barrier, meaning participants do not have to achieve abstinence, symptom stability, or medication adherence to enter the program. Instead, they need to meet the responsibility of a standard lease. Services and housing are separate in both models. However, in Progressive Housing, as guests/residents progress through the there is a requirement to engage in at least some form of treatment. Importantly however, such treatment is directly by guests/resident priorities, and does not include a requirement to receive substance use disorder treatment.

The service philosophy between the Progressive Housing Initiative and the Housing First model is similar, with a few notable differences. In both models, clients with SMI are not required to take medication, and participants with SUD are not required to participate in substance use treatment. In addition, clients provide input around what additional external services they would like to receive. The key differences are, in the Progressive Housing Initiative, guests/residents do not have input on their housing services, such as what their house level is in the progression of the program, the location of their housing, and which residents live with them in the home. Moreover, while abstinence from alcohol and/or drugs is not required off

premises, it is required in the homes to mitigate the impact of substance use on other guests/residents. Housing First clients are not required to abstain from alcohol and or drugs in or out of their residence and their housing services are less changeable (i.e., no levels, no housemates).

Factor two encompasses two domains, service array and team structure. Housing First programs offer a myriad of services, including SUD treatment, employment, educational, volunteer, general medical, and social integration services (Gilmer et al., 2013). The Progressive Housing program partners with SJCBHS to offer SUD treatment, employment, educational, and volunteer services. The Progressive Housing provision of services was significantly impacted from COVID-19, with most services halted for several months. However, as the impact of the pandemic has subsided, many of these services has since returned.

Both Housing First and Progressive Housing models have frequent, regular, staff meetings in which teams meet for multiple functions. The Progressive Housing model specifically uses team meetings to review guest/resident goals, discuss the need for proactive contact to prevent future crises, and review previous staff assignments and follow through.

Structure of Progressive Housing as it Relates to Housing First Principles Summary

The Progressive Housing model aligns with most of the validated interventions and program structures of Housing First. The most notable difference is the shift from single-resident occupancy in apartment complexes to group occupancy in single family homes. This shift also impacts the model's ability to allow substance use indoors, as it would impact other members of the program. This initiative could prove to be an expansion of Housing First to be more inclusive to suburban and rural areas that may have fewer appropriate apartment complexes available.

Impact of COVID-19 on the Implementation of the Progressive Housing Initiative

The most significant factor affecting the progress of the Progressive Housing Innovation Project has been the COVID-19 pandemic and the resulting shelter-in-place order that began in March 2020. The evaluation team has conducted multiple interviews with leadership at SJCBHS and SSHH to assess the impact the pandemic has had, both in terms of implementation and evaluation. To record the initial impact of COVID-19, the first set of interviews took place on June 5, 2020. To document the longer-term impact of COVID-19, a second round of structured interviews took place on April 27, 2021 (with the SSHH lead) and April 30, 2021 (with the SJCBHS lead), over a year after the initial shelter-in-place order began.

The Effect of COVID-19 on the SJCBHS Delivery of Services to Progressive Housing Guests/Residents

SJCBHS described three layers of services that were originally available to Progressive Housing guests/residents (see Figure 4). The first layer includes the SJCBHS Housing Services team that provides treatment (i.e., therapy groups, case management, etc.) directly in the Progressive Housing homes. The second layer is the wider SJCBHS team that provides more generalized behavioral healthcare services. Finally, the third layer is community resources such as Alcoholics Anonymous (AA), and organizations that provide services such as skills training and vocational support.

Figure 4: Levels of Care for Individuals in the Progressive Housing Initiative

In the initial stages of the shelter-in-place order, all services across three levels were halted. This period lasted roughly from March 2020 until June 2020. In June 2020, in-house services (layer 1) resumed through telehealth, using tablets provided by SSHH. Additionally, residents had the option to resume their regular behavioral health services appointment via telehealth (layer 2), but most opted out due to lack of privacy in the homes. The service team struggled to keep in contact with residents who did not have a personal cell phone. The Progressive Housing landlines are located either in the house leader's bedroom or in the common area, impeding the residents' ability to make and receive private calls. Therefore, from June 2020 to August 2020, most residents had only minimal contact with service providers.

In August 2020, more services returned. SJCBHS resumed going into the field once a week, the Independent Living Skills (ILS) program resumed services using telehealth on SSHH provided tablets, and multiple community services (layer 3) re-opened using telehealth. At this time, group interventions remained unavailable as leadership was still problem-solving ways to maintain confidentiality in telehealth group settings.

In October 2020, SJCBHS resumed face-to-face contact with residents, enabling case management, individualized treatment, linkage, transportation, and broader support. Significantly, due to social distancing requirements, group treatments were still not available to residents. Additionally, house leader meetings ended in October 2020 due to clinical staff turnover, given they had no one to facilitate the meetings.

Overall, for a significant proportion of the project period the Progressive Housing program was significantly impacted by issues attributable to the COVID-19 pandemic. SJCBHS leadership have indicated this could feasibly have led to higher dropout rates, substance relapse, decompensation, staff turnover, and hospitalization rates from the onset of the shelter-in-place order. Additionally, there was minimal movement between the levels to minimize possible resident exposure to COVID-19. Additional barriers to level advancement included loss of employment opportunities with limited options for new jobs, the inability to obtain documents (e.g., birth certificate, social security card) due to lack of transportation and online access, and therefore the inability to apply for SSI. Without an income, residents were unable to advance to Level 3. To mitigate some of these challenges SJCBHS changed its approach to handling rule violations during this time to a more tiered approach since residents had less support. For instance, in scenarios where a resident would previously had be evicted, staff has been reaching out and working with residents to acknowledge the issue and form an agreement with SSHH.

The Effect of COVID-19 on SSHH Delivery of Services to Progressive Housing Guests/Residents

From the onset of the stay-at-home order in early March 2020 through September 2020, there was very little movement of residents between homes to limit the spread of COVID-19. Operation staff were no longer permitted in homes, and houses were required to repurpose one of the bedrooms as an isolation room for any resident who was experiencing COVID-19 symptoms, or who left the house for greater than 24 hours. This change resulted in a significant reduction in the overall capacity of the program. In June 2020, a Level 3 house opened for Level 2 graduates, and in October of 2020, movement between the houses began to normalize. In January 2021, entry homes were implemented for residents to isolate for 10 days before they join the program.

SSHH focused its efforts on keeping the homes safe, resourceful, and entertaining to promote residents staying inside. In November 2020, they bought tablets for residents to resume services with SJCBHS and have access to resources. Tablets were originally delivered before

services and then picked up at the end of each service, but that became laborious for staff. House leaders became responsible for tablets to ensure their safekeeping. They also provided every home with a television, games, and books.

Around the holiday season, residents and house leaders were not permitted to see their families, to maintain quarantine regulations. Instead, they were gifted food rewards (i.e., meal delivery services, etc.), and new furniture in the homes to show SSHH's appreciation and to make residents and house leaders comfortable. Eventually, they loosened the no-visitation rules and required isolation upon return. Notably, even with these extra expenses, the budget was not drastically altered. The only factor that exceeded the budget noticeably was the utility bills.

During this period, new residents reported experiencing more severe mental health symptoms relative to prior months. The cause was unknown, but one factor could be the pandemic contributing to mental stress and the need for housing in populations that otherwise would not have sought help. This increase in guest/resident symptom severity led the SSHH team to reevaluate their screening methods. Ultimately, SSHH wants to promote housing first, but also need to take into consideration the individual's fit in the program and their potential impact on other residents' recovery.

During the pandemic, staff had noted an increase in drug use in the houses, which was attributed to the boredom from having to stay inside, and less opportunities to use substances away from the homes. Additionally, individuals who were in earlier stages of their recovery were found to be dropping out at a higher rate during the pandemic. Staff noted that individuals in active addiction had a harder time staying in the homes. Access to treatment and resources that individuals could use as coping mechanisms had been shut down, making it increasingly difficult to sit at home with minimal distraction.

Overall, SSHH was able to successfully house residents as intended, so the pandemic did not alter their ability to provide the proposed service substantially. However, the pandemic had a dramatic impact on the Progressive Housing Initiative's plan at large, limiting services and coping mechanisms, and adding unprecedented stress.

Impact of COVID-19 on Progressive Housing Implementation and Outcomes Summary

Based on the perspectives of both SSHH and SJCBHS leadership, the substantial upheaval to the implementation of the Progressive Housing Initiative is likely to have caused major disruptions to proposed processes and outcomes. This includes an increased dropout rate, a lower rate of engagement in services, a lower rate and proportion of clients that successfully transition through the stages, and poorer client recovery outcomes. This being the case, it is important to interpret the reported findings within the context of these unprecedented experiences that guests/residents, house leaders, and providers endured.

Capacity and Expansion of the Progressive Housing Initiative

The data contained within this section addresses **Output 3.1** of the logic model "Number of Progressive Housing units, and total spaces available".

Between July 2018 and October 2022, 19 Progressive Houses were leased. One was removed from the Progressive Housing inventory in December 2021 due to the property being sold by the owner, and two are currently being prepared for occupancy. Therefore, as of October 13, 2022, the Progressive Housing initiative included a total of 16 homes.

The current capacity and occupancy rates of the Progressive Housing initiative as of October 31, 2022, are detailed in Table 2. Across the 16 homes, one has been allocated as an entry home, four operate as a Level 1 home, eight operate as a Level 2 home, two operate as a Level 3 home, and one operates as Level 4 home. Across these 16 homes, 74 beds are available for Progressive Housing guests/tenants, not including the 8 beds in rooms designated as isolation rooms to comply with COVID-19 protocols. In total, 42 guests/residents are currently enrolled in the program, representing an occupancy rate of 56.8%. Of those 42 guests/residents, one is currently in the entry home (2.4% of the total enrolled in the program), 12 (28.6%) are in a Level 1 home, 19 (45.2%) are in a Level 2 home, 6 (14.3%) are in a Level 3 home, and 4 (9.5%) are in a Level 4 home. Notably, three Level 1-3 homes are currently empty due to a House Leader not being available to manage the property, which accounts for a reduction in capacity by 13 beds. This has been attributable to current challenges concerning the recruitment of House Leaders.

Table 2: Capacity and Occupancy Rates of the Progressive Housing Initiative as of October 31st, 2022

House #	Home Level	Home Capacity*	Isolation beds	Current Occupancy	House Leader
1	Entry	4	0	1	Yes
2	1	5	1	0	No
3	1	5	0	5	Yes
4	1	5	1	4	Yes
5	1	4	1	3	Yes
6	2	5	0	5	Yes
7	2	4	1	0	No
8	2	4	0	4	Yes
9	2	4	1	3	Yes
10	2	5	0	2	Yes
11	2	5	0	3	Yes
12	2	4	1	0	No
13	2	4	1	2	Yes
14	3	4	0	3	Yes
15	3	6	1	3	Yes
16	4	6	0	4	n/a
TOTALS		74	8	42	

*Home capacity for clients, not including spaces allocated for isolation protocols.

The rate of home leases and openings are presented in Table 2. During the period of implementation of the project, from July 18, 2018, to March 31, 2021, a Progressive Housing home was opened on average every 65.8 days. By March 2021, the expansion of the project was completed after achieving the top end of the proposed target of 12-18 homes. Expansion was re-initiated in December 2021 first to replace a home that was sold by the owner, and then more recently once it became evident that there were sufficient project funds remaining to open additional Progressive Housing homes. The expansion of the Progressive Housing initiative to 16 homes with two currently in development comes in at the top end of the original proposal of 12-18 homes being in operation, as detailed in the MHSOAC proposal (p.56). Furthermore, a Progressive Housing home being opened every 65.8 days during the expansion period is consistent with the shortest proposed timeline to make a residence available to guests/residents every 2-3 months (p.22).

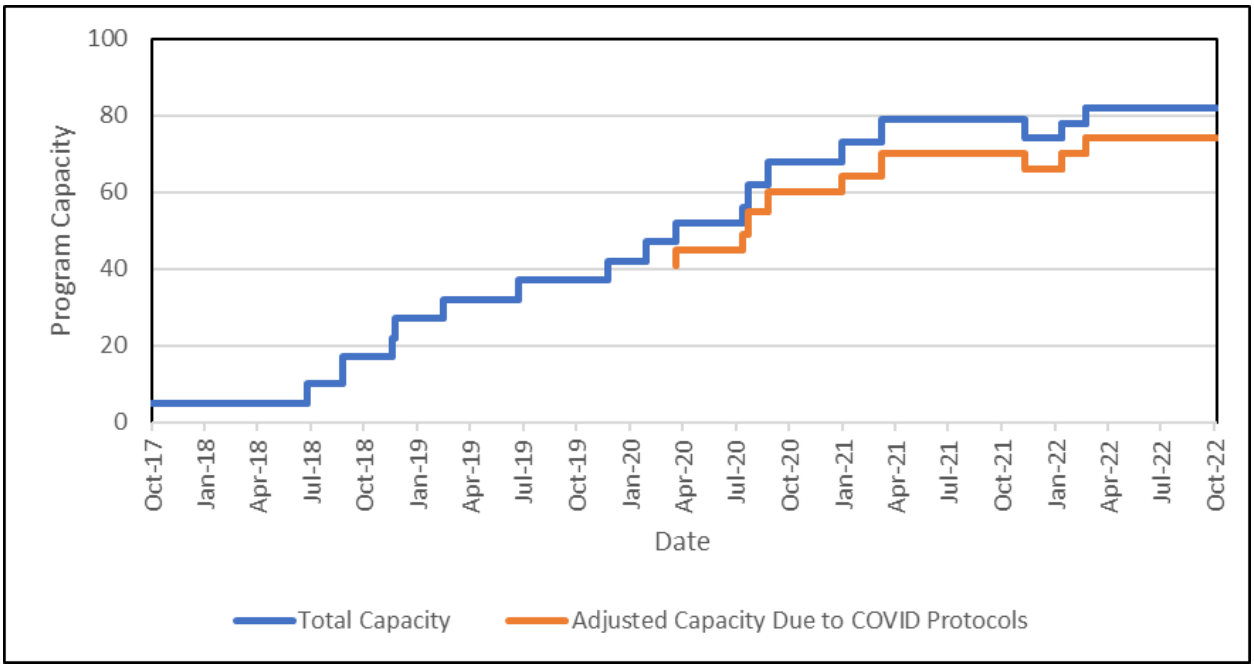
Table 2: Timeline of Progressive Housing Home Openings

Home Number	Date of Leasing Agreement	Occupancy Date	Total beds*	Adjusted Capacity
Home 1**	10/23/2017	10/23/2017	5	4
Home 2	7/5/2018	7/18/2018	5	4
Home 3	6/1/2018	9/17/2018	7	7
Home 4	12/10/2018	12/11/2018	5	4
Home 5	12/11/2018	12/15/2018	5	4
Home 6	1/21/2019	3/7/2019	5	4
Home 7	6/1/2019	7/16/2019	5	5
Home 8	11/1/2019	12/16/2019	5	5
Home 9	1/6/2020	2/20/2020	5	4
Home 10	2/25/2020	4/10/2020	5	4
Home 11	6/12/2020	8/2/2020	4	4
Home 12	6/30/2020	8/14/2020	6	6
Home 13	8/7/2020	9/17/2020	6	5
Home 14	12/28/2020	1/20/2021	5	4
Home 15	3/2/2021	3/31/2021	6	6
Home 16	12/10/2021	2/2/2022	4	4
Home 17	1/12/2022	3/15/2022	4	4
Home 18***	7/1/2022	N/A	5	
Home 19***	9/22/2022	N/A	5	

*Total beds, minus spaces that have been allocated as isolation rooms to meet COVID-19 protocols.
**Prior SSHH residence re-designated as Progressive Home at project initiation. This home was removed from the Progressive Housing inventory on 11/30/2021 when the owner put the property up for sale.
***Homes currently being prepared for occupation.

Notably, SSHH has achieved these significant milestones despite substantial challenges in purchasing and renovating the homes due to the pandemic. To achieve the target of 12-18 homes, the rate of openings increased after January 2020. From July 18, 2018, to December 16, 2019, a home opened every 73.9 days, whereas, from February 20, 2020, to March 31, 2021, a home opened every 50.8 days. In line with the expansion of the homes leased, the capacity of the program has increased substantially over time (see Figure 5). At present, the program has capacity for 82 guests/residents. However, these numbers have been reduced to 74 to temporarily allow for an isolation room, under COVID-19 protocols.

Figure 5: Expansion of Progressive Housing Initiative Over Time



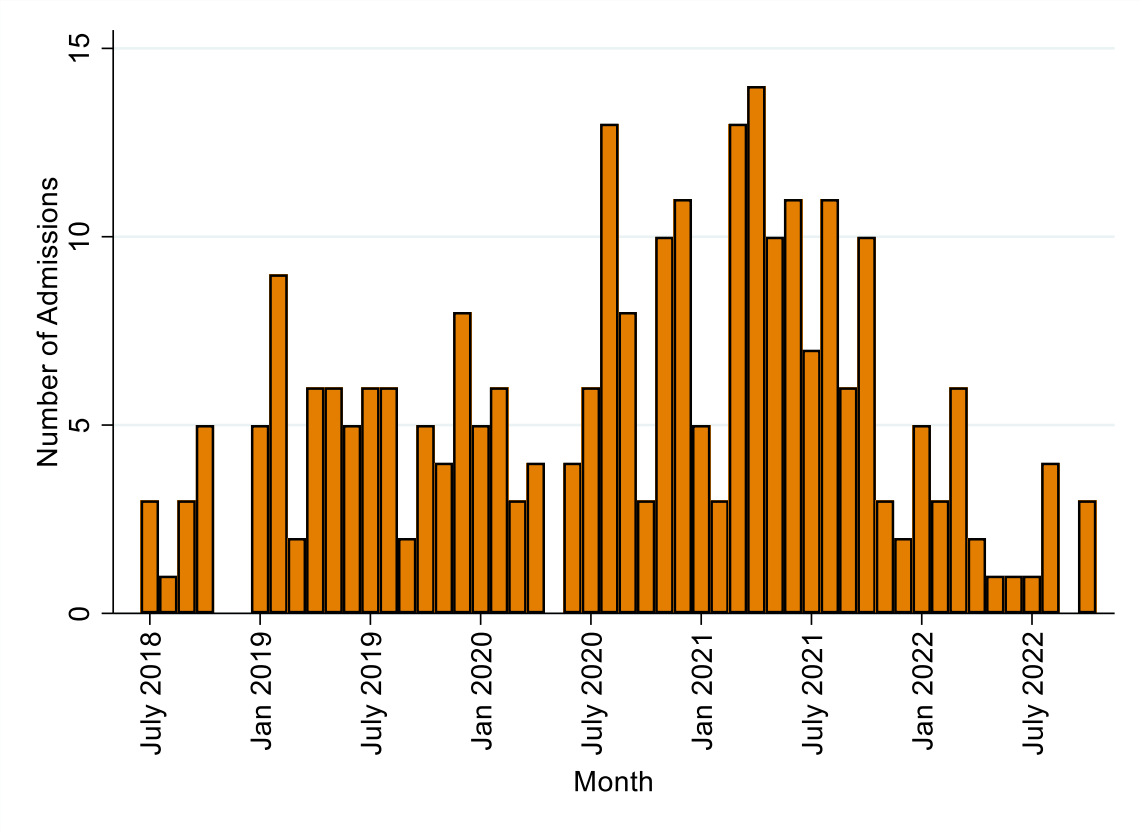
Resident Recruitment and Rate of Entry into the program

As of the end of October 2022, 268 clients have been enrolled in the Progressive Housing program. The rate of client enrollment over time is presented in Figure 6. This substantially exceeds the original target of 90-100 clients, as detailed in the proposal.

The substantially higher client enrollment rate than originally projected is likely attributable to multiple factors. One relates to the fact that SSHH and the Progressive Housing Initiative has been successful at opening homes at a rate towards the top end of projections, meaning more spaces have been available earlier. Another important factor has been the higher than anticipated client turnover rate. Possible reasons for this high turnover include the significant functional impairments that enrollees report, COVID-19 leading to significant reductions in the

range of services available, and the challenges of living in the group home environment. Regardless, the finding that the program can fill vacant spots quickly highlights the very high need for such services in the region. Additionally, it highlights the effectiveness of the referral pathway into the program.

Figure 6: Rate of Entry into the Progressive Housing Program over Time.



Expansion and Capacity Building Summary

The findings indicate that SSHH and SJBHS have been highly successful at implementing the expansion of the program, despite the challenges experienced by the pandemic. By leasing 16 homes for Progressive Housing clients with two more in development, the program has achieved towards the top end of the proposed target of 12-18 homes, as detailed in the original MHSOAC proposal. To achieve this target SSHH was successful at increasing the rate of home openings over time during the implementation period, despite the pandemic and the challenging home rental environment across Stockton. Additionally, the program has been highly successful at recruiting guests/residents into the program, highlighting both the clear

need for such a program in the area and the success of the referral pathway into the program. However, the very high recruitment rate is also indicative of the high turnover rate.

Progressive Housing Stage Program Retention and Transitions

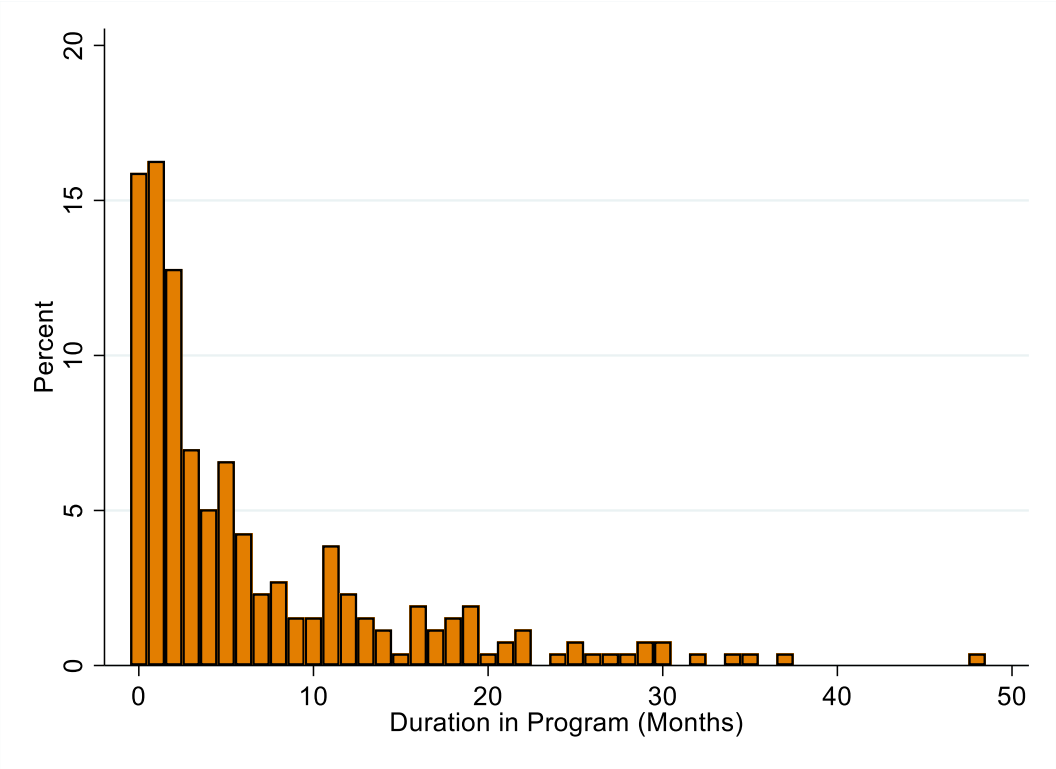
The data contained within this section relates specifically to **Output 3.2** "Rate of transition across Progressive Housing Levels", and **Output 3.4** "Number/proportion of that graduate from the program" of the Logic Model (Figure 3, p.13)

Program Retention

Between July 2018 and October 2022, 268 unique guests/residents have received Progressive Housing services.

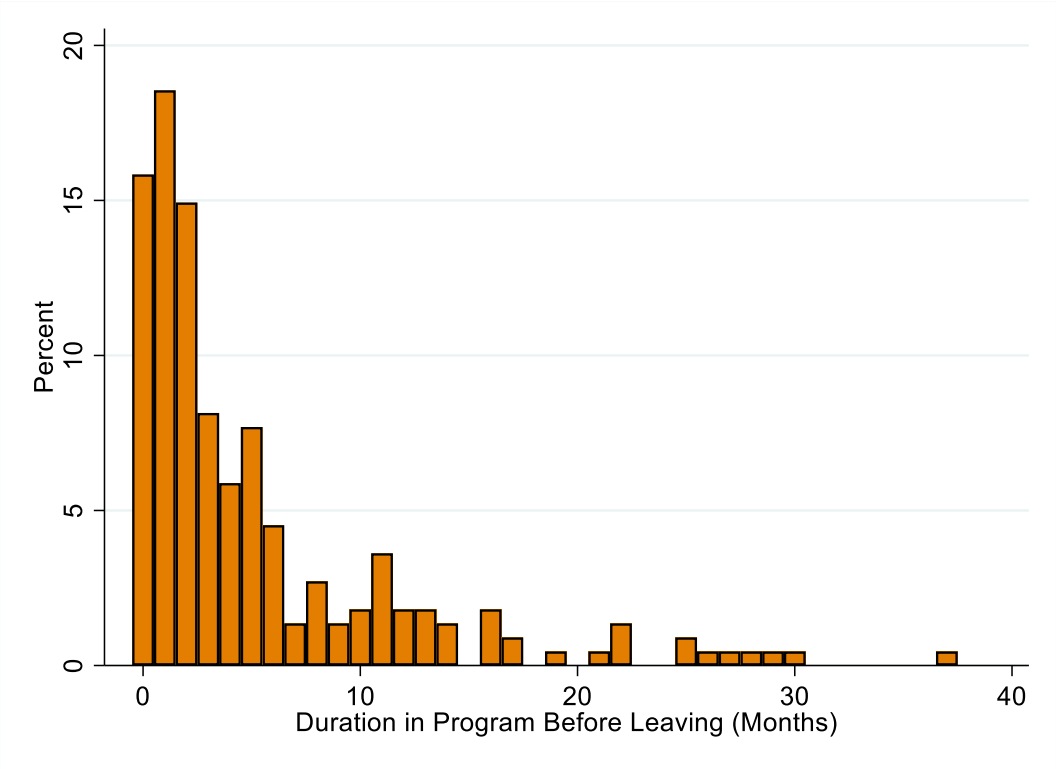
Of the 258 guests/residents housed between July 2018 and April 2022, longitudinal housing data was available for n=252 (97.7% of the sample). The distribution of their length of stay is presented in Figure 7. Of these, the median total duration of time spent in Progressive Housing is 3 months (Interquartile Range (IQR) 1 – 10). Of the 42 currently in the program, housing stay data was available for 41 clients. Of those, the median length of stay in a Progressive Housing home is 12 months (IQR 4 – 19). Eight guests/residents (19.5%) have been in the program two months or less, while 17 guests/residents (41.5%) have received housing for at least 18 months.

Figure 7: Duration Guests/Residents have Remained in the Progressive Housing Project who Enrolled Between July 2018 and June 2021



Among the available data of 211 guests/residents that have left the program since its start in July 2018, the median duration of the total time spent in the program was 3 months (IQR 1 – 6). The distribution of resident length-of-stay amongst guests/residents that leave is presented in Figure 8. Consistent with the findings from earlier reports, the data indicates that when clients leave, they are most likely to do so in the first three months of entry into the program (57.5% of the sample).

Figure 8: Duration Guests/Residents Remained in the Progressive Housing Program Before Leaving the Service



Of the 211 guests/residents that have elected to leave the program since July 2018 where housing data was collected, 25 (11.8%) have returned once, and two twice (0.9%). Of these, six (22.2%) have remained in the program, while the remaining 21 have since left again. The median length of time for the first stay of returners was 1 month (IQR 1-3). Not including the two clients that have only very recently returned, this total is similar to the median length of their second stay (median=1, IQR 1-5). In both cases, this is lower than the median length of time spent in the program of the remaining sample (n=219), which is 3 months (IQR 1-6). These data indicate that amongst those that return to the program after leaving, in most cases their second stay is typically not longer than the first and remains a lower duration to the norm. This suggests that amongst those that have previously disengaged from the program, a different approach may be necessary during their second stay to minimize the likelihood of another early termination.

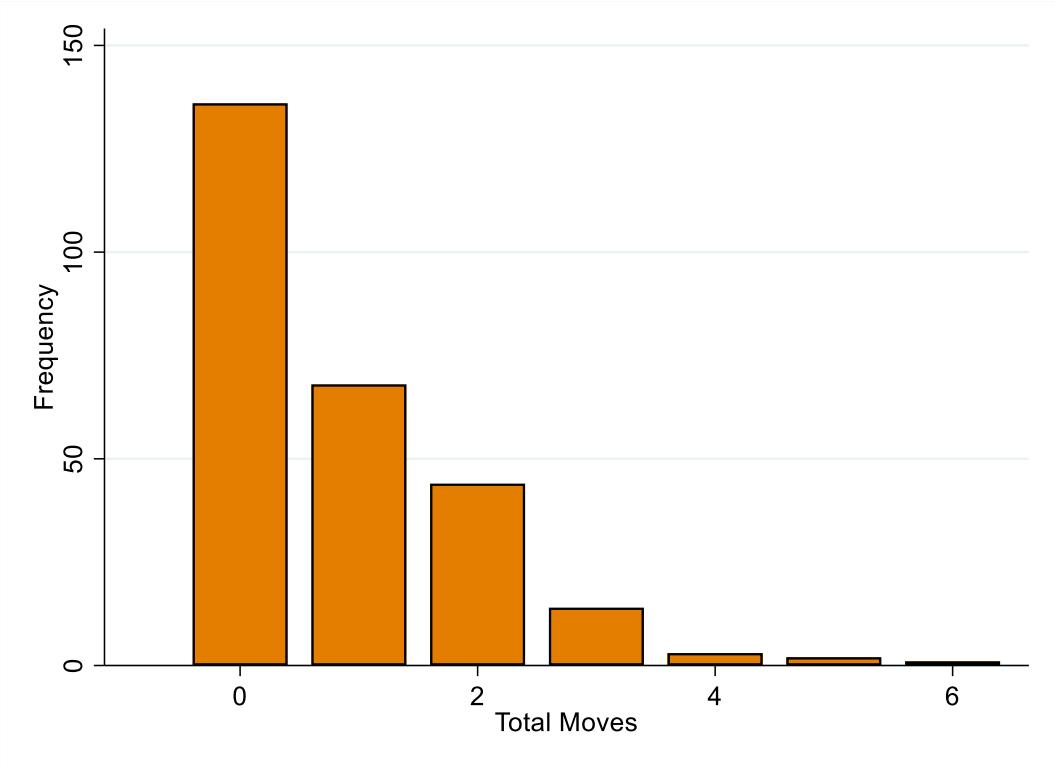
Transitions between Houses

From July 2018 to Oct 2022, 132 guests/residents (49.3% of the total) moved a total of 226 times between different Progressive Housing homes. The total number of moves experienced by guests/residents is presented in Figure 9. In total, 203 (75.8%) guests/residents experienced either one or no moves, 43 (16.0%) experienced two moves, 16 (6.0%) experienced three moves, three (1.2%) moved four times, two (0.8%%) moved five times, and 1 (0.4%) has moved a total of six times.

In an examination of moves between housing levels, a total of 140 occurred. In 119 (85.0%) of cases guests/residents moved to a higher-level home, and in 21 (15.0%) cases guests/residents moved to a lower-level Progressive Housing home. Consistent with the findings in the interim report only a relatively small proportion of clients that move to a lower level, which suggests that the program is not promoting guests/residents before they are ready.

Finally, guests/residents moved between Progressive Housing homes designated at the same level a total of 100 times. Part of the explanation for this relatively high number of lateral moves is attributable to COVID-19 protocols, where a series of re-organizations were necessary to accommodate the quarantine rooms required in each Progressive Housing home.

Figure 9: Number of Moves between Homes Made by Guests/Residents involve in the Progressive Housing Program



Guest/Resident Graduation between Levels

Of the 250 guests/residents that have entered the Progressive Housing system at a Level 1 home, complete moving data was available for 245 guests/residents. Of these, 148 (60.4%) left the program before graduating to a Level 2 home, 87 (35.5%) graduated to a higher-level home, and 10 (4.1%) are still in a Level 1 home.

Across 294 instances that a guest/resident resided in a Level 1 home, in 181 (61.6%) instances they left before moving levels, in 99 (33.7%) instances the guest moved to a higher-level home, and in 14 (4.8%) cases the client is still in the home.

Across 109 instances that a guest/resident resided in a Level 2 home, in 59 (54.1%) instances they left before moving levels, in 17 (15.6%) instances the guest moved to a higher-level home, in 18 (16.5%) instances they moved back to a Level 1 home, and in 15 (13.8%) cases the client is still in a Level 2 home.

Across 23 instances that a resident resided in a Level 3 home, in 7 (30.4%) instances they left before moving levels, in 6 (26.1%) instances the guest moved to a Level 4 home, in 3 (13.0%) instances they moved to a lower-level home, and in 7 (30.4%) cases the client is still in a Level 3 home.

Progressive Housing Stage Transitions and Program Retention Summary

Consistent with the findings from the interim report, the high dropout rate from the program remains notable. Of the 268 individuals who have joined the program, 84.3% have since left, with only six guests/residents graduating to a Level 4 home. Based on the testimony of guests/residents, house leaders, and project management, this is likely to be attributable to multiple factors, with the most significant being COVID-19 and the subsequent shelter-in-place mandate. The pandemic has resulted in numerous changes to house rules and procedures to keep guests/residents safe but has led to a more challenging environment to live in, increased stress amongst guests/residents, and a significant reduction in behavioral health services critical to support ongoing recovery. In addition, for much of the project duration employment opportunities were substantially curtailed. This limited opportunities for guests/residents to pay rent, which is a requisite to graduate to the higher levels. As behavioral health services have become more available and companies have begun rehiring, one may expect retention in the program to improve, and greater opportunities to move to higher Progressive Housing levels.

Regarding other ways to potentially increase program retention going forward, it is notable that disengagement from Progressive Housing services is most likely to occur within three months of joining the program (57.5%). This finding suggests that additional support during this period may be important to improve program retention.

Otherwise, client/resident transition between the Progressive Housing levels appears to remain on track. While there were a relatively high number of lateral moves between homes, in part due to the degree of reorganization required by COVID-19 protocols (n=100), most moves between levels were to a higher level, as opposed to lower-level homes (85% in comparison to 15%). This indicates that guests/residents are progressing through the Progressive Housing system-of-care as proposed. In addition, only 24.2% of guests/residents experienced more than one move during their period of stay which is important, given there were concerns that lots of transitions between homes may be disruptive to guests/residents, and may represent a limitation of the adapted model.

Progressive Housing Guest/Resident Characteristics

In this report, guest/resident characteristics including their sociodemographic information, prior housing status, sources of income, and educational and vocational health needs were explored. These data are important for two reasons. First, a significant component of the project relates to increasing access and availability of services for individuals who have historically been unserved or underserved by community services. Consequently, ensuring the

population served adequately reflects the population in need is critical. Second, such data is important to document and understand the needs of the population served, which is important to support programs and providers to better meet those needs.

Guest/Resident Demographics Relative to the Unsheltered Homeless Population of San Joaquin

The demographics of guests/residents in the Progressive Housing program are presented in Table 3. In total, 39.9% of guests/residents self-identified as women, 58.6% as men, 1.1% as non-binary, and 0.4% as transgender. Regarding ethnicity, 27.2% percent of guests/residents self-identified as Hispanic/Latinx. Regarding race, 27.8% of guests/residents self-identified as Black or African American, 50.6% identified as White, 3.9% identified as Native Hawaiian or other Pacific Islander, 2.7% identified as Native American or Alaskan Native, 0.8% identified as Asian, and 12.5% identified as more than one race. In total, 4.1% of guests/residents reported being veterans. Notably, almost all guests/residents had Medi-Cal or Medicare insurance coverage when they entered the program (94.3%).

The Progressive Housing demographics are consistent with figures reported for unsheltered individuals included in the San Joaquin 2019 Point in Time Count (San Joaquin Continuum of Care, 2019). In this report, 63.1% of unsheltered homeless individuals were men, 36.7% women; 5% identified as military veterans; 30.8% were Hispanic/Latinx; 69.6% White, 26.5% Black/African American, 2.4% Asian, 1.1% American Indian/Alaskan Native, and 1.8% Native Hawaiian/Pacific Islander. In particular, the proportion of Black/African American individuals, Hispanic/Latinx individuals, and the proportion of military veterans were almost identical between the Point-in-Time Count and the Progressive Housing Initiative. These findings further support early reports that the program has been successful at engaging historically underserved racial and ethnic minority groups, in addition to military veterans.

Table 3: Demographic Breakdown of Sample

Variable	N	%
Age (n=259, mean, Std)*	43.10	12.91
Gender (n =268)		
Men	157	58.6
Women	107	39.9
Non-binary	3	1.1
Transgender	1	0.4
Race (n =255)		
Black/African American	71	27.8
White	129	50.6
Native Hawaiian/Pacific Islander	10	3.9
Native American or Alaskan Native	7	2.7
Asian	2	0.8
More than one race	32	12.5
Guest/resident refused	2	0.8
Guest/resident doesn't know	2	0.8
Ethnicity (n =268)		
Non-Hispanic, non-Latinx	194	72.4
Hispanic/Latinx	73	27.2
Guest/resident refused	1	0.4
Veteran status (n =267)		
No	256	95.9
Yes	11	4.1
Medi-Cal / Medicare Insurance Coverage (n = 265)		
No	15	5.7
Yes	250	94.3

*To comply with data protection requirements all individuals over 65 were entered as 65 in age.

Guest/resident baseline housing status is presented in Table 4. Over four-fifths of the sample reported being homeless at baseline (82.8%), while 11.6% were at imminent risk of homelessness. Immediately prior to the assessment, most slept either in a place not meant for habitation (e.g., a car, tent, or abandoned building), or in emergency or transitional housing (28.5% and 32.6%, respectively). More than half (53.9%) had experienced homelessness for over a year and similarly, approximately half (45.3%) had experienced multiple episodes of homelessness.

These findings highlight the chronicity and severity of homelessness that many of the guests/residents experienced prior to engaging with the Progressive Housing Initiative. Additionally, this indicates Progressive Housing is successfully providing services to individuals the program was originally designed to serve, namely individuals with prolonged and repeated episodes of homelessness.

Table 4: Prior Housing Status

Variable	n	%
Housing status at entry (n = 268)		
Homeless	222	82.8
Imminent risk of homelessness	31	11.6
At-risk of homelessness	10	3.7
Stable housing	5	1.9
Where guest/resident slept last night (n = 267)		
Place not meant for habitation	76	28.5
Emergency shelter/transitional Housing	87	32.6
Family/friend's house	39	14.6
Hotel/hostel/motel without voucher	9	3.4
Long term care program or residential facility	15	5.6
Jail/prison	5	1.9
SUD treatment center/psychiatric facility	25	9.3
Foster care group home	1	0.4
Guest/resident rental with subsidy	3	1.1
Guest/resident rental, no subsidy	4	1.5
Non-psychiatric hospital / residential facility	3	1.1
Number of times homeless (n = 267)		
1 time	139	52.1
2 times	35	13.1
3 times	30	11.2
4+ times	56	21.0
Guest/resident doesn't know	7	2.6
Homelessness duration (n = 276)		
≤ 12 months	115	43.1
> 12 months	144	53.9
Guest/resident doesn’t know	8	3.0

Guest/resident sources of income are presented in Table 5. In total, 45.5% of participants had no source of cash income through work or benefits, and only ten individuals (6.9%) reported

some form of employment. Notably, amongst those that did receive some form of income, for most (73.8%) this was received exclusively in the form of SSI, SSDI, or SSA.

Table 5: Guest/Resident Sources of Income at baseline

Variable		N	%
Cash income (n = 267)			
	No	122	45.5
	Yes	145	54.1
	Guest/resident refused	1	0.4
Sources of Income (n = 145)			
	Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI)/Social Security (SSA)	107	73.8
	Temporary Assistance for Needy Families (TANF)/ CalWorks/General Assistance Program (GA)	8	5.5
	Unemployment Insurance	6	4.1
	Pension	1	0.7
	Employment	10	6.9
	Other	1	0.7
	More than one	12	8.3
Non-cash benefits (n = 267)			
	No	106	39.7
	Yes (SNAP/CalFresh)	160	59.9
	Guest/resident refused	1	0.4

Guest/Resident Educational, Vocational, and Health Needs

The educational and vocational needs of guests/residents at baseline are presented in Table 6. Almost all the sample (94.8%) reported being unemployed at baseline, and of those, most were not actively seeking employment opportunities (90.6%).

Education may represent a significant barrier to employment. One third (33.8%) reported not having a high school diploma or GED equivalent, and only 10.6% reported completing some form of a post-secondary school course. Additionally, only six guests/residents reported being in some form of education or vocational training at baseline.

The finding that almost all guests/residents are unemployed and not in education at the point of entry into the program, and that over one-third did not have a high school diploma or GED equivalent highlights the clear need for vocational and educational support amongst Progressive Housing clients. However, for much of the project providing support in this area has been highly challenging during the pandemic, given local supported employment and education

programs were halted, and few organizations were seeking employees. More recently, these services have been available again, and the requirement for clients to be actively engaged in some form of services from level 2 onwards has meant more guests/residents have participated in employment and educational support. As a result, one may expect employment and educational engagement may improve going forwards.

Table 6: Educational and Vocational Health Needs of Progressive Housing Guests/Residents

Variable	N	%
Highest Educational Level Completed (n = 254)		
≤ 8th grade	15	5.9
9-12th grade, no diploma	71	27.9
High school diploma	112	44.1
GED	26	10.2
Post-secondary school	27	10.6
Guest/resident refused/Didn't know	3	1.2
Enrolled in School (n = 268)		
No	263	98.1
Yes	4	1.5
Guest/resident refused	1	.5
Employed (n = 268)		
No	254	94.8
Yes	13	4.9
Guest/resident refused	1	0.4
If not employed, seeking employment? (n = 256)		
No	232	90.6
Yes	22	8.2
Guest/resident refused or didn't know	2	0.8
Vocational or apprenticeship program (n = 266)		
No	262	98.4
Yes	2	0.8
Guest/resident refused or didn't know	2	0.8

Progressive Housing Guest/Resident Characteristics Summary

Overall, the guests/residents who have received Progressive Housing services to date appear to be highly representative of the San Joaquin County homeless population, as recorded in the 2019 Point-in-Time Survey. The findings indicate the program has been successful at engaging guests/residents across different genders, races, and ethnic groups. Additionally, the program appears to be successfully engaging military veterans, which is important given the commitment by SSHH to support those who had previously served in the armed forces.

These data also provide a comprehensive summary of what guest/resident needs may be as they enter the program. For example, almost all guests/residents reported either not being in education or employment, highlighting this as a key area for outcome evaluation and emphasizing the importance of vocational support services that were originally embedded within the program.

Finally, it was notable that most guests/residents entered the program with Medi-Cal or Medicare insurance coverage, given one aim of the project was to increase Medi-Cal enrollment for those who did not have existing insurance. These findings suggest that either enrollment in Medi-Cal is much higher than anticipated amongst this population, or the program is not effectively engaging those that do not have Medi-Cal insurance. If it is the latter, additional outreach and engagement efforts may be necessary to further facilitate access to services. Regardless, this finding indicates that evaluating the proportion that gain Medi-Cal insurance following engagement in the program is not feasible in the currently recruited population due to ceiling effects.

Guest/Resident Health Needs and Services Utilization

The data contained within this section relates specifically to **Output 3.3** “Number/proportion of clients that engage with local behavioral health services”; and **Outcome 4.2** “Increase engagement with consumers who had not previously received services over time” of the Logic Model.

The clinical presentation of the Progressive Housing Initiative’s guests/residents is presented in Table 7. Approximately two-thirds of guests/residents met the criteria for a SUD at baseline (67.3%), and amongst the available data, 96.2% reported using drugs or alcohol at least to some extent at the point of entry into the program. The most frequently used drug was amphetamine/methamphetamine, with 48.1% of guests/residents reporting using the drug either alone or in combination with other substances such as alcohol, cannabis, cocaine, PCP, and/or heroin. The most frequent primary mental health diagnoses were psychotic disorders (50.0%) and affective disorders (33.5%).

Consistent with prior formative evaluations, the clinical presentation of the sample confirms that the program is providing services to the target population, namely individuals with SMI and SUD that would lead to significant barriers to housing in other models.

Table 7: Clinical Presentation of the Sample

Variable	N	%
Substance use (n = 208)		
Amphetamine/methamphetamine	86	41.4%
Cannabis	44	21.2%
Alcohol	41	19.7%
Cocaine/crack cocaine	3	1.4%
Heroin/Opioids	2	1.0%
Ecstasy	1	0.5%
Benzodiazepines	1	0.5%
None reported	8	3.9%
Multiple primary substances reported (n=19)		
Methamphetamine and alcohol	5	2.4%
Methamphetamine, cannabis, and alcohol	4	1.9%
Heroin and methamphetamines	3	1.4%
Cannabis and Alcohol	3	1.4%
Methamphetamine, PCP, alcohol	1	0.5%
Methamphetamine, cocaine, alcohol	1	0.5%
Multiple Not specified	2	1.0%
Diagnosed with Substance Use Disorder (SUD) (n =254)		
No	83	32.7%
Yes	171	67.3%
Primary Diagnosis (n = 248)		
Psychotic disorder	124	50.0%
Affective disorder	83	33.5%
Anxiety disorder	29	11.7%
Personality disorder	1	0.4%
Primary Substance use disorder	1	0.4%
Do diagnosis/does not meet diagnostic criteria	7	2.8%
Unknown	3	1.2%

The developmental and physical health needs of guests/residents at baseline are presented in Table 8. There is a high prevalence of physical disability (34.5%) and chronic health conditions (48.7%) amongst Progressive Housing guests/residents. Encouragingly, most are receiving at least some form of services for these health concerns (84.8% and 86.2% respectively) at the point of entry into the program. A lower proportion of guests/residents (29.5%) were

diagnosed with a developmental disability. However, relative to other conditions, a lower proportion of those diagnosed with a developmental disability were receiving services at baseline (63.3%).

Overall, these data indicate relatively high behavioral, developmental, and physical health needs for this population. While most guests/residents are receiving services for these conditions, some are not, particularly those with developmental disabilities. Consequently, the Progressive Housing Initiative team needs to connect guests/residents with services in cases where support is required but they are not yet receiving services.

Table 8: Developmental and Physical Health Needs

Variable	N	%
Physical disability (n =267)		
No	174	65.2
Yes	92	34.5
Guest/resident refused	1	0.4
Has physical disability and is receiving services for physical disability (n = 92)		
No	14	15.2
Yes	78	84.8
Chronic health condition (n = 267)		
No	135	50.6
Yes	130	48.7
Guest/resident refused or doesn't know	2	0.8
Has chronic health condition and is receiving services for condition (n = 130)		
No	18	13.8
Yes	112	86.2
Developmental disability (n = 268)		
No	176	65.7
Yes	79	29.5
Guest/resident refused	3	1.1
Guest/resident doesn't know	10	3.7
Has a developmental disability and is receiving services for disability (n = 79)		
No	26	32.9
Yes	50	63.3
Guest/resident doesn't know or refused	3	3.8

Guests'/residents' utilization of SJCBHS services at baseline is presented in Table 9. Almost all guests/residents had received some form of services from SJCBHS in the past (89.5%). Due to

limitations in the data, it is not clear what proportion of these guests/residents were actively engaged in behavioral health services immediately prior to receiving Progressive Housing services, and who may have previously received care but have long since disengaged. Additionally, the number and proportion of homeless individuals who had never received SJCBHS is also unknown, meaning it is unclear how effective the program is at engaging such individuals. Regardless, these findings do indicate that the program is not engaging many clients who have never previously received SJCBHS services.

Importantly, at the point of assessment very few guests/residents were actively receiving treatment for SUD either from SJCBHS (8.1%), or other community organizations or groups such as Alcoholics Anonymous or Narcotics Anonymous (9.9%). This indicates that while the program may not be effective at engaging clients who have never received SJCBHS services, the program has been highly effective at engaging individuals not actively involved in SUD treatment. These findings indicate that the Progressive Housing Initiative may represent one important pathway to facilitating access to SUD care for homeless individuals residing in San Joaquin County.

Table 9: San Joaquin County Behavioral Health Service Utilization at Baseline

Variable		N	%
Have ever received SJCBHS services (n =248)			
	No	26	10.5%
	Yes	222	89.5%
Engaged in SUD care at baseline (n = 111)			
	No	102	91.9%
	Yes	9	8.1%
Engaged in SUD maintenance support at baseline (i.e., AA, NA meetings) (n = 101)			
	No	91	90.1%
	Yes	10	9.9%

Guest/Resident Health Needs and Services Utilization Summary

Many clients engaging in the Progressive Housing program reported experiencing a range of chronic physical and developmental health needs. Encouragingly, the majority reported already experiencing support in these areas, although some did not, particularly with regards to developmental disabilities. Guests/residents also reported significant mental health and substance use disorder needs, highlighting the success in engaging the target population, and the broad and complex array of needs that those served present upon entry into the program. While the program may not be successful at engaging individuals previously unserved by SJCBHS, it has been highly effective at engaging individuals not in active SUD treatment. This

suggests the Progressive Housing initiative may represent an important pathway to improving access to SUD treatment amongst those who are homeless in San Joaquin County.

Improving Guest/Resident Outcomes

The data contained within this section relates specifically to **Outcome 4.1** "Improve consumer outcomes over time" in the Logic model.

Impact of Progressive Housing on Functional Outcomes

To track functional impairment both at the point of entry into the Progressive Housing program, and over time, guests/residents were assessed utilizing key items from the ANSA (Lyons et al., 2013). In total, nine items were selected by SJCBHS leadership as areas considered likely to be the greatest needs amongst guests/residents, and most likely to be positively impacted through engagement in Progressive Housing services. These include impairments relating to residential stability, guest/resident living situation, substance use, social functioning, self-care, sleep, independence regarding transportation, medical needs, and criminal justice involvement. Where possible, guests/residents completed an assessment with a SJCBHS provider at the point of entry into the program (baseline), at yearly intervals from the point of entry, at discharge, and at the point of re-entry into the program.

The number and proportion of clients that experienced moderate or severe functional impairment across selected domains over time is presented in Table 10. In total, 211 (78.1%) of guests/residents completed a baseline assessment. At this baseline assessment stage, a substantial proportion of the sample reported at least moderate impairments in their residential stability and housing situation (85.4% and 71.0%, respectively). Given the main purpose of this program is to improve the housing situation of San Joaquin County residents in need, this supports earlier findings that indicate that the program is currently providing services to the targeted population.

Regarding other areas of impairment, 38.4% of guests/residents reported at least moderate impairments due to substance use, 34.5% in social functioning, 21.7% in self-care, 25.7% reported moderate impairments in sleep, 24.6% required significant transport support to manage appointments, 13.2% reported significant physical or medical issues, and 7.1% reported impairments related to criminal justice involvement. Overall, these findings point to the range of complex needs and impairments that Progressive Housing guests/residents experience.

Table 10: Proportion of residents that experience at least moderate levels of impairment at baseline

ANSA Item	Baseline		1 - Year Follow Up		Comparison of baseline 1-year follow-up responses (n=22)	
	n/N	%	n/N	%	χ^2	P
Residential Stability	176/206	85.4%	14/34	41.2%	9.31	.002*
Living Situation	147/207	71.0%	10/34	29.4%	9.31	.002*
Substance Use	79/206	38.4%	5/34	14.7%	2.76	.103
Social Functioning	71/206	34.5%	14/34	41.2%	1.29	.257
Sleep	53/206	25.7%	8/34	23.5%	0.11	.739
Self-Care	45/207	21.7%	6/34	17.7%	0.20	.655
Transport Support	51/207	24.6%	9/34	26.5%	0.14	.706
Physical Medical	27/204	13.2%	10/34	29.4%	.33	.564
Criminal Justice Involvement	15/210	7.1%	0/34	0%	1.00	.317

Regarding follow-up assessments of functioning, ANSA data from 34 guests/residents were available at the 1-year follow-up stage. Given this represents only a small proportion of the total population, caution should be exercised in interpreting the findings. However, while impairment levels were largely stable across most domains (i.e., social functioning, sleep, self-care, transport dependence, and criminal justice needs), a substantial reduction in impairment was evident in domains concerning residential stability (from 85.4% of guests/residents to 41.2%), in guest/resident living situation (from 71.0% to 29.4%), and in substance use (38.4% to 14.7%). In a pre-post comparison of these ratings amongst the 22 guests/tenants where data were available at both timepoints, a significant improvement in residential stability ($\chi^2 = 9.31$, p=.002), and living situation ($\chi^2 = 9.31$, p=.002) was evident. No significant differences were found in other domains, although the reduction in impairments related to substance use was found to be trending towards significance 9 ($\chi^2 = 2.67$, p=.103). Further data would be necessary to explore this potential difference more fully.

Interestingly, a moderate increase in medical needs was evident between baseline and the 1-year follow-up stage. However, this may be a feature of people with notable medical needs being more likely to stay in the homes. As evidence of this, amongst the 22 guests/tenants where medical need data were available at both timepoints, in most cases (86.4%) the guest/residents' ANSA score on this item remained stable.

Guest/Resident Return to Employment or Education

In addition to assessing functional impairment, the rate at which guests/residents engaged in school or work over time was also explored. Similarly to the ANSA data, a substantial amount of

missing data was evident, with data from only 33 guests/residents at the 1-year follow-up stage, and 10 at the 2-year follow-up stage. Therefore, caution should be exercised in interpreting the findings.

Amongst the 33 guests/residents surveyed at the one-year follow-up stage, five were employed (15.2%), four reported they were actively seeking employment (12.1%), and 24 (72.7%) were neither employed nor seeking employment. At the 2-year stage, one was employed (10%), and nine were neither employed nor seeking employment. While these figures are still relatively low, they do compare favorably to the previous report submitted in March 2022. In this report, all 19 clients assessed at the 1-year follow-up stage and 5 clients at the 2-year stage reported not being in employment, with only 1 client actively seeking employment. SJCBHS leadership has indicated that COVID-19 has been a major barrier to employment for guests/residents during much of the project duration. This may account for the notable increase in engagement in employment activities over the past 10 months as the impact of the pandemic has subsided. If so, it is possible to expect for this recent positive trend to continue.

Regarding education and training, of the 33 guests/tenants surveyed at the 1-year follow up stage two (6.1%) were enrolled in school, while 31 were not. At the two-year follow-up stage, all 10 guests/residents surveyed reported they were not enrolled in higher education.

Program Outcomes Summary

Overall, clients reported substantial impairments in functioning across a key range of outcomes, and almost all were unemployed and not in education programs at program entry. Unfortunately, there is limited data to explore symptom trends over time. However, in a small subsample of guests/tenants where baseline and 1-year follow up data were available, a substantial reduction in impairments related to their living situation and residential stability was evident, with weaker evidence to suggest impairments related to substance use also improved. This is notable, given the dramatic impact that COVID-19 has had both on service delivery and the additional stresses guests/tenants have experienced. Additionally, while few guests/residents appear to be engaging in education or vocational training, the recent data shows encouraging trends regarding an uptick in employment and employment seeking activities. Overall, these tentative findings point to positive outcomes amongst those that are able to engage in the Progressive Housing Initiative for a prolonged period of time. That being the case, in future work additional efforts to support guest/tenant retention may be merited. As the program continues additional data collection may provide a clearer picture of the true impact of the service.

The Progressive Housing Approach Relative to Alternatives Delivered in San Joaquin County

This section aims to address one output and two outcomes specified in the logic model: **Output 3.5** "Total costs associated with developing and maintaining each Progressive Housing unit"; **Outcome 4.3** "Provide housing for at least equivalent costs to alternatives delivered in San Joaquin County for Consumers with comparable needs"; and **Outcome 4.4** "Deploy Progressive Housing units quicker than other housing solutions for similar clients."

In this report, costs and deployment data regarding housing projects for housing-insecure individuals with SMI and/or SUD approved by the San Joaquin County Board of Supervisors since 2010 were collected and compared to Progressive Housing deployment data.

To be identified as an appropriate comparison housing project the project was required to 1) be funded using County mental health services funds, and 2) provide housing for adults either homeless or at significant risk of homelessness with SMI including individuals with co-occurring SUD.

Across the different projects, the target population typically had frequent contact with law enforcement, primarily as a result of their untreated behavioral health concerns and lack of a support system. For many, psychiatric hospitalizations and hospital emergency room visits are the only "treatment" they would have received. A high percentage of the individuals had no income, having either minimal work history and/or a lost connection with the Social Security Administration for entitlements.

Summary of Alternative SJCBHS Funded San Joaquin Housing Programs

In a review of SJCBHS funded housing programs completed by the evaluation team and SJCBHS staff, four eligible programs were identified. These include Anchor Village, Zettie Miller's Haven, Crane's Landing (formerly Tienda Drive), and Crossways. A summary of each project is detailed below.

Anchor Village

Anchor Village was a new construction project located in Stockton, California. The project was approved by SJCBHS in February 2015, developed through a partnership between Domus Development and SJCBHS. The project consisted of building a total of 51 units (including one manager's apartment), of which 11 were made available for SJCBHS clients through a grant from the MHSOAC. These homes were made available for occupancy in November 2018.

Zettie Miller's Haven

Zettie Miller's Haven was a new construction project approved by SJCBHS in 2008. The site was developed as part of a joint venture between the Central Valley Coalition for Affordable Housing, Service First of Northern California, the Community Housing Development Group, and SJCBHS. The homes are located in Stockton, California. The project included 82 units over seven residential buildings, of which 20 were dedicated to people with SMI, and was funded utilizing MHSOAC grant dollars. The homes were made available for occupancy in April 2017.

Cranes Landing

Cranes Landing (formerly Tienda Drive) was a new construction project approved by SJCBHS in June 2014. The proposal included an 81-unit development including one manager's premises on a vacant 3.4-acre site located in Lodi, California. Of these, 8 units were set aside for SJCBHS service users, ages 55 and above, with SMI, and either homeless or at high risk for homelessness. The homes were made available for occupancy in August 2017.

Crossways

The Crossways project involved the modification of existing Housing Authority administrative buildings in the downtown Stockton area to create housing units for individuals with SMI. The project proposed the creation of 37 units and two resident manager apartments across three separate buildings. The project was approved by SJCBHS in June 2017 and was completed across three phases. The first unit to be opened was Crossway at Center Street in December 2020, the second was Crossway at Park Street in February 2021, and the third and final phase was Crossway at El Dorado Street, which was opened in June 2021.

The Progressive Housing Initiative

Unlike the other housing projects detailed in this deliverable that either involves the repurposing of existing buildings not previously designated for housing, or the construction of new homes, the Progressive Housing initiative exclusively utilizes existing single-family homes available on the rental market. The project was funded by SJCBHS MHSA Innovation funds, with approval from the MHSOAC, and was implemented through a collaboration between SJCBHS and SSHH. In this model, SSHH representatives identified available four- to six-bedroom homes to rent in the San Joaquin County region of sufficient size to house approximately 6 individuals (5 beds for guests/residents, and one single room for the House Leader who manages the property). Once the leasing agreement was secured, SSHH furnished the properties and made minor modifications and renovations to the properties over a period of approximately 45 days before residents were moved into the homes. Under this model, SSHH held the building lease and managed the property for SJCBHS service users.

The Progressive Housing Initiative was approved by SJCBHS in November 2017 and by the MHSOAC in January 2018. The first new home was opened in July 2018. As of March 15, 2022,

17 homes had been secured for Progressive Housing guests/residents, one of which was recouped by the owner. Across the 16 remaining homes, the total capacity of the Progressive Housing Initiative stood at 82 beds, which was reduced to 74 to comply with COVID-19 protocols and enable spaces for isolation. While an additional two Progressive Housing homes are currently in preparation, these have not yet completed and so have not been included in the following calculations.

Costs data for the Progressive Housing Initiative were available up until the period of November 2021, and so the analysis of costs was conducted up until this period.

Progressive Housing Deployment Relative to Alternative Projects

Details of the project deployment times across different MHSA-funded projects for housing-insecure individuals with SMI in San Joaquin County are presented in Table 11. Across the three new construction projects identified (Anchor Village, Zettie Miller's Haven, and Crane's Landing) the projects took between 3.2 – 8.8 years from approval to completion, with the number of units designated specifically for SJCBHS service users totaling between 8-20. Therefore, in each project, between 2.5 – 3.0 additional units for housing insecure SJCBHS services users with SMI were created per year. In the Crossways renovation project, the final phase of the project was completed in June 2021 and resulted in 37 new housing units. This equates to a total of 9.3 additional units created for each year of the project.

In the Progressive Housing project, the first unit was developed within six months of receiving project approval from the SJCBHS Board of Supervisors. The final home during the expansion period was made available for clients in March 2022, meaning the project took 4.2 years to implement. Over this period 16 homes were available for residents, resulting in a final number of 82 beds (temporarily reduced to 74 due to COVID-19 protocols). Therefore, over the expansion period the Progressive Housing initiative created 19.5 additional beds for the target population per year.

Table 11: Deployment Times across San Joaquin County Projects for Housing-Insecure Individuals with SMI.

MHSA Housing Project	Nature of Project	Date of final approval	Date of completion	Duration from approval to completion (years)	No. of units/beds	No. of units/beds created per year
Anchor Village	New Construction	2/2015	11/2018	3.7	11	3.0
Zettie Miller's Haven	New Construction	2008*	4/2017	8.8	20	2.3
Crane's Landing	New Construction	6/2014	8/2017	3.2	8	2.5
Crossways	Renovation	6/2017	6/2021	4.0	37	9.3
Progressive Housing	**Existing Home Rentals**	**1/2018**	**03/2022**	**4.2**	**82 (74)***	**19.5(17.6)**

*Month of final approval not available in records

**Total guest/resident capacity of the program was reduced to 71 during the pandemic.

In a comparison of bed/unit creation rates over time, the Progressive Housing Initiative was found to develop 660% - 848% more living spaces relative to recent new construction projects. In comparison to the Crossways administrative building renovation project, the Progressive Housing rate created 210% more units over the same period.

In the Cranes Landing project, 8 units were created after 3.2 years, in the Anchor Village project 11 units were created after 3.7 years, and in the Zettie Miller's Haven project 20 units were created after 8.8 years. In the Progressive Housing Initiative, these figures were exceeded within 9 months, 12 months, and 12 months, respectively. In the Crossways renovation project, the 37 units were created after 4.0 years, a figure that the Progressive Housing initiative achieved within 24 months.

Progressive Housing Costs

The total costs for SSHH to deliver Progressive Housing services for the 5-year project are projected to be $4,087,953.33. This figure includes all startup and ongoing costs until December 2022. Current ongoing monthly operating costs for SSHH to deliver Progressive Housing services, as of November 2021, totals $94,952.62, during which period the program had 15 homes occupied by guests/residents. The breakdown of these costs is presented in Table 12. SSHH staff costs include Progressive Housing program leadership, operations supervisors, case managers, and maintenance workers. Due to the unique role of the House Leaders in the Progressive Housing initiative, these were included as a separate line item. Operating expenses

included utilities, maintenance, client food, supplies, office space, IT, home furnishings, and maintenance.

Table 12: Monthly ongoing costs of Progressive Housing Services, as of November 2021.

SSHH Expenses	Ongoing monthly costs as of November 2021
Staff Salaries (not including costs associated with House Leaders)	$27,126
Costs associated with House Leader positions	$14,882 ($992.13 per home)
Rent for Progressive Housing homes	$37,310 ($2,487.33 per home)
Operating expenses	$15,634.62
TOTAL	$94,952.62

Progressive Housing Costs Relative to Alternative Projects

A direct comparison of costs across the different housing programs is challenging for multiple reasons. First, it is important to acknowledge the very different nature of the projects. New construction projects are likely to have very high start-up costs, and then relatively smaller ongoing costs. Renovation projects may have smaller initial costs, but rely on owning existing buildings/infrastructure that may not be adequately reflected in the actual cost to implement. In the case of Progressive Housing, the program relies on utilizing existing homes on the rental market. As a result, the initial costs may be relatively low (e.g., deposit, minor renovations, and furnishing costs); however, ongoing costs – in the form of rent – may be higher. Linked to this, future costs may be more volatile based on fluctuations in the local housing rental market. Additionally, in the Progressive Housing model, as individuals progress up the hierarchical levels the expectation is that residents begin to pay a proportion of their rent, based on their income, indicating that the costs of the program to SJCBHS may reduce over time. Second, projects such as Zettie Miller's Haven and Anchor village were delivered as part of much larger housing development projects. In these situations, the costs shared may not represent an adequate reflection of the actual costs of the development if needed to be delivered in isolation. Third, in the case of Zettie Miller's Haven, the approval for the project was completed 10 years before Progressive Housing, at which time costs were likely to be much lower due to inflation. Fourth, while the Progressive Housing costs presented are based on projected expenditures at the point of project completion in December 2022, for the other projects the project costs are based on the project proposals, given actual spending data were unavailable. Acknowledging these significant caveats, the proposal costs for Progressive Housing and each of the comparison housing programs are presented in Table 13. Across the five projects, Cranes Landing was found to have the highest cost per unit at $179,250. The Progressive Housing initiative was found to have the lowest cost, at $49,853 per bed.

Table 13: Comparison of San Joaquin County Project Costs for Housing-Insecure Individuals with SMI.

Site	Number of Beds/Units	Total Project Cost*	Cost per unit
Anchor Village	11 units	$1,697, 269	$154,297
Zettie Miller's Haven	20 Units	$3,327,258	$166,363
Crane's Landing	8 units	$1,434,000	$179,250
Crossways	37 units	$3,500,000	$94,595
Progressive Housing	82 beds	$4,087,953	$49,853

*In programs where only a proportion of the total development costs were serviced by SJCBHS funds, only the SJCBHS proportion is presented.

Comparison to Progressive Housing to alternative SJCBHS programs summary

Relative to other SJCBHS initiatives for housing-insecure individuals with SMI, the Progressive Housing Initiative was found to provide more beds over a shorter timescale. When compared to new construction projects, the Progressive Housing Initiative was found to develop 6.5-8.5 times more beds over the same period. Relative to the Crossways housing renovation project, Progressive Housing has developed over twice as many units. Collectively, these findings indicate that the Progressive Housing model of utilizing existing rental housing stock, as opposed to new construction or renovation projects may be one way to significantly expand the supply of housing appropriate for the population over a shorter timescale, which is critical to help meet the current unmet need and San Joaquin County residents quicker.

In addition to providing a greater number of homes over the same period, an additional strength of the existing home rental model relates to the fact that beds can be made much earlier in the project's lifespan, with the total capacity then steadily increasing over time. This compares to new construction or renovation projects where the units are typically only ready for habitation towards the end of the project when the building work is finalized. As a result, this means the Progressive Housing initiative can start to make a positive impact on the housing crisis much earlier, relative to programs that utilize other models.

Another possible advantage of the Progressive Housing model relates to the potential to scale up to help address the size of the housing crisis experienced in San Joaquin County. Across the five housing projects detailed, the housing stock for housing insecure individuals with SMI has been increased by 161. However, in the 2022 PIT survey, 2,319 sheltered and unsheltered homeless individuals were recorded as residing in the County, of which 33% reported having a mental health concern (n=765). Therefore, the current projects cover only 20.7% of the current unmet need amongst individuals with a mental health concern, and only 6.8% of the unmet housing need in San Joaquin County overall. While new construction and renovation projects are discrete operations, the utilization of the existing rental market can be continually expanded, contingent only on the finances made available and the existing rental house stock

in the region. As an indication of this, the parent company to SSHH - Sacramento Self Help Housing – is currently serving approximately 1,000 housing insecure individuals in the Sacramento region: a total almost 12 times larger than the capacity of the Progressive Housing initiative. This raises the possibility that the rental housing model currently being utilized under the Progressive Housing initiative could be expanded to serve an even greater proportion of San Joaquin County individuals currently in need.

Despite these strengths, the Progressive Housing model of utilizing the rental market comes with caveats. First, it is important to note that the housing solutions developed are not equivalent. For example, the other programs detailed in this deliverable concern the building of single-occupancy units, while the Progressive Housing model utilizes multiple beds within a single-family home. This is an important distinction, given in a survey completed by San Joaquin County stakeholders as part of the San Joaquin County Community Supports and Services (CSS) plan (San Joaquin County Behavioral Health Services, 2006), 83.7% of respondents identified single living units as the preferred housing type. Second, it is important to note that the shared housing model is not a one-size-fits-all solution. Some individuals may require a greater level of on-site support than what is available from a peer house leader, while for others who are more stable or higher functioning, the greater autonomy afforded by independent housing may be more appropriate. Third, the implementation of such a model is contingent on the availability of appropriate rental housing stock, which may fluctuate depending upon population migration and the number of new homes produced over time. Notably, expansion of the project was halted for 9 months in 2021 in part due to a significant increase in rental costs in the Stockton area. This suggests that the model may be challenging to implement in regions where the rental market for homes of sufficient size is either small, or highly volatile.

Due to the substantially different nature of the housing projects implemented by SJCBHS since 2008, a direct comparison between housing model costs was not feasible. However, the available data appears to suggest that the Progressive Housing model may require substantially fewer funds to initiate. Of the different projects examined, the Progressive Housing initiative was found to have the lowest start-up costs adjusted for the number of beds/units created, at $49,853 per bed. However, it is important to acknowledge that the ongoing costs may be higher. The unique features of the Progressive Housing approach (namely the renting of privately owned homes, and the costs associated with House Leaders) were estimated at $8,350 per bed, per year, based on November 2021 projections. Therefore, these should be considered as ongoing additional yearly costs that may be associated with the program’s structure. Overall, these findings suggest that the Progressive Housing service model can be delivered for at least equivalent costs to other housing approaches for equivalent target populations, with the likelihood that the Progressive Housing model has substantially lower initiation costs, and possibly higher ongoing costs.

Overall, the findings indicate that Progressive Housing represents a model where more homes can be made available for clients over a shorter timescale, and at a lower upfront cost. As a result, the program may represent one important avenue to help address the significant issue of homelessness present in San Joaquin County today. However, due to the range of housing needs present amongst housing insecure individuals experiencing SMI, the utilization of the Progressive Housing approach in conjunction with other may methods may represent the most appropriate path forward to expanding the housing supply needed for this population.

Satisfaction with Progressive Housing Service

The data contained within this section relates specifically to **Outcome 4.5** "Clients and house managers report high a level of satisfaction with services" of the Logic Model.

Guest/resident and House Leader service satisfaction were explored qualitatively through an in-depth semi-structured interview study. The interviews were conducted at the beginning of 2020, immediately before the COVID-19 pandemic began in the US. Consequently, the impact of COVID-19 on service delivery was not explored in this study. In addition to the interviews, guest/resident satisfaction was also explored quantitatively utilizing the CSQ-8 survey (Larsen et al., 1979) completed both at baseline (i.e., within 1 month of program entry) and then again 12 months into the program. A summary of these findings is presented below.

Qualitative Assessment of Satisfaction with Progressive Housing Services

Twenty-three participants completed the interview, including 18 guests/residents and five House Leaders. Two of the 18 guest/residents had left the program and one of the House Leaders had moved to a different role within SSHH before the interviews took place. Interviews ranged from 35-60 minutes. No participants refused to participate or did not complete the interview.

The demographic characteristics of the sample are presented in Table 14. Participant ages ranged from 21 to 59 (M = 44.12) and 41.2% identified as women. The most frequent duration of stay in the Progressive Housing homes amongst guest/resident participants was one to three months (n = 6, 35.3%); however, participating guests'/residents' length of stay ranged from two weeks to two years. Most participating guests/residents (n = 9, 52.9%) were in level 1 at the time of the interview. No participants were in level 3 or level 4. Participating guests'/residents' previous or current drug of choice included none (n = 2), alcohol (n = 1), cannabis (n = 2), cocaine (n = 2), heroin (n = 1), and methamphetamine (n = 9). Five guests/residents reported their prior living status as unsheltered homeless immediately prior to moving into one of the Progressive Housing homes, while 10 reported their situation as sheltered homeless (62.5%).

Table 14: Demographic Breakdown of Guest/Resident and House Leader Participants

Variable		
Age* (n=21 M SD)	44.12	10.4
Sex* (n=22, n %)		
Male	13	58.8
Female	9	41.2
Length of Stay (n=17, n %)		
Less than 1 month	2	11.8
1-3 months	6	35.3
4-6 months	2	11.8
7-11.9 months	4	23.5
1 year +	3	17.6
Current Level (n = 16, n %)		
Left program	2	11.8
Level 1	9	52.9
Level 2	5	29.4
Primary Substance (n = 17, n %)		
N/A	2	11.8
Alcohol	1	5.9
Cannabis	2	11.8
Cocaine	2	11.8
Heroin	1	5.9
Methamphetamine	9	52.9
Prior Living Situation (n = 16, n %)		
Housed / Housing Insecure	1	6.3
Sheltered Homeless	10	6.3
Unsheltered Homeless	5	31.3

* Totals Include both residents and house leaders

Guest/Resident Appraisal of the Progressive Housing Initiative

Almost all participants interviewed were positive in their appraisal of the services provided through the Progressive Housing Initiative. When asked, many participants struggled to identify anything they considered to be negative. Most guests/residents compared their current

situation either to living on the streets or to sheltered housing programs. Relative to unsheltered homelessness, participants described the program as something that enables them to focus on more aspects of life than just basic survival.

> *"What I've seen so far, I like everything. I mean I haven't seen nothing I dislike. I pretty much liked the whole thing. It's just a matter of time before I move up to level two or whatever and go from there. But I pretty much like the whole program. They laid everything out to me, the rules and everything when I first got off in the program. So, from what I've seen, I like the whole program."*
>
> -Guest/Resident 11

.

> *"I'm so comfortable from sleeping outside and having to survive, I'll go right back to surviving. But surviving is not living. Being in the house, I'm living again. I'm living a life instead of survival of the fittest. That's how I looked at it. Being homeless, it's survival of the fittest. Physically, mentally, emotionally, spiritually. Spiritually of all things. At the house, you don't have to survive, you can live."*
>
> -Guest/Resident 5

In comparison to alternative rehabilitation and sheltered living options, guest/resident participants identified many reasons why they prefer the services provided by Progressive Housing. Participants described other programs as much stricter, which impedes upon guests'/residents' ability to engage in normative behaviors/routines and to have the autonomy to make one's own choices. Participants also enjoyed the space provided by Progressive Housing, and recounted alternative programs as being overcrowded. The Progressive Housing homes were described as a place where one can relax and not feel constantly guarded and fearful of what may happen, which some guests/residents had felt in prior placements. Another essential aspect of Progressive Housing was the continuity of the program, allowing guests/residents to stay and continue to work on recovery and finding housing beyond the time it takes to become sober.

> *"I could not have been happier and more in awe of just all the services and how everything – it was like winning the lottery, really. All of a sudden, I get to live in a house with one roommate, where I'd been living in a dorm with 50 women for years, you know?"*
>
> -Guest/Resident 8

Addressing Needs and Goals

One frequent topic expressed by participants when appraising the program related to how the program serves participants' immediate and basic needs and supports their longer-term goals. In particular, guests/residents reported that by having their basic needs supported, they could then work towards more longer-term goals. Regarding long-term goals, some talked about concrete goals, such as securing their own apartment, obtaining appropriate documentation, going back to school, or achieving financial security. Many others talked about Progressive Housing facilitating a journey to recovery, developing self-worth, and resiliency.

> *"Self-Help Housing is making amazing strides for the community. I think what they're doing is an amazing thing because I've never heard of it before. And I was homeless for a minute, and it sucks to be somewhere with no roof over your head and you're hungry. And then they come in, they pick these people up off the street, they give them shelter, they give them food, they give them a bed, brand new beds. They give them hygiene. They give them everything that they need, you know what I mean? So, it doesn't get better than that. Their basic needs are met."*
>
> -House Leader 1

> *"This is the only chance I'm going to get. This is free housing; they actually want to help me better myself. So why not take advantage of it? So, I am. So, I went ahead, and I cleared up my tickets, I got my license taken care of. I'm going to become a citizen. I'm going to take care of my divorce. I'm doing all these little steps, and I'm staying clean."*
>
> -Guest/Resident 5

> *All the things that seemed so impossible like, "Oh, my god. I'll never do this. Oh, my god. I'll …". Now, it's like, "Oh, yeah. I can do this shit. Watch, I'll do this." And so far, I've been doing it. I've been doing little by little."*
>
> -Guest/Resident 10

The Homes

Almost all guests/residents were very positive about the homes themselves. Participants typically described the homes as large, clean, and safe. This is important, as residing in what

they considered to be good quality housing was identified as an important facilitator to recovery. The homes reportedly fostered a sense of pride, self-worth that was previously absent, and incentivized the guests/residents to remain sober.

> *"I love the way they bring you in and you have this beautiful, gorgeous home and you actually have your own space. I think it's gorgeous. I want to maintain it, it's a wonderful dream. "*
>
> -Guest/Resident 1

> *"It's kind of like an incentive almost. You're giving us a nice house, a nice place to live, there should be no reason for the alcohol use or the drug use."*
>
> -Guest/Resident 5

While everyone was very positive about the homes themselves, some offered suggestions to improve the amenities. Guests/residents noted that the homes lacked decorations, which made the houses feel less like a home. Others talked about the issue of not being able to send mail out from the home and how that impedes their ability to get in touch with essential providers such as doctors, potential employers, and financial communications, which creates barriers to recovery efforts. Similarly, guests/residents suggested providing office supplies like computers, printers, and fax machines to support vocational activities. Lastly, guests/residents had mixed thoughts on the gates around the property. Some felt it contributed to their sense of safety, while others felt more trapped and related it to the experience of being in prison.

> *"If I wasn't there, it wouldn't feel like a house because we have little cheap furniture. You know what I'm saying? There's no pictures on the wall. We got little bitty TV that sits way over there and stuff. If you guys are going to do anything, make this house into a home."*
>
> -House Leader 4

> *"If they provide something like that, maybe a computer inside the home, then that would be a little bit nicer to be able to complete your homework and complete your assignments and whatever you have to complete, real quick and type it. There's no fax machine. There's no printer. There's nothing like that. So, it's basic. But it's a beautiful house. It's great."*

-Guest/Resident 1

> *"Only thing I don't like, is when they lock that gate up at 11 o'clock. I had a problem with that when I first got off in the program because I have flashbacks every day. And when he locked that gate that reminded me of prison…They locked the gate at 11 o'clock, you got to be in about 11. The first night I got down here, locked that gate, I didn't know they was going to do that. So, I had all kinds of flashbacks to prison."*

-Guest/Resident 11

While guests/residents were mostly positive about the homes themselves, the perception of the neighborhoods they live in was mixed. Some thought that the neighborhoods were safe, while others did not. Other issues around the location of the homes identified by participants related to the proximity of the homes to triggers, such as areas where they may have typically sourced drugs in the past. Local amenities such as nearby parks, stores, and bus stops were central to feeling less isolated, and providing a space for residents to go if they needed time away from other housemates.

> *"Yeah, there's drugs up north too, I mean, but not like how it is down here. I mean, this house.. I don't got to walk out front and see some homeless guy screaming at nothing, or himself, or… I've seen some wild stuff just coming out of my house. And just like, "Really dude?" So, it's like since it is a program for people to try to get back on their feet, I think they should steer away from having houses in that area."*

-Guest/Resident 2

> *"Well, fortunately, we have a lovely park across the street from where we live, so I can go walk around in there, and they have everything from tennis courts to basketball courts to- where you play soccer or playground for the kids, all that good stuff. So fortunately, I had that to kind of distract me."*

-Guest/Resident 4.

House Rules

Participants discussed two main categories of rules: the importance of second chances in the model, and abstinence not being required for entry. Notably, a couple of participants also

mentioned the importance of being allowed to have pets in the homes. Pets provide comfort and support for individuals and having one is often a barrier to entering other housing services.

Importance of Second Chances

With regards to house rules, one that was frequently identified as a critical feature of the program was the importance of allowing second chances, and the non-punitive manner in which infractions were handled. Guests/residents indicated that this led to them feeling respected and fostered more open communication, which in turn better supports recovery. Guests/residents contrasted this with other programs in the area, where they reported that infractions typically led to eviction or expulsion.

> *"I like the way they respect us. I like the way that they give you chances here. Other substance abuse programs you mess up, you're out. You know?"*
>
> -Guest/Resident 8

> *"Instead of, 'Okay. You're being punished. This is what you did wrong. This is what you need to do. Deal with it.' It was more like, 'Hey, you did this. What can we do together to help that there's not another time that you do this?' I love that, because me being someone that doesn't like to hide anything, I was truthful. I wasn't trying to hide it. It wasn't like, 'Oh, no. Somebody put that there.' No, I did it. I own up to my mistakes. That's different -it's different for me- because I've always ran from my mistakes. So, I'm trying to do something different."*
>
> -Guest/Resident 5

Abstinence

The rule of abstinence not being a barrier to entry was frequently discussed. While many recognized that the low barrier model was critical for them being able to initiate engagement in the program, others talked about the challenges this can create for other guests/residents. Some guests/residents expressed a desire for stricter rules around sobriety, such as mandating sober living in Level 2 or enforcing sobriety with drug tests upon entry. Another guest/resident described entering the program sober, but then struggling with their sobriety once they saw that using was acceptable in the beginning.

> *"I do really feel like the way that they do it is right because you can't really expect someone to come off the street and just stop using like that, especially say, for*

me, for instance. Before I got in the shelters, I had six years on the streets […]. It's like, to go from using on the streets to coming into the house and just stopping like that? It's not going to happen. And if you're kicked out because you used as soon as you came in, then we're never going to get anywhere. We're going to continue to be homeless."

-Guest/Resident 8

"The only complaint I have with Progressive Housing is when I came into Progressive Housing all of a sudden, I had three months to clean up, because they give you—They expect most of the people are going to come in using, right? ...And they're going to get clean then. Well, I was the opposite. I had come in clean, but then all of a sudden, I got this feeling like, "Oh my gosh, I could use maybe a couple times, because I really have three months... It messed me up, yeah."

-Guest/Resident 8

Relationships amongst Guest/Residents

Positive Relationships amongst Guests/Residents

Most participants discussed having positive relationships with other guests/residents. Some participants described the house dynamic as familial, and guests/residents expressed feeling safe with their housemates and less lonely because of their relationships in the homes. Only two participants discussed how actively not making friends with their housemates enabled them to focus solely on themselves and their recovery.

"Everybody pretty much knows what everybody's doing. And if you need help or whatever, if you need something, you can ask them. We're buddies."

-Guest/Resident 4

"Yeah, we cool. Everybody cool. But I'm not that happy-go-lucky, I'm primarily focused on myself. I'm not in there to make no bestie and all that, focus on myself. If I can't love myself and take care of myself, how am I going to be good to anybody else?"

-Guest/Resident 13

Challenges of Living with Other Guests/Residents

While many individuals highlighted the positive dynamics in the house, the challenges of living with other guests/residents were also discussed frequently. The most pertinent issue was guests'/residents' verbally aggressive expressions. Both guests/residents witnessing and those perpetrating aggressive expressions discussed this discomfort. Those witnessing aggressive behaviors were distressed and sometimes afraid of the aggressor, and those committing aggressive behaviors felt distressed that they had no room to safely express negative emotions in the tight quarters of the house. Moreover, participants also noted struggles associated with living with individuals with SMI and that individuals' externalizing symptoms can be disruptive to the homes. In addition, participants communicated the challenges around guests/residents using substances. Not only was this behavior triggering to participants' recovery, but some suggested that others using substances were upsetting because they were "abusing the system" and taking recovery opportunities away from someone else.

> *"Sometimes I get a severe schizophrenic who talks all day and all night, and sometimes very loudly, and has a very disruptive, very insane type of laughter all night. All night, and people are losing sleep. I'm losing sleep. It gets very, very challenging sometimes. It gets very challenging."*
>
> -House Leader 2

> *"They were doing drugs and alcohol in the room the whole time I was there. In the Level 2 house. Not on Level 1. The Level 1, we were all clean. But the Level 2 house, I mean, one of the guys was always going to the store and getting beer. And they were smoking meth. And they were smoking weed. Oh god, it was just crazy, and that's not something that I want to be around."*
>
> -Former Guest/Resident 14

Another challenge in the homes was living in a mixed-gender environment. This was particularly important to some of the guests/residents who had previously experienced sexual trauma. Others, however, did not see it as an issue. Overall, safety amongst housemates was a frequent topic of conversation. While some guests/residents talked about specific incidents or individuals that led them to not feel safe, most guests/residents reported feeling safe in the homes amongst other guests/residents. Safety appeared more of a concern with newer guests/residents. For guests/residents who had been in the program longer, concerns around safety primarily came from proximity to those considered to be highly unstable due to mental health or substance use issues.

> *"The safety issue… is a little it's high-risk right now. Not sure if I'm safe where I'm at, you know? It's definitely new, and I don't really live with men. I usually stay with women, or one boyfriend and he blocks all the men. But this time, there's men in the house and so I'm a little scared as their outburst or my outburst or I don't want to fight with them, so it's a little uncomfortable. But I got to make it happen. You know what I mean? So, it's okay…I'm thinking if it was a all-girl house, I'd probably feel a little bit more comfortable. But, it is co-ed, so I do feel a little more cautious. You know?"*
>
> -Guest/Resident 1

Both the positive and negative experiences that guests/residents reported between housemates appeared even more acute when it concerned their roommate specifically, with twice as many participants discussing the difficulties of room sharing than positive experiences. Proximity led to either strong bonds, or flashpoints.

> *"If you've got a depressed [person] like that, they close the blinds. All they do is sleep, so if you're the roommate, how can you enjoy little time in your bed, if you don't want to go to sleep? You don't want to be asleep all fucking day. You can't even relax in the room, because if she's asleep, you don't want to bother her. So, I had to be outside, the whole fucking day."*
>
> -Guest/Resident 10

> *"I got to go into a much larger room with my own bathroom and what ended up being, so far, my favorite roommate. We got along the whole time. I was really happy to do stuff for her because she's quite a bit older than me and not as able as I am, so we got along real well."*
>
> -Guest/Resident 8

Housemates Impacting Recovery

Unsurprisingly, given the intensity of the relationships amongst housemates, both positive and negative, many talked about how these relationships impacted their recovery. Participants conveyed how relationships in the homes both facilitated and hindered recovery. Facilitators included addressing loneliness, friendships bolstering mental health, and other guests/residents serving as reminders of the life they don't want to go back to. On the other hand, when dynamics were tense in the house, participants discussed wanting to use substances to cope with their frustration. Seeing other people in the house use substances also triggered some

individuals to relapse. However, multiple individuals said other housemates did not impact their recovery.

> *"So, living with people that are fresh in their recovery, for me, it reminds me of what I don't want to go back…Not at all. Not at all. Not at all. If anything, it reminds me of what I don't want anymore, and how happy I am with my life today, and just to go back out and relapse, disappointing God, disappointing my family, losing my job. All the progress I've made in the last year, month, and 25 days would be for nothing. I just can't."*
>
> -House Leader 1

> *"Yeah, that's always good. Making friends is always healthy and it's something that gets you away from the bipolar-ness, and gets your mind off of the racing thoughts or the mania or the symptoms that occur."*
>
> -Guest/Resident 1

> *"You can't expect that nobody's going to break the rules, but my roommate was bringing meth in the room…And smoking it while I was asleep. One morning I rolled over and I saw her pipe and her torch laying right next to her. I had been depressed and we hadn't been getting along. I was like, "Oh, this might be a way to get high and maybe we could get along," you know? Because we would have that to share, because we had been fighting and stuff because I knew she had been doing this. So that's how I relapsed."*
>
> -Guest/Resident 8

Staff

With regards to the roles and characteristics of the staff involved in Progressive Housing, staff roles were broken down into two categories: House Leaders, and all other staff. Three main categories emerged: 1) the importance of communicating hope and encouragement, 2) House Leaders, 3) other housing staff. Notably, one participant also mentioned the need for more SSHH Staff to more adequately serve the growing number of guests/residents.

The Importance of Communicating Hope and Encouragement

Regardless of role, guests/residents and House Leaders emphasized the importance of communicating hope and encouragement in supporting guests'/residents' path to recovery.

Linked to this, almost all guests/residents reported having a positive, supporting relationship with staff involved in the program, both on the SSHH and SJCBHS side.

> *"They were just so supportive of me bettering myself, that I'd never had that with my family. I never had that with my ex-husband… when I came to this, it was like, "Oh, my god. They really give a fuck, so why am I going to let them down?" They have so much faith in me, that I can at least put 50%. And then I started putting 60%, and then until little by little, I was like, "I don't need a ride anymore, it's okay. I got it."*
>
> -Guest/Resident 10

> *"They push me because they know I can do it. Sometimes I do feel like I won't, like I'm losing. But I'm winning and they know I can do it. So, I appreciate the encouragement they're giving to me. Sometimes they've got to show me tough love and show me that they know I can do it and I know I can too."*
>
> -Guest/Resident 7

> *"[BHS staff are] so accepting and kind. They have hearts. When I was homeless, they helped feed me. I was hungry as shit sometimes, and all I need is just- I don't want money. I'm not trying to get drugs or alcohol or none of that shit. I just want something to eat. They've gotten into their own bag, in their own lunch sack and said, "Here, have my lunch instead." People don't do that. People don't just do that anymore. People with hearts do. People that care do. And those people out there, they care…It makes me emotional, because I have nothing to hide from it. It wasn't for behavioral health, I'd be dead. I would be dead, because I deal with so much inside. I'm a self-inflictor. I have self-hatred. I have all this no self-worth. They bring all that away and give me that self-love."*
>
> -Guest/Resident 5

House Leader Role

With regards to the House Leader role, most guests/residents saw it as an important and necessary position that does not need modification. House Leaders themselves talked about their role in very positive terms, saying the job provided a sense of purpose and felt that they are having a positive impact on the lives of some of the most vulnerable in their community. Others talked about how the role has had a positive impact on their own recovery. The most frequent criticism of House Leaders related either to not effectively implementing the rules, or

not being available, either due to being in their room too often or out of the house too much of the time.

> *"I absolutely love my job. I absolutely love this company. I think the things that they're doing in our community are amazing."*
>
> -House Leader 1

> "*It works both ways. You know what I mean? That person that's sitting over there, that could be me. Well, matter of fact, that was me at one time. It helps me a lot."*
>
> -House Leader 4

Progressive Housing as a Multidimensional System of Care

A key component of the Progressive Housing model is the integration of behavioral health services and housing together. Separately, neither can fulfill the stated aims. However, inter-agency work can be challenging, specifically regarding communication. Participants noted when guests/residents had a mental health concern or risk to themselves or others, then communication between House Leader reports to SSHH supervising team and SJCBHS seems to be quick. However, outside of the communication of risk issues, some guests/residents did voice concerns about the degree of communication and coordination between entities. Additionally, there was some suggestion that in situations where there is less immediate risk involved, while SSHH responds quickly, the House Leaders experienced some delays on the SJCBHS side. Furthermore, some guests/residents expressed frustration that they had reported incidents, but that this did not lead to the issue being resolved, or not being appropriately communicated up the chain of command. While most guests/residents and house leaders suggested that communication and response between the house leaders and the SSHH supervisors were prompt related to risk issues, others suggested that maintenance requests could take a long time to be fulfilled.

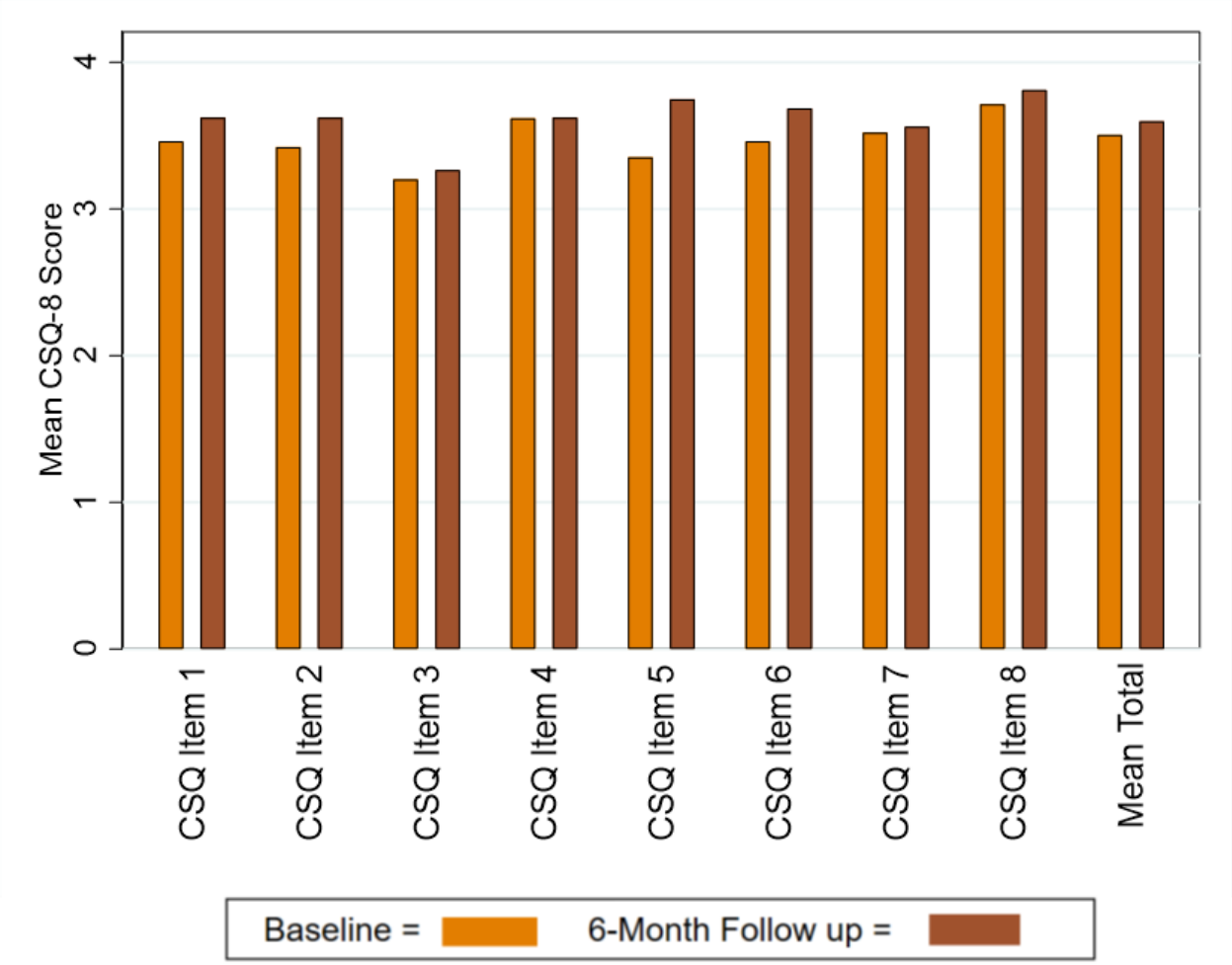
> *"So, if it was just housing without BHS, then we would just be housing hardcore drug addicts that are continuing to use drugs hardcore. And if it was just to be BHS without the housing, then it wouldn't be stopping, so nothing would change. So together, once we're done ironing out the kinks, it's looking to be an excellent program. So, they definitely need each other."*
>
> -House Leader 3

> *"I love that they really listen to us. Anytime there's a problem in the house, or there's a, what do you call it? An incident or something, the very next morning they're there to like figure out what happened."*
>
> -Guest/Resident 8

Quantitative Assessment of Satisfaction with Progressive Housing Services

The CSQ-8 was administered at baseline and one-year follow-up to gauge guests/residents' satisfaction with the Progressive Housing Initiative. Findings from both time points are presented in Figure 10. At baseline (n = 93), guest/resident overall satisfaction of the Progressive Housing Initiative was found to be high (M = 3.51, SD = 0.48). Notably, clients reported high levels of satisfaction on every item of the CSQ-8. After one year, while data was only available for a small subsample of the population (n=16), this very high level of satisfaction was maintained. Overall, this appears to indicate that amongst the clients who reported their satisfaction with Progressive Housing, they were very satisfied with the services they received. However, due to the large degree of missingness, particularly at the one-year follow-up stage, it is unknown if this degree of service satisfaction translates to the whole sample.

Figure 10: Guests/Residents Satisfaction with Progressive Housing Services at Baseline and One-Year Follow up.



Satisfaction with Services Summary

Overall, guests/residents and house leaders consistently reported a highly positive experience of being involved in the Progressive Housing system of care, particularly in comparison to previous housing experiences or what they consider to be realistic alternative options. In addition, most participants exhibited support for the overall structure of the program, including the role of the house leaders, the hierarchical structure of the program, and the multidimensional approach that incorporates both housing and community behavioral health treatment. The consensus was that the Progressive Housing Initiative is addressing an important unmet need for the San Joaquin area. Many guests/residents suggested that the initiative is providing critical services that support their long-term recovery. Those interviewed supported the structure of the program itself as currently delivered, which is significant given

the novel implementation of the Housing First system of care model. Additionally, some guests/residents proposed amendments that could potentially better address guest/resident needs or improve the implementation of the program. Such proposals are relevant both to the current program and to possible future iterations of the Progressive Housing Initiative.

Consistent with the qualitative interviews, when client satisfaction was examined quantitatively the available data indicates that guests/residents are highly positive about the services they receive, both at the point of program entry and one year into the program. This finding is particularly positive given the backdrop of COVID-19, where for much of the study period clients have experienced a significant reduction in services available, in addition to stricter controls around reduced visitation and isolation protocols.

Guidelines for Progressive Housing Implementation

The data contained within this section relates specifically to **Outcome 4.6** "Develop guideline for Progressive Housing Implementation" in the Logic Model.

Guest/resident and house leader proposals came from the qualitative interview study detailed in the "satisfaction with services'' section. The interviews were conducted in January 2020, immediately prior to the pandemic significantly impacting the implementation of the project. Therefore, the delivery of Progressive Housing services against the backdrop of the pandemic and the subsequent shelter-in-place mandate was not explored.

The participants interviewed identified multiple key features of the program, in addition to proposals for improved implementation. This feedback related to the homes, house rules, transitions between homes, facilitators to improved guest/resident relationships, the guest/resident selection process, House Leader role and characteristics, and the link between behavioral health treatment and housing.

Main Study findings

The Homes

- Good quality housing was considered as an important component of their recovery; helping to develop self-worth, foster pride, and provide an incentive to remain sober. Almost all guests/residents and house leaders were positive about the homes available through the program.
- The location of the homes was considered very important by participants. Being near parks, bus stops, and stores were viewed as helpful to recovery. Being away from potential triggers, such as areas with a high concentration of drug use/sales, or areas where they used to use was considered important to minimizing substance use.

- That the homes are stocked with essential hygiene and food supplies was considered very helpful, particularly to new guests who typically enter the home with very little. In homes with women guests/residents, what is available for new guests should be extended to include feminine hygiene products.
- In situations where this may be financially viable, some guests/residents suggested that access to a shared computer and more furnishings would improve the environment and support vocational activities.
- While this may not be viable due to leasing laws, some guests/residents suggested that having the ability to lock their rooms would be helpful to maintain safety and minimize the risk of theft.

House Rules

- Most participants recognized that the housing rules are more lenient than those typically employed in sheltered environments, and this was appreciated. For some, this was considered an important facilitator to remaining in the program.
- Allowing guests/residents to leave the homes for up to three days was considered important to ensure that guests/residents got the space they needed, particularly in moments of high stress.
- Abstinence not being a requirement to entry into services was also seen as a key component of the program. A number of those interviews suggested that if there was a requirement for abstinence at the beginning then they would not have been able to successfully engage in the program.
- Allowing for second chances, and the collaborative manner that infractions were dealt with was consistently praised by guests/residents. The approach appeared to make guests/residents feel supported and cared for, and lead to many guests/residents progressing further in their recovery rather than being evicted or leaving the program.
- Only a minority of those interviewed had pets. However, amongst pet owners, they reported that the fact they could have them in the home was considered critical to them engaging in the program. Moreover, being allowed to bring in pets was considered particularly important in the winter given temporary shelters do not typically accept animals.

Transitions Between Homes

- While the experience of transitioning between homes was mixed, almost all participants saw the progression between stages as an important component of the program.
- Guests/residents identified an important facilitator to improved transitions as communication. For new guests/residents, a clear timeline of when they may be moving was considered important to help plan for changes and alleviate the stress of moving. For existing guests/residents, prior notice for when somebody is moving into the home,

particularly when the person is a roommate, was considered important to ease the transition.
- Some thought hosting a welcome meeting each time a new person joins the home would be helpful both for new and existing guests/residents.

For new guests/residents in particular:

- House leaders emphasized the importance of giving new guests/residents space at first when they move into the home, particularly when the guests are first entering the program.
- Some house leaders also emphasized the importance of leniency about rules at the beginning to help with the transition. It was recognized that the shift from unsheltered housing to group housing is a major transition that individuals need time to successfully navigate.

Facilitators to Improve Guest/Resident Relationships

Many participants considered group cohesion within the home as critical to implementing the program successfully and supporting their ongoing recovery. In situations where relationships amongst housemates were difficult, this was seen to negatively impact both their recovery and their engagement in the program. Participants identified the following factors as important to fostering a positive group dynamic:

- Frequent group activities between the housemates were considered important to foster positive relationships within the homes, in addition to minimizing boredom and serving as a distraction from using substances.
- Group activities around food were seen as integral to fostering positive relationships. These include both hosting special events (birthdays, Thanksgiving meals, etc.), and preparing and eating food together as part of typical daily activities.
- Good communication between the housemates was considered important both to minimize the risk of conflicts and resolve situations where conflicts arise.
- Ensuring all guests/residents adhere to the rules was considered key to minimizing conflicts within the homes. Not using substances within the homes, doing chores, and respecting each other's possessions were identified as rules which had the greatest impact on the group dynamic.
- To support adherence to these rules, some guests/residents suggested that the house rules should be presented on the house notice boards.
- Some guests/residents highlighted the ability to have space away from the home during periods of high stress as important to maintaining relationships.
- Finally, participants emphasized the importance of compassion towards other guests/residents, recognizing that many had complex needs and had possibly experienced significant trauma in their lives.

The Guest/Resident Selection Process

- Guests/residents that are acutely ill or highly functionally impaired may face challenges to engaging in the program. This may lead to the guests/residents leaving the program prematurely and can create additional challenges for other housemates. To address this, some guests/residents suggested that these guests/residents identified as more acutely ill should instead be housed in an alternative service that can provide a higher level of care.

House Leader Role and Characteristics

- The role of house leader was considered integral to the successful implementation of the program.
- The most important characteristics for being a good house leader including strong communication skills; being friendly and approachable; being available, having strong observational skills; being able to maintain interpersonal distance from guests/residents; being respectful of boundaries; and being proactive, vocal, and consistent in the implementation of rules.
- Recruiting house leaders with lived experience was an important feature of the program, leading to a better understanding of guests'/residents' needs and supports, and serving as a positive role model for recovery. However, house leaders must be sufficiently progressed in their own recovery to ensure it does not negatively affect their ability to fulfill the role.
- When placing house leaders in homes, different characteristics were considered important for different stages. House leaders suggested a more nurturing, supportive approach as more important in Level 1, relative to Levels 2-3. At higher levels, more distance was considered helpful to further facilitate resident independence.
- Some house leaders felt that the pay should be more, given the challenges inherent to the role, and the amount of hours there required to be on site.

The Link between Behavioral Health and Housing

- The provision of community behavioral health treatment and secure, stable housing in unison was both considered critical in ensuring the success of the other and supporting ongoing recovery.
- When risk issues or behavioral health concerns arose within the home, most participants felt that both SSHH and SJCBHS responded quickly and proactively. This was considered to be important to the successful implementation of the program, ensuring all the guests/residents were safe and that the house leaders felt adequately supported.
- To improve interagency collaboration, some guests/residents suggested that it would be helpful for the separate entities to have a better understanding of the range of services that each provides.

Guidelines for Implementation Summary

Participants identified multiple core elements to the successful implementation of the program, which is important information both for the ongoing implementation of the current initiative, and in any future iterations that may adopt a stepped-care, group-housing approach to the Housing First model. In addition, participants identified numerous areas that could potentially better address the needs of those served.

In response to these recommendations, SSHH and SJBHS implemented a series of modifications and improvements to the program. The most substantial modification included the integration of “entry point homes”, implemented in January 2021. Multiple residents reported concern that some new clients enter the system that are not sufficiently stable to successfully integrate into a shared home environment, and that this led to significant disruptions to the home dynamic and the recovery trajectories of other guests. To address this, the program incorporated a home where clients would stay for approximately 10 days, before entering the program into a level 1 home. Doing so served two purposes: 1) The entry-point home served as a space where potential guests could be screened for COVID-19, thus limiting exposure to other guests. 2) They served as a space where a preliminary assessment could be performed to determine their suitability for the program, and provide short-term, elevated level of support as needed in a space that did not impact clients who had already engaged in the program.

Regarding other modifications in response to the interviews, SSHH have worked to improve the furnishings of the homes and supported more social events around food to facilitate relationships between guests (e.g., BBQ and ice cream days, holiday celebrations). Towards the end of the project, tablets were made available to provide internet access and promote telehealth options.

Discussion

Over the course of the project, SSHH and SJCBHS met the primary goals and objectives regarding the implementation of the Progressive Housing Project. By leasing 17 properties, the program has achieved the top end of its target of 12-18 homes, as detailed in the original MHSOAC proposal. Notably, this is despite the substantial challenges brought on by the COVID-19 pandemic and a challenging rental market in Stockton. Additionally, the program has successfully recruited a substantially higher number of clients than originally proposed.

The Progressive Housing Initiative has also been highly successful at engaging and providing services to Black/African American and Hispanic/Latinx individuals who are historically underserved in community behavioral health settings (California Pan-Ethnic Health Network, 2015). The racial and ethnic breakdown of the current Progressive Housing sample is broadly consistent with the demographic distribution of the unsheltered homeless detailed in the 2019 Point in Time survey of the unsheltered homeless (San Joaquin Continuum of Care, 2019). The Progressive Housing Initiative has also been successful at recruiting a representative sample of homeless military veterans into the program, which is important given SSHH's commitment to end local homelessness among veterans (https://www.stocktonselfhelp.org/what-we-do). These findings highlight the success of the engagement, outreach, and referral pathway into care operated by SJCBHS.

The data collected both quantitatively via surveys and through the qualitative interviews indicate that guests/residents engaged in the Progressive Housing Initiative are overall highly satisfied with the services they receive. In the quantitative interviews, guests/residents spoke positively of the quality of the housing, particularly when compared to other housing solutions available. The relatively low barrier to entry, the leveled housing approach, the collaborative relationship between providers and guests/residents, and the critical role of House Leaders were all identified as important components of the project that led to high satisfaction levels. More mixed was the relationship between guests/residents in the homes, where this was considered both a significant advantage of the project, but also in many cases a significant cause of stress.

The high levels of satisfaction reported by guests/residents were evident both at entry into the program and after one year of receiving services. Encouragingly, there was no evidence of a reduction of satisfaction with the program with the onset of COVID-19, despite it causing a substantial reduction in available services and restrictions around home visitations. While the reasons for satisfaction remaining so high was not explored quantitatively, one factor for this may be the increase in social events hosted by SSHH and efforts to further renovate the homes to offset the challenges experienced as detailed in the interviews. However, it is important to note that satisfaction was only measured for clients currently enrolled in the program. It may be that dissatisfied clients dropped out of the program.

Consistent with early evaluations, the baseline guest-/resident-level data indicates that the program is continuing to be successful at engaging individuals from the target population. This includes individuals with SMI who have experienced homeless over a prolonged period, often over multiple episodes. Additionally, all clients reported some combination of an active SUD and multiple areas of impairment in functioning. Almost all the guests/residents included individuals who had already been seen by SJCBHS previously, so it is unclear how successful the program has been at engaging "unserved individuals" (i.e., those who have not received any form of behavioral healthcare). However, almost no guests/residents were actively engaged in any form of substance use counseling at the point of program engagement, indicating that the Progressive Housing Initiative could represent an important pathway to engaging guests/residents in appropriate care.

Regarding challenges to the implementation of the program, it is important to highlight the very high dropout rate from the Progressive Housing Initiative, particularly when compared to other Housing First models. The high dropout is likely to be attributable to multiple factors, including a low barrier to entry model, meaning multiple individuals came into the project that were later found to need a higher level of care, the group home structure leading to a significant source of stress and conflict for some individuals who exhibit significant impairments in social functioning, and the additional challenges caused by COVID-19. Notably, when people did leave the project, in the majority of cases (57.5%) it was within the first three months of engagement. These findings suggest that in future iterations of the project greater support for individuals entering the program during the initial stages, and potentially more stringent eligibility criteria to ensure that people who engage in the project are sufficiently able to manage a shared home environment may be important to improving program retention.

The outcomes of the project were examined utilizing selected items from the ANSA and exploring the proportion of individuals who returned either to work or some form of education. Unfortunately, baseline and follow up data was only available for a small proportion of guests/residents (n=22, 8.2% of all participants). However, in this small cohort it was evident that over the course of a year participants experienced significant improvements in residential stability and living situation, while there was also some evidence to suggest impairments related to substance use also improved. In addition, relative to earlier reports the data indicates some positive trends regarding guests/residents entering the workforce. Due to the small sample size these findings should be interpreted with caution. However, these tentative findings are encouraging, and merit further exploration.

When the Progressive Housing project was compared with other housing projects completed in San Joaquin County for SJCBHS clients with SMI it was evident that homes could be made available at a much faster rate relative to renovation and new build projects. Additionally, the initial project costs appeared to be far lower for the Progressive Housing model that relied on utilizing the rental market, rather than projects that center around new construction or

repurposing existing structures. That said, it is important to note that this does not take into consideration ongoing costs, which may be higher for Progressive Housing. Given the scale of the current homelessness evident in San Joaquin County (2,319 individuals were identified as homeless in the 2022 Point-in-Time Survey), a housing model that can be implemented quickly, and with relatively low initial costs, may represent an important path forward to addressing a critical need in the region. However, a shared housing solution may not be appropriate for everyone, and so the broader implementation of some variation of the Progressive Housing model in conjunction with projects that deliver single occupancy units may represent the most appropriate path forward to address the current needs of the community.

Conclusion

The findings indicate that the Progressive Housing Initiative has been highly successful at delivering low-barrier housing for San Joaquin County residents with complex needs in a manner broadly consistent with Housing First principles. SSHH has successfully opened 17 homes meaning they have achieved the target originally outlined in the MHSOAC proposal. Clients who are receiving services report being highly satisfied with the care that they receive, despite the additional restrictions and reductions in services available due to COVID-19. Consistent with the findings from the interim report, the program has been highly successful at engaging a representative sample of the San Joaquin County homeless population, including a representative proportion number of women, Black/African American people, Hispanic/Latinx people, and military veterans. The program is successfully engaging clients who report experiencing complex behavioral health needs, significant functional impairment, and have experienced chronic homelessness that the program was designed to serve. Finally, relative to alternative housing solutions the Progressive Housing model of care is quick to implement with lower initial costs, although ongoing costs may be higher.

In future iterations of the project, more refined selection criteria to identify those most appropriate for a shared home environment, greater support for guests/residents at the point of entry in the program, addressing the challenge of providing ongoing services during the pandemic in a shared home environment, and providing greater occupational support to guests/residents as they progress through the service may represent important modifications to the model. These changes could improve program retention and recovery outcomes for the individuals served.

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Appendix I: Housing First Fidelity Assessment

Please select the answer choice that best describes the **housing process and structure** that this program offers its participants (Questions 1-2).

1. What percent of participants live in housing that is considered emergency, short-term, transitional, or time limited, in that participants are expected to move when either standardized criteria or individual milestones are met?

0-14% 15-29% 30-44% 45-59% 60-84% 85-100%

2. What percent of participants live in scattered-site permanent supported housing, wherein less than 20% of the units are leased by the program?

0-14% 15-29% 30-44% 45-59% 60-84% 85-100%

Please select the answer choice that best describes **how housing and services are related** in this program (Questions 3-4).

3. What requirements do program participants have to meet in order to gain access to permanent housing? (**choose all that apply**)

Completion of a period of time in transitional housing, outpatient, inpatient, or residential treatment

Sobriety or abstinence from alcohol and/or drugs

Compliance with medication

Psychiatric symptom stability

Willingness to comply with a treatment plan that addresses sobriety, abstinence, and/or medication compliance

Agreeing to face-to-face visits with staff

Meeting responsibilities of a standard lease

4. If yes, which of the following provisions does the lease or agreement contain? (**choose all that apply**)

Provisions regarding adherence to medication, sobriety, and/or a treatment plan

Provisions regarding adherence to program rules such as curfews or overnight guests

Provisions regarding adherence to face-to-face visits with staff

Provisions regarding creating behavioral disturbances with respect to other residents

Please select the answer choice that best describes the **service philosophy** of this program (Questions 5-8).

5. To what extent do program participants choose the type, sequence, and intensity of services on an ongoing basis?

Services are chosen by the service provider, with little no input from the participant

Participants have some say in choosing, modifying, or refusing services, although program staff determinations usually prevail

Participants have some say in choosing, modifying, or refusing services, although participant preferences usually prevail

Participants have the right to choose, modify, or refuse services and supports at any time, except one face-to-face visit with staff a week

6. What are the requirements for participants with serious mental illness (SMI) to take medication or participate in psychiatric treatment such as attending groups or seeing a psychiatrist?

All participants with SMI are required to take medication and/or participate in treatment

Most participants with SMI are required to take medication and/or participate in treatment, but exceptions are made

Participants with SMI who have not achieved symptom stability are required to take medication and/or participate in treatment

Participants with SMI are not required to take medication and/or participate in treatment

7. What are the requirements for participants with substance abuse (SA) disorders to participate in SA treatment such as inpatient treatment, attending groups, or counseling with a substance use specialist?

All participants with SA disorders, regardless of current use or abstinence, are required to participate in SA treatment

Participants with SA disorders who have not achieved a specified period of abstinence must participate in SA treatment

Participants with SA disorders who are currently actively using substances must participate in SA treatment

Participants with SA disorders are not required to participate in SA treatment

8. What is the program's approach to substance use among participants?

Participants are required to abstain from alcohol and/or drugs at all times

Participants are required to abstain from alcohol and/or drugs while they are in their residence

Participants are not required to abstain from alcohol and/or drugs, but staff work with participants to achieve abstinence

Participants are not required to abstain from alcohol and/or drugs, but staff work with participants to reduce the negative consequences of use and/or utilize appropriate stage matched interventions

Please select the answer choice that best describes the **service array** of this program (Questions 9-14).

9. What types of services, if any, are available to participants who are in need of substance use treatment? (**choose all that apply**)

Substance use treatment services are not available

Systematic and integrated screening and assessment

Interventions tailored to change readiness

Outreach or motivational interviewing CBT, relapse prevention, or other EBP or Promising Practice (e.g. BRITE)

10. What types of services, if any, are available to participants who are interested in paid employment opportunities? (**choose all that apply**)

Employment services are not available

Vocational assessment

Individualized short-term employment (e.g. day labor)

In-house work experience or sheltered work (e.g. Goodwill)

Community based employment

11. What types of services, if any, are available to participants who are interested in education? (**choose all that apply**)

Educational services are not available

Educational assessment

In house education (e.g. literacy remediation)

Adult school, vocational training, trade school / apprenticeship

Supported education in the community (e.g. community college)

12. What types of services, if any, are available to participants who are interested in volunteering? (**choose all that apply**)

Volunteering services are not available

Volunteering capability and interest assessment

Individualized short-term volunteering

In house volunteer experience or sheltered experience

Community based volunteering

13. What types of services, if any, are available to participants who have medical (physical health) issues? (**choose all that apply**)

Medical/physical health services are not available

Screening for medical problems or medication side effects

Managing medication related to physical health

Communicating and coordinating services with other medical providers

Health promotion, prevention, education activities

On-site diagnosis and treatment of physical health conditions

14. What types of social integration services, if any, are available to participants? (**choose all that apply**)?

Social integration services are not available

Basic social skills training (e.g., maintaining eye contact, holding a conversation)

Group recreational/ leisure activities (lunches, sporting events, senior center)

One-on-one support for developing social competencies (e.g., help with empowerment, resolving problems with members of social network, establishing trust)

Services to help support or expand participants' social roles (e.g., employee / volunteer, sibling/ parent / grandparent, neighbor)

Support for activities pertaining to citizenship or civic participation (e.g., help with advocacy, voting, community involvement, faith community involvement)

Please select the answer choice that best describes the **team structure/human resources** of this program (Questions 15-16).

15. How often do program staff meet to plan and review services for participants?

Program staff meet less than one day a month

Program staff meet 1 day per month

Program staff meet 1 day per week

Program staff meet 2-3 days per week

Program staff meet at least 4 days per week

16. To what extent does the program use its team meetings to meet the following functions? (**choose all that apply**)

Conduct a brief, but clinically relevant review of any participants with whom they had contact in the past 24 hours

Conduct a review of the long-term goals of all clients on a regularly scheduled basis

Develop a staff schedule based on participant schedules and emerging needs

Discuss need for proactive contacts to prevent future crises

Review previous staff assignments for follow through

Appendix II: Qualitative Interview Guides

Interview Guides for Guests/Residents

Introductory Questions:

- How long have you been a guest/resident at one of the Progressive Housing homes?
- What was your housing situation immediately before staying in one of the Progressive Housing homes?
- What level home do you currently live in?

Questions Specific to the Housing Model:

- What has your experience been of living in the homes at each level?
    - Were there any levels where you found it easier or harder to manage?
- Have you ever switched levels during your stay at a Progressive Housing home?
    - If so, did you move to a new house, or did the rules of the home itself change?
        - What was that experience like for you?
- If you have had to move homes during your stay in the Progressive Housing system, did you find that move easy or difficult?
    - Was there anything that made it harder to manage?
    - Was there anything that made it easier to manage?
    - What type of changes could be made to make it easier in the future?
- Have you had new residents move into a home in which you have stayed?
    - Was having a new resident easy or difficult to manage for you as an existing resident?
    - What kind of changes could be made to make it easier for the existing residents in the future?
- When it's time to move to the next level of housing, would you prefer it if you moved to a new home, or if the whole house together moved up to the new level?
    - Why?
- What has your relationship been like with the other residents?
    - Do you think having a good relationship with the other residents is important, or unimportant? Why?
        - Have your relationships with other residents made it easier or harder to adjust to your living situation?
        - Has having relationships made it easier or harder to achieve your treatment or life goals?
    - Can you think of any changes might help improve the relationships between residents?

Acceptability/Challenges/Solutions to living in PH model:

- What are some of the things you like about this Progressive Housing system?
- Is there anything you dislike about this housing system?

- If so, what?
- What has been helpful for you in adjusting to this new living situation?
  - [Refer back to previous living situation as appropriate]
- What have been some of the biggest challenges you have had to deal with while living in these homes?
  - If so, has there been anything that has helped you overcome these challenges?
  - Did anything make it harder to overcome these challenges?

Safety:

- What has your experience of safety or lack of safety been like since moving into these homes?
  - What, if anything, has made you feel safe?
  - What, if anything has made you feel unsafe?
  - What, if anything, would you change to make it feel more safe living in these homes?

Questions about House Leaders:

[FIRST: EMPHASISE ANONIMITY. THIS WILL NOT BE COMING BACK TO THE HOUSE LEADER. ALSO, THIS IS NOT NECESSARILY A CRITIQUE OF THE HOUSE LEADER THEMSELVES, BUT MORE ABOUT UNDERSTANDING IF THE ROLE IS HELPFUL/UNHELPFUL, AND IF THERE IS ANYTHING THAT CAN BE DONE TO MAKE THE ROLE MORE HELPFUL TO ADDRESS YOUR PARTICULAR NEEDS]

- Have there been any advantages to having a peer in the House Leader role in the house?
  - If so, what?
- Have there been any disadvantages to having a peer in the House Leader role in the house?
  - If so, what could be done to help address these disadvantages?
- What other changes that could be made to the House Leader role that could better help you achieve your goals?

Final Questions:

- Are there any other important issues about living in this housing system that we haven't discussed?
- Do you have any final thoughts about how the experience of living in this housing system could be improved?

Interview Guide for House Leaders

Introductory Questions:

- How long have you been a House Leader at one of the Progressive Housing homes?
- Prior to being a House Leader, did you stay in one of the Progressive Housing homes as a guest/resident?
- What level home do you currently live in?
- Have you been a House Leader for a home at any other level?
- Have any of the homes you have led switched levels?

Questions Specific to being the House Leader:

- What made you decide to be a House Leader?
- Do you think having a house leader in the home plays any role in resident's recovery?
- Have you had any experience going through recovery?
    - IF YES: How has being a House Leader impacted your recovery (be it good or bad)?
        - If there have been challenges, what, if anything, have you found helpful to deal with them?
- Have you previously been a guest or resident of this program?
    - If yes: Has the increased responsibility of being a House Leader, as opposed to resident been easy or difficult to handle?
    - What might be done to make the role easier to manage?
- What do you think makes it easier or harder for the new resident to adjust to the new home?
- What do you think makes it easier or harder for the existing residents to adjust to living with the new resident?
- What is the relationship between you and the other residents in the home like?
    - Do think this this relationship impacts their recovery in any way? If so, how?
- From what you have seen, what have the relationships been like between the residents in the homes you have led?
    - In what way do these relationships impact resident's recovery?
    - What types of things might help improve the relationship between the residents?

Acceptability/Challenges/Solutions to living in PH model:

- What, if anything, do you like about this Progressive Housing system?
- What, if anything, would you improve in the program?

Safety:

- Have you felt safe or unsafe living in these homes?
    - Has there been anything that has made you feel more or less safe?
    - Do you think the other residents feel safe?
    - Is there anything that could be changed to make the home feel safer?

Final Questions:

- Are there any other important issues about being a House Leader in this housing system that we haven't discussed?
- Do you have any final thoughts about how the experience of being a House Leader could be improved?

Appendix III: SJCBHS Baseline Data Collection Tool

Progressive Housing Program Data Collection Tool (6/25/20)

INTERVIEWER: Statements/questions in bold text below are questions and/or verbal prompts that should be used as close to verbatim as reasonably possible. *Unless otherwise noted, all questions pertain to the individual's status at the time of interview.*

1) Unique Identifier (Number provided only upon placement at SSHH house): _____

2) Housing Start Date (Date individual is actually placed at a SSHH house): _____

3) **What is your full name?**: _____

4) BHS Medical Record # (if applicable): _____

5) Case Manager (if applicable): _____

6) **What is your age?**: _____

7) **Are you currently participating in any type of educational or vocational support program to help you with school or get a job**?

   YES __ NO ___

   If "YES": Month and year (best estimate is okay) participation in education or vocational support program began:

   _____/00/_____

8) **Are you currently participating in any type of substance use disorder (SUD) treatment?**

   YES ___ NO ___

   If "YES", Month and year (best estimate is okay) SUD treatment participation began:

   _____/00/_____

9) **Do you currently have or have you ever been given a substance use disorder diagnosis?**

YES ___ NO ___

If "YES", **If you can recall, what was your most recent substance use disorder diagnosis was?** Enter stated primary diagnosis below:

_____

If "NO" or the individual cannot recall, verify in CG. If history is present, take the primary substance use disorder SUD diagnosis from the following sources, in the order listed:

a. Most recent CG psychiatrist note
b. Most recent Adult Assessment
c. Most recent Crisis Screening

If "NO" or the individual does not know or is unable to recall, but a substance use disorder diagnosis is suspected and there is no information from one of the sources above, enter "F19.00, Unspecified Other (or Unknown) Substance-Related Disorder"

10) If individual has a history of or is currently using substances, **"What's your drug or substance of choice?"** Alternate question if individual has a difficult time answering: "**If all the substances you've ever used were on a table in front of you, and you could only choose one, which one would you choose?"** _____

11) **Are you currently or have you ever participated in outpatient mental health services before?** Participation is defined as opened to BHS Outpatient Case Management services and having attended at least one psychiatric appointment. If services were provided in SJC, verify in CG before completing. If outside of County, rely on individual's self-report:

YES ___ NO ___

If "YES": Month and year of opening to BHS Outpatient Case Management services. If services were provided in SJC, verify in CG before completing. If outside of County, best estimate is okay:

_____/00/_____

12) **Do you currently have a BHS Case Manager**? Verify in CG, if needed.

YES ___ NO ___

If "YES", **Do you know which program?** _____(Staff member: if individual is unsure, verify in CG, and/or consult with a Supervisor or Manager. Please note that not all programs qualify as BHS Case Management services.)

13) **Do you currently have, or have you ever been given a mental health diagnosis?**
YES ___ NO ___

If "YES": **If you can recall, what your most recent mental health diagnosis was?** Enter stated diagnosis/diagnoses below:

_____

If "NO" or the individual cannot recall, verify in CG. If history is present, take the primary mental health diagnosis from the following sources, in the order listed:

a. Most recent CG psychiatrist note
b. Most recent Adult Assessment
c. Most recent Crisis Screening

If "NO" or the individual does not know or is unable to recall, but a mental health diagnosis is suspected and there is no information from one of the sources above, or if services were in another County, enter: "R69, Diagnosis Deferred"

14) **Do you currently have Medi-Cal benefits?** YES __ NO ___

If "YES", **Do you have your Medi-Cal card with you, or can you remember what year you first received Medi-Cal benefits?** If the individual can remember the year, but not the month, help them narrow it down by asking if they recall what season it was (i.e. winter, spring, summer, fall). The best estimate is better than nothing.

Month and year (best estimate is okay) Medi-Cal Benefits began:
_____/00/_____

15) **Do you currently have reasonably easy access to these documents? If you don't, this will <u>not</u> affect your ability to participate in the Progressive Housing program:**

a. IDENTITY: **A birth certificate, paycheck, driver license, U.S. passport, U.S. military ID, school records, State ID, or Indian Native Tribal documents?**
YES _ NO___

b. SOCIAL SECURITY NUMBER: **A social security card, Medicare card, or Award Letter? YES _ NO___**

c. IMMIGRATION STATUS: **If applicable, Immigration and Naturalization Service documents to verify your immigration status?**

YES _ NO___

d. RESIDENCE: **A California driver's license or Identification Card, utility bill, rent receipt, mortgage receipt, check stub, any official document showing a California address to provide your state residency?**

YES ___ NO____

e. INCOME: **Recent pay stubs, a signed statement from an employer, a copy of tax returns, or bank statements?**
YES _ NO___

f. UNEARNED INCOME: **A recent Cost-Of-Living Increase Notice or Award Letter from Social Security, a current bank statement and copy of a current Social Security check, or a statement signed by a person who has provided you with unearned income? YES _ NO___**

g. RESOURCES: **If you have assets such as a checking or savings account, life insurance policy, trust, or other property, do you have documents that prove their value?**

N/A __ YES ___ NO ___

POINT OF FIRST CONTACT CANSA ITEMS

Unless otherwise noted, base your ratings on the 30 days prior to interview. For each item, circle the number of one response item that best captures the individual's status and/or history, as appropriate.

"The following section involves answering some questions that give us an idea of what areas of life you might be struggling in, and how, should you participate in it, the Progressive Housing Program might best support you."

1) CRIMINAL/DELINQUENT BEHAVIOR

Within the last 30 days, even if you weren't caught or arrested, have you engaged in any behavior that could have resulted in police involvement or arrest? Have you ever been arrested?

0 No evidence of any needs. No evidence or no history of criminal/delinquent behavior.

1 Requires monitoring, watchful waiting, or preventive action. This may have been a risk behavior in the past. History or suspicion of criminal/delinquent behavior, but none in the recent past. Status offenses would generally be rated here.

2 Action or intervention is required to ensure the identified need is addressed. Currently engaged in criminal/delinquent behavior (e.g., vandalism, shoplifting, etc.) that puts individual at risk.

3 Intensive and/or immediate action is required to address the need or risk behavior.

Serious recent acts of delinquent activity that place others at risk of significant loss or injury, or place individual at risk of adult sanctions. Examples include car theft, residential burglary, and gang involvement.

2) SUBSTANCE USE

Have you or anyone else ever had concerns about your own alcohol or substance use? Have you ever been arrested or hospitalized due to anything related to your alcohol or substance use? Have you ever participated in a recovery program for drugs or alcohol?

0 No current need; no need for action or intervention. Individual has no notable substance use difficulties at the present time.

1 Identified need requires monitoring, watchful waiting, or preventive activities. Individual has substance use problems that occasionally interfere with daily life (e.g., intoxication, loss of money, reduced work/school performance, parental concern). History of substance use problems without evidence of current problems related to use is rated here.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with individual's functioning. Individual has a substance use problem that consistently interferes with the ability to function optimally, but does not completely preclude functioning in an unstructured setting.

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Individual has a substance use problem that represents complications to functional issues that may result in danger to self, public safety issues, or the need for detoxification of the individual.

3) RESIDENTIAL STABILITY

What is your current living situation? How many times have you moved in the last year?

0 No current need; no need for action or intervention. Individual has stable housing for the foreseeable future.

1 Identified need requires monitoring, watchful waiting, or preventive activities. Individual has relatively stable housing, but has either involuntarily moved in the past three months or there are indications housing problems could arise at some point within the next three months.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with individual's functioning. Individual has moved multiple times in the past year. Housing is unstable.

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Individual has experienced periods of homelessness in the past six months.

4) SOCIAL FUNCTIONING (INTERVIEWER: Do you feel that the individual can act appropriately in social settings?)

Would you say that you get along with others easily, or do you find yourself frequently having disagreements, or getting into arguments with others?

0 No current need; no need for action or intervention. No evidence of problems and/or individual has developmentally appropriate social functioning.

1 Identified need requires monitoring, watchful waiting, or preventive activities. There is a history or suspicion of problems in social relationships. Individual is having some difficulty interacting with others and building and/or maintaining relationships.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with functioning. Individual is having some problems with social relationships that interfere with functioning in other life domains.

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Individual is experiencing significant disruptions in social relationships. Individual may have no friends, have constant conflict in relations with others, or have maladaptive relationships with others. The quality of the individual's social relationships presents imminent danger to the individual's safety, health, and/or development.

5) SLEEP

About how many hours do you sleep each night? Do you have trouble falling asleep, staying asleep, or waking up early? Do you often find yourself sleepy during the day?

0 No current need; no need for action or intervention. Individual gets a full night's sleep each night.

1 Identified need requires monitoring, watchful waiting, or preventive activities. Individual has some problems sleeping. Generally, individual gets a full night's sleep but at least once a week problems arise. This may include occasionally awakening, bed wetting, or having nightmares.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with individual's functioning. Individual is having problems with sleep. Sleep is often disrupted and individual seldom obtains a full night of sleep.

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Individual is generally sleep deprived. Sleeping is almost always difficult and the individual is not able to get a full night's sleep.

6) ACTIVITIES OF DAILY LIVING (INTERVIEWER: Does the individual appear to be able to take care of themselves?)

How do you get the basic things you need, such as food, clothing, and hygiene supplies? Are you able to cook your own meals and clean your own living area? Do you have any difficulty with toileting, including making it to the restroom on time or cleaning up after yourself if you aren't able to?

0 No current need; no need for action or intervention. No evidence of problems with activities of daily living. The individual is fully independent across these areas, as developmentally appropriate.

1 Identified need requires monitoring, watchful waiting, or preventive activities. Mild problems with activities of daily living. The individual is generally good with such activity, but may require some verbal prompting or support to complete some specific developmentally appropriate activities.

2 Action or intervention is required to ensure that the identified need is addressed; need is interfering with individual's functioning. Moderate problems with activities of daily living. The individual has difficulties with developmentally appropriate activities. For example, they may require assistance (physical prompting) on self-care task or attendant care on a single self-care task (e.g., eating, bathing, dressing, or toileting).

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Severe problems with activities of daily living. The individual requires significant and consistent support to complete developmentally appropriate activities such as eating, bathing, dressing, toileting.

7) TRANSPORTATION

Do you have your own transportation? Do you use public transportation? If not, what keeps you from using public transportation? How do you get to the places you need to go?

0 No current need; no need for action or intervention. Individual has no transportation needs. Individual is able to get to appointments, school/work, activities, etc.

1 Identified need requires monitoring, watchful waiting, or preventive activities. Individual has occasional transportation needs. Individual's difficulties getting to appointments, school/work, activities, etc. do not significantly impact the individual's participation in these activities.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with functioning. Individual has frequent transportation needs – getting to appointments, school/work, activities, etc. – which impact the individual's ability to consistently participate in these activities. The individual needs assistance and access to transportation resources, which may include a special vehicle (such as a bus or modified vehicle).

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Individual has no access to appropriate transportation and is unable to get to appointments, school/work, activities, etc. Individual needs immediate intervention and development of transportation resources, which may include a special vehicle (such as a bus or modified vehicle).

8) LIVING SITUATION (INTERVIEWER): If the individual has been in respite, brief detention/jail, and brief medical and psychiatric hospitalization for the last 30 days, based on current presentation, consider what the individual's behavior would likely have been in a community setting.)

How have you managed your living situation within the last month? What's the most difficult part of how, where, or who you are living with now?

0 No current need; no need for action or intervention. No evidence of problem with functioning in current living environment. Individual and caregivers feel comfortable dealing with issues that come up in day-to-day life.

1 Identified need requires monitoring, watchful waiting, or preventive activities. Individual experiences mild problems with functioning in current living situation. Caregivers express some concern about individual's behavior in living situation, and/or individual and caregiver have some difficulty dealing with issues that arise in daily life.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with individual's functioning. Individual has moderate to severe problems with functioning in current living situation. Individual's difficulties in maintaining appropriate behavior in this setting are creating significant problems

for others in the residence. Individual and caregivers have difficulty interacting effectively with each other much of the time.

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Individual has profound problems with functioning in current living situation. Individual is at immediate risk of being removed from living situation due to problematic behaviors.

9) MEDICAL/PHYSICAL

Do you have any medical or health issues that limit your physical abilities? If so, how much would you say these limitations interfere with your ability to do the things you want and need to on a daily basis?

0 No current need; no need for action or intervention. No evidence of medical or physical health problems. Caregiver is generally healthy.

1 Identified need requires monitoring, watchful waiting, or preventive activities. There is a history or suspicion of, and/or caregiver is in recovery from, medical/physical problems.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with functioning. Caregiver has medical/physical problems that interfere with their capacity to provide care for the individual.

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Caregiver has medical/physical problems that make providing care for the individual impossible at this time.

Appendix IV: The Client Satisfaction Questionnaire (CSQ-8)

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much; we really appreciate your help.

Circle your answer:

1. How would you rate the quality of service you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	2	3	4
No, definitely	No, not really	Yes, generally	Yes definitely

3. To what extent has our program met your needs?

4	3	2	1
Almost all needs met	Most needs met	Only few needs met	No needs met

4. If a friend were in need of similar help, would you recommend our program to him or her?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you have received?

1	2	3	4
Quite dissatisfied	Mildly dissatisfied	Mostly satisfied	Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
They helped a great deal	Yes, they helped	No, they didn't help	They make things worse

7. In an overall general sense, how satisfied are you with the service you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our program?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

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Behavioral Health Services
A Division of Health Care Services Agency

Genevieve G. Valentine, LMFT, BHS Director
Cara Dunn, BHS Assistant Director

San Joaquin County mhsa

Transforming Mental Health Services

November (In Person)
2023-24 Community Planning Meetings
Mental Health Services Act (MHSA)

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

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

Please join us at one of the following in-person community meetings to discuss the needs and opportunities to strengthen mental health services in San Joaquin County. These meetings will include a brief training on the stakeholder process, an update on how MHSA funds are currently being used, as well as a chance to share your opinion and recommendations on how to enhance programs and services. Your feedback is needed to inform the 2024-2025 Annual Update to the 2023-2026 Three Year Program and Expenditure Plan.

We are counting on your voice to help guide us!

Thursday, November 2, 2023	**Tuesday, November 14, 2023**	**Wednesday, November 15, 2023**	**Thursday, November 16, 2023**
1:00 – 3:00 p.m.	1:00 -3:00 p.m.	5:00 – 7:00 p.m.	2:00 – 4:00 p.m.
Catholic Charities (Spanish Session)	**Kennedy Community Center**	**Behavioral Health Advisory Board**	**Golden Acres Community Center**
1106 N. El Dorado St. Stockton, CA 95202	2800 S. D St. Stockton, CA 95206	1212 N. California St Stockton, CA 95202	607 Bird Avenue, Stockton, CA 95215

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

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

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Transforming Mental Health Services

OCTOBER 2023-24 Community Planning Meetings Mental Health Services Act (MHSA)

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

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Please join us at one of the following community meetings to discuss the needs and opportunities to strengthen mental health services in San Joaquin County. These meetings will include a brief training on the stakeholder process, an update on how MHSA funds are currently being used, as well as a chance to share your opinion and recommendations on how to enhance programs and services. Your feedback is needed to inform the 2024-2025 Annual Update to the 2023-2026 Three Year Program and Expenditure Plan.

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Tuesday, October 24, 2023	**Wednesday, October 25, 2023**	**Thursday, October 26, 2023**	**Tuesday, October 31, 2023**
10 A.M. – 12 P.M.	2 P.M. - 4 P.M.	1 P.M. – 3 P.M.	10 A.M. – 11:30 A.M.
Lodi Public Library	**Tracy Community Center**	**Manteca Library**	**ZOOM Call** https://shorturl.at/cNUX4
201 W. Locust St. Lodi, CA 95240	11157 W. Larch Road Tracy, CA 95304	320 W. Center St. Manteca, CA 95336	Phone: (669) 900-6833 Meeting ID: 929 9612 0355 Passcode: 486601

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

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San Joaquin County mhsa

Transforming Mental Health Services

Consumer/Family Member Community Planning Focus Groups
Mental Health Services Act (MHSA)

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

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

Please join us at one of the following consumer and family member focused community meetings to discuss the needs and opportunities to strengthen mental health services in San Joaquin County. These meetings will include a brief training on the stakeholder process, update on how MHSA funds are currently being used, as well as a chance to share your opinion and recommendations on how to enhance programs and services. Your feedback is needed to inform the 2024-25 Annual Update to the 2023-2026 Three Year Program and Expenditure Plan.

We are counting on your voice to help guide us!

Gipson Center **Tuesday, October 17, 2023** **10 A.M. – 11:30 A.M.** **405 E. Pine St.** **Stockton, CA 95204**	**Wellness Center** **Thursday, October 19, 2023** **1:30 P.M. – 3 P.M.** **1109 N. California St.** **Stockton, CA 95202**

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

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Genevieve G. Valentine, LMFT, BHS Director
Cara Dunn, BHS Assistant Director

San Joaquin County mhsa

Transforming Mental Health Services

November (Zoom Community Meetings)
2023-24 Community Planning Meetings
Mental Health Services Act (MHSA)

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

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

Please join us at one of the following zoom community meetings to discuss the needs and opportunities to strengthen mental health services in San Joaquin County. These meetings will include a brief training on the stakeholder process, update on how MHSA funds are currently being used, as well as a chance to share your opinion and recommendations on how to enhance programs and services. Your feedback is needed to inform the 2024-2025 Annual Update to the 2023-2026 Three Year Program and Expenditure Plan.

We are counting on your voice to help guide us!

MHSA Consortium	**General Meeting (Spanish Session)**	**General Meeting**
Wednesday, November 1, 2023 3:00 – 4:30 p.m.	Tuesday, November 7, 2023 10:00 a.m. – 12:00 p.m.	Wednesday, November 8, 2023 3:00 – 4:30 p.m.
Join Zoom Meeting https://shorturl.at/cNUX4 Phone: (669) 900-6833 Meeting ID: 929 9612 0355 Passcode: 486601		

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

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A Division of Health Care Services Agency

Genevieve Valentine, LCSW, BHS Director
Cara Dunn, BHS Assistant Director

Transformando
Los Servicios de Salud Mental

Octubre 2023-24
Reuniones de Planificación Comunitaria
Ley de Servicios de Salud Mental (MHSA)

La Ley de Servicios de Salud Mental (MHSA) tiene como objetivo transformar el cuidado público de salud mental para niños, jóvenes, adultos y adultos de la tercera edad. La MHSA proporciona asignaciones de fondos para servicios comunitarios de salud mental en cinco áreas de programas:

- Servicios y Apoyos Comunitarios (CSS)
- Prevención e Intervención Temprana (PEI)
- Educación y Capacitación Laboral (WET)
- Obras de Infraestructura y Necesidades Tecnológicas (CF/TN)
- Innovación (INN)

Por favor, acompáñenos en una de las siguientes reuniones comunitarias para hablar sobre las necesidades y oportunidades para fortalecer los servicios de salud mental en el Condado de San Joaquín. Estas reuniones incluirán una capacitación breve sobre el proceso de las partes interesadas, un informe sobre cómo se utilizan actualmente los fondos MHSA, así como la oportunidad de compartir su opinión y recomendaciones acerca de cómo mejorar los programas y servicios. Se necesita su opinión para informar la Actualización Anual 2024-25 del Programa Trienal y Plan de Gastos 2023-2026.

¡Contamos con su voz para ayudar a guiarnos!

Martes, 24 de Octubre, 2023	Miércoles, 25 de Octubre, 2023	Jueves, 26 de Octubre, 2023	Martes, 31 de Octubre, 2023
10 A.M. – 12 P.M.	2 P.M. - 4 P.M.	1 P.M. – 3 P.M.	10 A.M. – 11:30 A.M.
Biblioteca de Lodi	**Centro Comunitario de Tracy**	**Biblioteca de Manteca**	**Llamada por ZOOM** https://shorturl.at/cNUX4
201 W. Locust St. Lodi, CA 95240	11157 W. Larch Rd. Tracy, CA 95304	320 W. Center St. Manteca, CA 95336	Teléfono: (669)900-6833 Reunión#: 929 9612 0355 Clave: 486601

La accesibilidad a las reuniones es importante. Favor de contactarnos al 209-468-8750 para tratar preguntas sobre la accesibilidad. Todas las reuniones se llevan a cabo en ubicaciones accesibles. Asistencia de interpretación está disponible bajo petición. Las familias son bienvenidas.

Favor de colocar esta invitación en una ubicación pública y distribuirla a través de sus listas de correo. Gracias por compartir esta invitación.

SAN JOAQUIN COUNTY
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Behavioral Health Services
A Division of Health Care Services Agency

Genevieve G. Valentine, LMFT, BHS Director
Cara Dunn, BHS Assistant Director

San Joaquin County mhsa

Transformando
Los Servicios de Salud Mental

Noviembre (En Persona)
Reuniones de Planificación Comunitaria 2023-24
Ley de Servicios de Salud Mental (MHSA)

La Ley de Servicios de Salud Mental (MHSA) tiene como objetivo transformar el cuidado público de salud mental para niños, jóvenes, adultos y adultos de la tercera edad. La MHSA proporciona asignaciones de fondos para servicios comunitarios de salud mental en cinco áreas de programas:

- Servicios y Apoyos Comunitarios (CSS)
- Prevención e Intervención Temprana (PEI)
- Educación y Capacitación Laboral (WET)
- Obras de Infraestructura y Necesidades Tecnológicas (CF/TN)
- Innovación (INN)

Por favor, acompáñenos en una de las siguientes reuniones comunitarias en persona para hablar sobre las necesidades y oportunidades para fortalecer los servicios de salud mental en el Condado de San Joaquín. Estas reuniones incluirán una capacitación breve sobre el proceso de las partes interesadas, un informe sobre cómo se utilizan actualmente los fondos MHSA, así como la oportunidad de compartir su opinión y recomendaciones acerca de cómo mejorar los programas y servicios. Se necesita su opinión para informar la Actualización Anual 2024-25 del Programa Trienal y Plan de Gastos 2023-2026.

¡Contamos con su voz para ayudar a guiarnos!

jueves, 2 de noviembre, 2023	**martes, 14 de noviembre, 2023**	**miércoles, 15 de noviembre, 2023**	**jueves, 16 de nov, 2023**
1:00 – 3:00 p.m.	1:00 -3:00 p.m.	5:00 – 7:00 p.m.	2:00 – 4:00 p.m.
Caridades Católicas (Sesión en Español)	**Centro Comunitario Kennedy**	**Consejo Asesor de Salud Conductual**	**Centro Comunitario Golden Acres**
1106 N. El Dorado St. Stockton, CA 95202	2800 S. D St. Stockton, CA 95206	1212 N. California St Stockton, CA 95202	607 Bird Avenue, Stockton, CA 95215

La accesibilidad a las reuniones es importante. Favor de contactarnos al 209-468-8750 para tratar preguntas sobre la accesibilidad. Todas las reuniones se llevan a cabo en ubicaciones accesibles. Asistencia de interpretación está disponible bajo petición. Las familias son bienvenidas.

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Behavioral Health Services
A Division of Health Care Services Agency

Genevieve G. Valentine, LMFT, BHS Director
Cara Dunn, BHS Assistant Director

Transformando
Los Servicios de Salud Mental

Grupos de Enfoque de Planificación Comunitaria para Consumidores y Miembros de la Familia Ley de Servicios de Salud Mental (MHSA)

La Ley de Servicios de Salud Mental (MHSA), tiene como objetivo transformar el cuidado público de salud mental para niños, jóvenes, adultos y adultos de la tercera edad. La MHSA proporciona asignaciones de fondos para servicios comunitarios de salud mental en cinco áreas de programas:

- Servicios y Apoyos Comunitarios (CSS)
- Prevención e Intervención Temprana (PEI)
- Educación y Capacitación Laboral (WET)
- Obras de Infraestructura y Necesidades Tecnológicas (CF/TN)
- Innovación (INN)

Por favor, acompáñenos a una de las siguientes reuniones comunitarias enfocadas en los consumidores y miembros de la familia para hablar sobre las necesidades y oportunidades para fortalecer los servicios de salud mental en el Condado de San Joaquín. Estas reuniones incluirán una capacitación breve sobre el proceso de las partes interesadas, un informe sobre cómo se utilizan actualmente los fondos MHSA, así como la oportunidad de compartir su opinión y recomendaciones acerca de cómo mejorar los programas y servicios. Su opinión es necesaria para informar la Actualización Anual 2024-25 del Programa Trienal y Plan de Gastos 2023-2026.

¡Contamos con su voz para ayudar a guiarnos!

Centro: **Gipson Center** **Martes, 17 de Octubre, 2023** **10 A.M. – 11:30 A.M.** **405 E. Pine St.** **Stockton, CA 95204**	Centro: **Wellness Center** **Jueves, 19 de Octubre, 2023** **1:30 P.M. – 3 P.M.** **1109 N. California St.** **Stockton, CA 95202**

La accesibilidad a las reuniones es importante. Favor de contactarnos al 209-468-8750 para tratar preguntas sobre accesibilidad. Todas las reuniones se llevan a cabo en ubicaciones accesibles. Asistencia de interpretación está disponible bajo petición. Las familias son bienvenidas.

Favor de colocar esta invitación en una ubicación pública y distribúyala a través de sus listas de correo. Gracias por compartir esta invitación.

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Behavioral Health Services
A Division of Health Care Services Agency

Genevieve G. Valentine, LMFT, BHS Director
Cara Dunn, BHS Assistant Director

San Joaquin County mhsa

Transformando
Los Servicios de Salud Mental

Noviembre (Reuniones Comunitarias por Videollamada Zoom)
Reuniones de Planificación Comunitaria 2023-24
Ley de Servicios de Salud Mental (MHSA)

La Ley de Servicios de Salud Mental (MHSA) tiene como objetivo transformar el cuidado público de salud mental para niños, jóvenes, adultos y adultos de la tercera edad. La MHSA proporciona asignaciones de fondos para servicios comunitarios de salud mental en cinco áreas de programas:

- Servicios y Apoyos Comunitarios (CSS)
- Prevención e Intervención Temprana (PEI)
- Educación y Capacitación Laboral (WET)
- Obras de Infraestructura y Necesidades Tecnológicas (CF/TN)
- Innovación (INN)

Por favor, acompáñenos en una de las siguientes reuniones comunitarias por videollamada vía Zoom para hablar sobre las necesidades y oportunidades para fortalecer los servicios de salud mental en el Condado de San Joaquín. Estas reuniones incluirán una capacitación breve sobre el proceso de las partes interesadas, un informe sobre cómo se utilizan actualmente los fondos MHSA, así como la oportunidad de compartir su opinión y recomendaciones acerca de cómo mejorar los programas y servicios. Se necesita su opinión para informar la Actualización Anual 2024-25 del Programa Trienal y Plan de Gastos 2023-2026.

¡Contamos con su voz para ayudar a guiarnos!

Consorcio MHSA	**Reunión General (Sesión en Español)**	**Reunión General**
miércoles, 1 de noviembre, 2023 3:00 – 4:30 p.m.	martes, 7 de noviembre, 2023 10:00 a.m. – 12:00 p.m.	miércoles, 8 de noviembre, 2023 3:00 – 4:30 p.m.
Únase a la reunión por Zoom https://shorturl.at/cNUX4 Teléfono: (669) 900-6833 ID de la reunión: 929 9612 0355 Clave: 486601		

La accesibilidad a las reuniones es importante. Favor de contactarnos al 209-468-8750 para tratar preguntas sobre la accesibilidad. Todas las reuniones se llevan a cabo en ubicaciones accesibles. Asistencia de interpretación está disponible bajo petición. Las familias son bienvenidas.

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Welcome to 2023-24 MHSA Community Planning

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- Please sign in by providing name and email address in ZOOM Chat Box
- Please complete Survey Monkey Demographics (link in the chat box)
- Meeting will be recorded for transcribing purposes

1

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San Joaquin County Behavioral Health Services Mental Health Services Act – Overview and Planning

Community Program Planning for the 2024-25 MHSA Annual Update to the 2023-26 MHSA Three Year Plan

2

Part 1: Overview of BHS

WELCOME AND INTRODUCTIONS
BHS MISSION, VISION, AND VALUES

3

Mission and Vision

Mission Statement

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

Vision Statement

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

4

Core Values

SERVICE:

We are dedicated to serving our community through the promotion of behavioral health and wellness.

RESPECT:

We value diverse experiences, beliefs, and backgrounds and strive in our interactions to keep everyone's dignity intact.

RECOVERY:

We share a belief that all individuals can find a path towards health and well-being.

INTEGRITY:

Our values guide us as individuals and as an organization to be responsive and trustworthy.

Providing our clients with the same quality of care that we all would want our families to receive.

5

Part 2: Community Training on Mental Health Services Act

OVERVIEW OF MHSA
COMMUNITY INVESTMENT
STAKEHOLDER INPUT

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Mental Health Services Act (MHSA)

Purpose of MHSA Funding

- Expand and enhance mental health services for individuals with serious mental illness.
- Provide prevention and early intervention services for those at risk of developing a mental illness.
- Promote innovative solutions that will advance the field of mental health.
- Strengthen the personnel, technology, and facilities through which services are offered.

Common Acronyms

(MHSA) Mental Health Services Act, Prop. 63

(CSS) Community Services and Supports
(PEI) Prevention and Early Intervention
(INN) Innovation
(WET) Workforce Education and Technology
(CFTN) Capital Facilities and Technology

7

MHSA Core Principles

- **Client/family driven**
- **Cultural competence**
- **Community collaboration**
- **Service integration**
- **Focus on recovery, wellness, and resilience**
- **Serving the unserved and underserved**

8

2022-23 Essential Community Planning Meetings and Stakeholder Presentations & Feedback:

- 20 Public Community Planning Meetings / Stakeholder Presentations – 11/2022 – 3/2023
- Over 300 Attendees of which 80% self identified as a consumer or as a family member of a consumer with mental health or substance use challenge.
- Black/African American & Latino/x Community Members attended at record rate – 60% of total participants
- Meetings spread geographically throughout San Joaquin County – Lodi, Tracy, Manteca, Ripon, Escalon, and North/South/Central Stockton locations.

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Stakeholder Themes = MHSA PLANNING Priorities in the 2023-2026 Three Year Plan

- **ACCESS TO TREATMENT & HOUSING STABLITY**
- **BEHAVIORAL HEALTH AND JUSTICE COLLABORATIONS**
- **COMMUNITY PARTNERSHIPS WITH CULTURALLY FOCUSED BEHAVIORAL HEALTH CARE**

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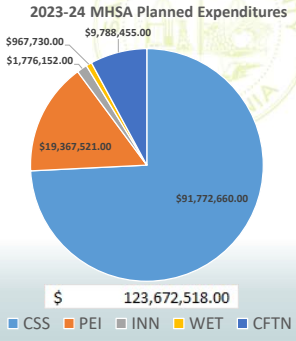
MHSA Programming in San Joaquin County

Program Areas

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



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2023-2024 New and Expanded MHSA Programs

Coming Soon!

- Expansion of Transitional Aged Youth (TAY) FSP Services (Intensive Care Coordination / Intensive Home-Based Services)
- Contract FSP and Outpatient Services for La Familia and Black Awareness Community Outreach Program (BACOP) to enhance community culturally congruent services
- Expand Community Corrections FSP for Misdemeanor Diversion
- Expansion of Skill Building for Parents and Guardians Project
- Expansion of Mentoring for Transitional Age Youth (to include vocational and employment training component)
- Expansion of Community Trauma Services for adults (to include TAY population)
- Expansion of Increasing Recognition of Mental Illnesses Project - (Mini Grants to local CBO's to be Mental Health First Aid and/or Youth Mental Health First Aid Trainers)
- *New* Housing Stabilization FSP Services – for Whole Person Care and Homeless and Transitional Housing SMI Clients
- *New* Co-Occuring Disorder Program – w/ SUD focus
- *New* TAY Outpatient Care (Step down program for TAY FSP clients)
- *New* Justice Decriminalization Forensic Restart Program
- $12Mil invested in Project Based Housing in partnership with San Joaquin County Housing Authority
- *New* Prevention and Early Intervention for Older Adults
- *New* Forensic Prevention and Engagement (justice involved mild to moderate population)
- *New* Cultural Brokers Program

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MHSA planning benefits from community stakeholder input

- Consumers, family members, providers, and Community
- Review programs and make recommendations
- Input for improvements outlined in Annual Update
- Plan reviewed (30 days) & public hearing at Behavioral Health Board

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Part 3: Planning Discussion

GROUP BRAINSTORM
- What works?
- What needs Improvement?

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Community Program Planning

Purpose: *To assess the mental health needs of the entire community, including those that are currently served, and those that are unserved, underserved, or inappropriately served.*

Feedback Requested:

1) What is working?
2) What needs improvement?
3) How can we better serve consumers in San Joaquin County?

Definitions:

Gap or Need – Services do not exist, or does not exist for a specific population.

Issue or Concern – Services exist, but there is an issue or concern to be addressed.

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Planning Activities for the Annual Update

- **Community Planning Meetings (including face-to-face)**
  - Lodi, Tracy, Manteca (October 2023)
  - Consumer/Family Member Focus Groups (October 2023)
- **Stakeholder & Consumer / Family Members Surveys (Oct-Jan)**
- **Key Informant Interviews (January 2024)**
- **Stakeholder Feedback Meetings (December (2023)**
- **MHSA Consortium (November 2023 & December 2023)**
- **Behavioral Health Board (November 2023 & December 2023)**
- **Draft Plan for 30-day Public Review (March 2024)**
- **Public Hearing (April 2024)**
- **Presentation to the Board of Supervisors (May 2024)**

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Collecting your Feedback!

- **Please make sure to:**
  - Sign-in to the meeting via the chat .
  - Complete the linked demographic form (SurveyMonkey).
  - Complete the confidential stakeholder feedback form (SurveyMonkey).
  - Consider sending additional feedback, suggestions or ideas to:

Mail:

MHSA Comments
c/o MHSA Coordinator
1212 N. California St.
Stockton CA 95202

E-mail:

mhsacomments@sjcbhs.org

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Angelo Balmaceda
MHSA Coordinator
abalmaceda@sjcbhs.org

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San Joaquin County Behavioral Health Services
Mental Health Services Act – Stakeholder Feedback Overview

Community Program Planning for Fiscal Year 2023-2024
for the 2024-25 MHSA Annual Update to the 2023-26
Three Year Plan

1

Mission and Vision

Mission Statement

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

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Providing our clients with the same quality of care that we all would want our families to receive.

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Mental Health Services Act (MHSA)

Purpose of MHSA Funding

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- Provide prevention and early intervention services for those at risk of developing a mental illness.
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4

MHSA Core Principles

- Client/family driven
- Cultural competence
- Community collaboration
- Service integration
- Focus on recovery, wellness, and resilience
- Serving the unserved and underserved

SAN JOAQUIN COUNTY

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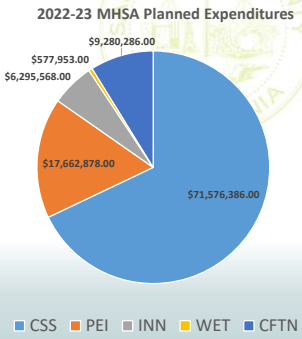
MHSA Programming in San Joaquin County

Program Areas

- Community Services and Supports
- Prevention and Early Intervention
- Innovative Programs
- Workforce Education and Training
- Capital Facilities and Technology Needs



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New and Expanded MHSA Programs

2022-23 New and Expanded Programs

- Community Trauma Services for Adults (PEI)
- CalMHSA Semi-Statewide Electronic Health Records Innovation Project
- Wellness Center Expansion to North and South County
- Investment to expand Project Based-Housing / Intensive FSP Teams
- Funding to expand FSP Housing Empowerment Services

Program Operations have Begun

2023 New Programs

- Information and Education Campaign (PEI)
- Suicide Prevention in the Community (PEI)
- Community Trauma Services for LGBTQ
- Adult Residential Facilities (Two 16-Bed) for Justice Involved Consumers – Men and Women Facilities
- Prevention for Children 0-5

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7

MHSA planning benefits from community stakeholder input

- Consumers, family members, and providers
- Review programs and make recommendations
- Input for improvements outlined in Annual Update
- Plan reviewed (30 days) & public hearing at Behavioral Health Board

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Mental Health Services Act – 2023-24 Community Planning

PLANNING SESSION ATTENDANCE
WHAT IS WORKING?
WHAT NEEDS IMPROVEMENT?
NEEDS AND CONCERNS (COMMUNITY UNDERSERVED/UNSERVED)

SAN JOAQUIN COUNTY

2023-24 Planning Session Attendance (So Far)

13 Community Planning Events -

- Wellness Center, Gipson Center (Consumer/Family Member Focus)
- 7 Face-to-Face Sessions
  - Lodi, Tracy, Manteca,, Behavioral Health Board, Garden Acres (East Stockton), Kennedy Community Center (South Stockton) and Catholic Charities (Spanish/Central Stockton)
- 3 General Zoom Sessions
  - Consortium and 3 General Zoom Calls

Total Attendees: **145** (117 Previous Year)

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2022-23 Planning Session Demographics

Age Range		Gender Identity		Sexual Orientation		Primary Language		Race/Ethnicity		Consumer Affliation	
18-25	9.76%	Female	59.76%	Heterosexual	85.37%	English	87.80%	Native American	2.44%	Consumer	57.32%
26-59	71.95%	Male	37.80%	LGBTQI	8.54%	Spanish	9.76%	African American	21.95%	Family Member	23.17%
60 and Older	18.29%	Transgender	1.22%	Prefer Not To Answer	1.22%	Other	2.44%	Latino/Hispanic	28.05%	None of the above	34.15%
								Southeast Asian	2.44%		
								Other Asian/Pacific Islander	3.66%		
								White/Caucasian	37.80%		
								Mixed Race	3.66%		

Stakeholder Affiliation-

- Community Based Mental Health Service Providers
- Community Based Non-Mental Health Providers
- Advocates
- Children & Family Service Providers
- K-12 Education Providers
- Veterans Services
- Senior Services
- Law Enforcement
- Hospital/Health Care Providers
- BHS (MH and SUD) Services Staff
- Behavioral Health Board
- Public Health

SAN JOAQUIN COUNTY

Community Program Planning

Purpose: *To assess the mental health needs of the entire community, including those that are currently served, and those that are unserved, underserved, or inappropriately served.*

Feedback Requested:

1) What is working?
2) What needs improvement?
3) Community-Defined – underserved, unserved groups

Definitions:

Gap or Need – Services do not exist, or does not exist for a specific population.

Issue or Concern – Services exist, but there is an issue or concern to be addressed.

SAN JOAQUIN COUNTY

What is WORKING?

- Return of the MHSA Showcase (Helps Community Learn about MHSA Programs)
- Expansion of Wellness Centers to Lodi and Manteca
- Involvement of consumers in peer led services (Wellness Center Activities)
- Some improvement in housing availability of folks with SMI
- CYS warm hand process; refers clients to other agencies
- Recreational and recovery-oriented activities in the PHF
- Parent Support Program (Catholic Charities) – Educating Family Members
- Transportation with MHOW's are helping clients get around
- Multiple agencies working together for consumer's interests
- BHS relationship with other agencies being positive and collaborative
- Ability to access services in school campuses after pandemic
- Efforts between school districts and BHS has begun to flourish
- Suicide Prevention in the Schools are working well
- Peer Support has been essential in connecting clients and family members to services
- Warm-Line has been valuable to the community
- Community Trauma program successful in helping mono-lingual Spanish speakers to obtain services
- Breaking through barriers in the Spanish speaking community through PEI, but need more outreach

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What Needs Improvement?

- Short Term Interventions (6 months for Trauma Services) should be increased to 9-12 months
- Communities (specifically underserved) are in need of outreach (cultural brokers program and promotoras program) to enhance community education and engagement
- Parental involvement – Bridge between school, caregiver capacity, family stressors protective factors, integrating home and case management
- Collaborating with systems that are operating in the schools (Parent/Teacher/Student collaboration)
- Expansion of Home-Based Services for Families (assessing the whole family needs)
- GAP in aftercare/supportive services for youth
- Housing for TAY Clients
- Peer Socialization – Youth talking to Youth
- Gaps in information on MHSA funded resources for the community (Navigation resources between programs).
- Outreach and Engagement that is community driven and culturally competent.
- Additional training in Health Equity for providers in the community
- Cultural CBO's need to be involved in providing outreach, case management, therapy, social work, job training, mentoring for youth, housing assistance and other services from a culturally competent perspective.

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What Needs Improvement?

- BHS Education for teachers on mental health challenges. SJCOE has a training portal but are old and need to be updated/interactive and training for different generations.
- Expanding Nurturing Parenting classes
- Training and Outreach for Faith Based Communities (MHFA Training, Etc.)
- Afterschool Services focused on Prevention for Children and TAY.
- Educating community on services and available programs in their area (Marketing Plan for ALL MH and SUD Programs)
- Education/Training on Suicide Prevention
- Safe places youth to hang out after school (specifically LGBTQ youth) – Drop In Center type PEI Program
- TAY Peers getting involved in Safe Space/Drop in Center Planning
  - TAY Focused Community Planning across San Joaquin County – Having Youth at the table to be involved in decision making
- Prevention Services for 60+ Older Adults – Isolation, Depression and Anxiety (Home Services for this population)
- Respite Centers in North and South County – Alternative to Clinical Crisis – Peer Driven, Peer Run, RECOVERY APPROACH Model

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What Needs Improvement?

- Need to bring back funding for Outreach and Engagement for specific unserved and underserved community. Working with local cultural CBO's to provide training in the community and link community to services.
- Expansion of MH Services in afterschool programs
- CBO Communication with contracted schools for school based interventions
- Expanding School Based Interventions that include the family (parents might have traumas and stressors of their own).
- Reduce Stigma around mental health through after school programs for parent nights – programming for MH Prevention (BEYOND THE BELL)
- Expanding Community Health Workers in the community specific to MH and SUD education
- Teens need community activities and transitioning to adults for those within the system.
- Tracy is in need of Mobile Evaluation Team with focus on intensive outreach services for the homeless.
- Promoting MH Services/ Warm Line Number in all public places in communities (Libraries, City Halls, County Buildings)
- Utilizing Public Libraries and Community Centers throughout the County to educate Community

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Needs and Concerns – Community Groups

- Focus on Youth specifically TAY of color – Services that are provided by trusted cultural community based organizations.
- Expand services of peer support and provide funding for faith-based organizations to conduct training/outreach
- Outreach and Engagement for Spanish and Asian Language speaking communities – Utilize community organizations that have developed trust within each unserved/underserved communities
- Working with Sikh Community in Tracy and Lodi to educate on MH Services and Stigma Reduction
- MH Resources for LGBTQIA community in Tracy and Lodi
- MH and SUD Information campaign for Spanish Speaking Community focused in areas where Latino Businesses and Community reside (stores, flea markets, churches)
- Access for Justice Involved (Forensic) Community – Bring back the PEI Forensic Access and Engagement Program

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Needs and Concerns – Community Groups

- Utilize existing Community Centers to provide community driven/culturally appropriate Outreach and Engagement / Education for communities of color and develop SUPPORT Groups for these communities that are in need
- Focused Outreach and Engagement with Education to faith based communities both in the Latino and African American Communities
- Need for a strong community network navigation map to inform community where to access services. Develop strong warm hand approach for consumers/clients between outreach team, case management and providers in San Joaquin County
- LGBTQIA training for school, parents and school community
- Senior Support (60+) for folks in the LGBTQIA Community
- MH groups and therapy for Trans Services (to support transition in the Trans Community)
- Utilize Cultural CBO's and organizations to provide MH education services (MHFA, MHFA for Youth) for afterschool programs in the county.
- Utilize Cultural CBO's to enhance and provide culturally appropriate CASE MANAGEMENT SERVICE to Cultural FSP specific programs.

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Program Expansion Opportunities from Community Planning Conversations

- **Themes**
  - Underserved Communities need education and engagement (Community Outreach Programs)
  - Parenting Classes for additional underserved populations
  - Mental Health First Aid (MHFA) Training for Community Based Organizations and Faith Based Communities
  - Transitional Aged Youth (TAY) Services geared towards vocational and employment training
  - Committed partnerships with local Cultural community-based organizations
  - Access Program Justice-Involved Community (formally funded)
  - Cultural CBO's as partner in providing intensive case management for FSP Programs
- **Expansion Opportunities for Next Plan MHSA 3-Year Plan**
  - PEI Cultural Brokers Program (formally funded)
  - Expand Parenting Classes
  - Expand PEI Trauma Services to include TAY and AA providers
  - Forensic Access and Engagement (formally funded)
  - Fund Workforce Education and Training to provide MHFA Train-the-Trainer program for faith-based community leaders
  - Expand TAY Mentoring program to include employment and vocational component

19

Remaining Activities for the MHSA Three Year Plan

- ~~Community Planning Meetings~~
- ~~Consumer Discussion Groups~~
- ~~Stakeholder Presentations – Happening Now~~
- Stakeholder Surveys – Coming in 2 weeks
- Key Informant Interviews – to be scheduled
- Behavioral Health Board
- Draft Plan for 30-day Public Review (April)
- Public Hearing at Behavioral Health Board (May)
- Presentation to the Board of Supervisors (June)

20

Collecting your Feedback!

Consider sending additional feedback, suggestions or ideas to:

Mail:

MHSA Comments
c/o MHSA Coordinator
1212 N. California St.
Stockton CA 95202

E-mail:

mhsacomments@sjcbhs.org

SAN JOAQUIN COUNTY

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Angelo Balmaceda
MHSA Coordinator
abalmaceda@sjcbhs.org

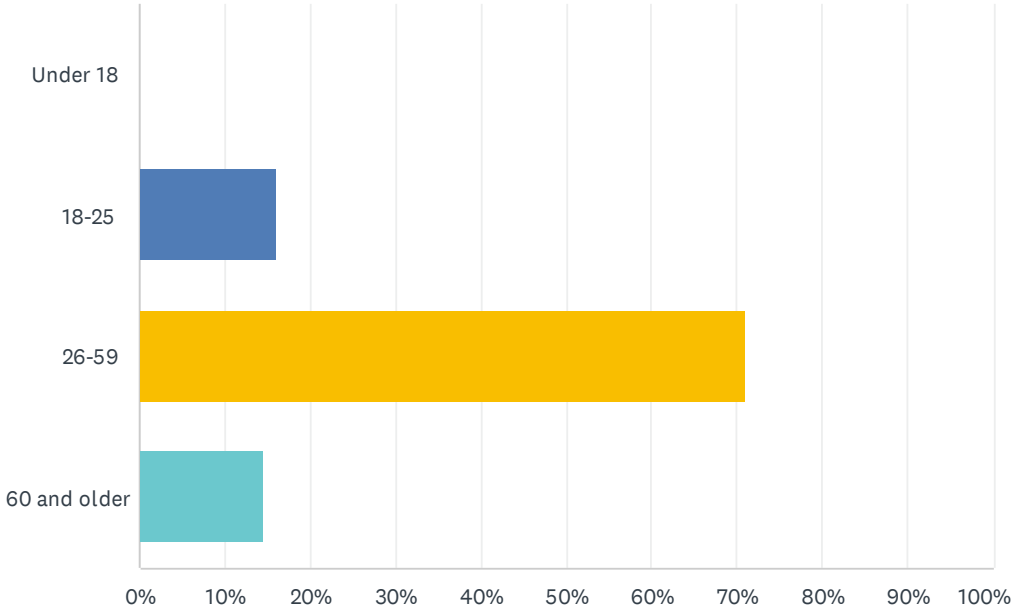
SAN JOAQUIN COUNTY

22

22

Q1 Please indicate your age range.

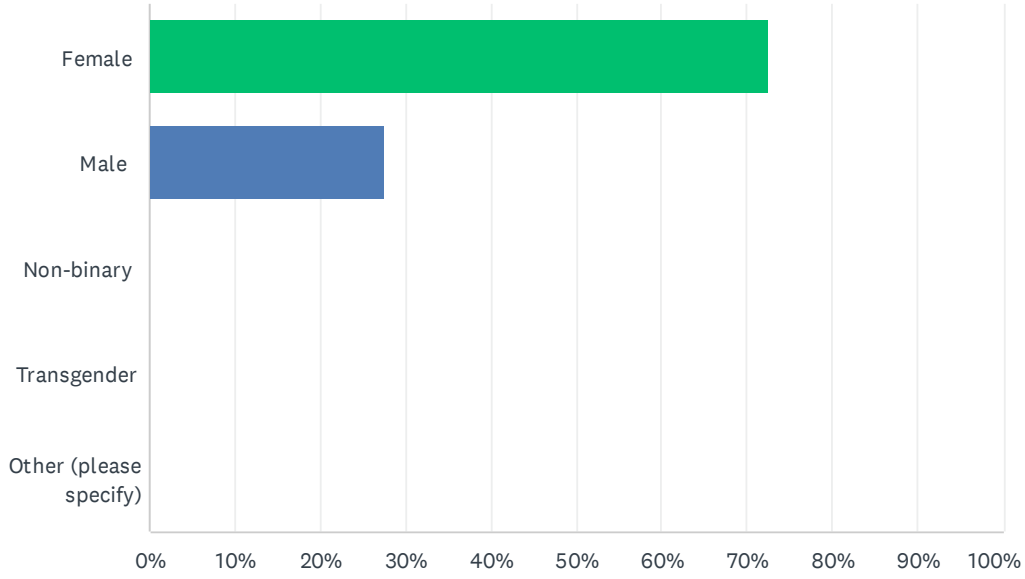
Answered: 69 Skipped: 0



ANSWER CHOICES	RESPONSES	
Under 18	0.00%	0
18-25	15.94%	11
26-59	71.01%	49
60 and older	14.49%	10
Total Respondents: 69		

Q2 What is your gender identity?

Answered: 69 Skipped: 0

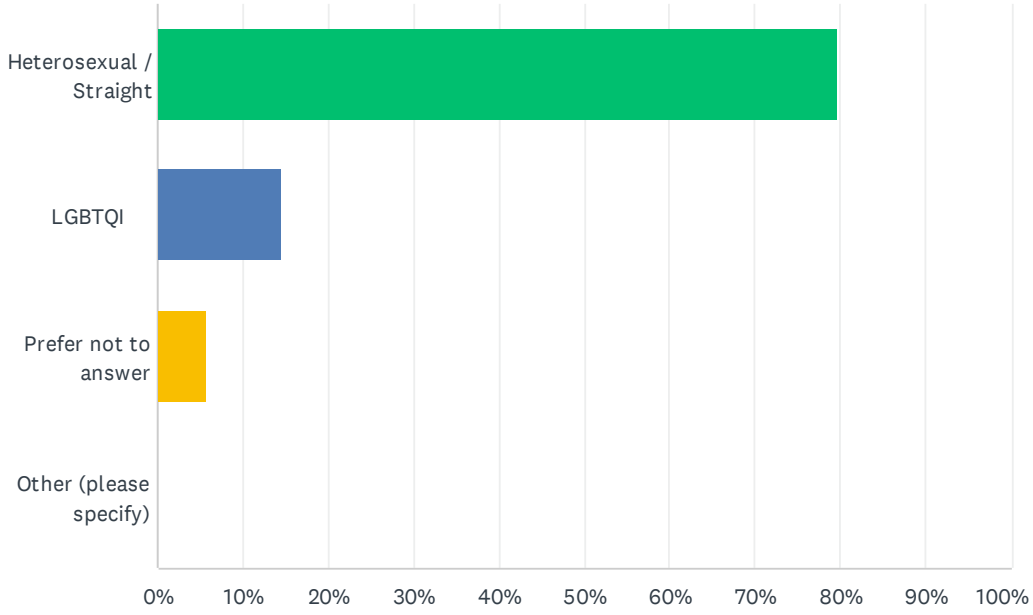


ANSWER CHOICES	RESPONSES	
Female	72.46%	50
Male	27.54%	19
Non-binary	0.00%	0
Transgender	0.00%	0
Other (please specify)	0.00%	0
TOTAL		69

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q3 What is your sexual orientation?

Answered: 69 Skipped: 0

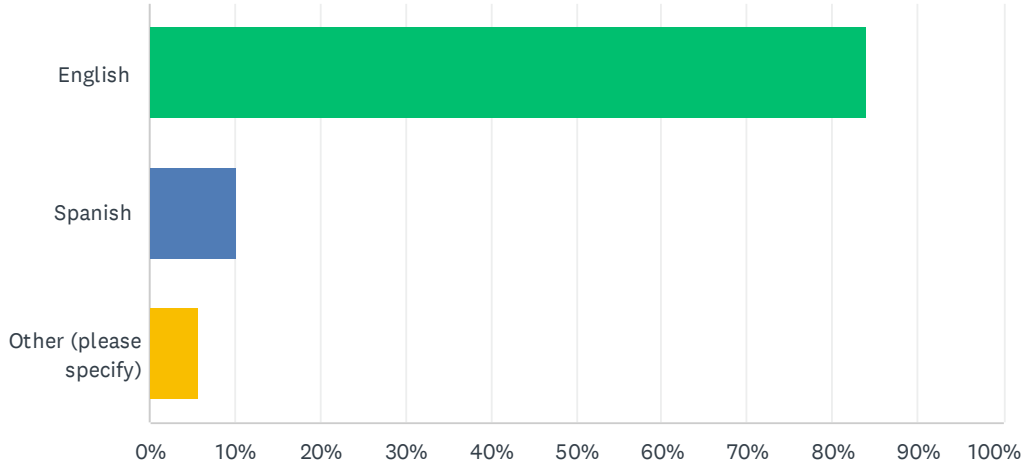


ANSWER CHOICES	RESPONSES	
Heterosexual / Straight	79.71%	55
LGBTQI	14.49%	10
Prefer not to answer	5.80%	4
Other (please specify)	0.00%	0
TOTAL		69

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q4 What is the primary language spoken in your home?

Answered: 69 Skipped: 0

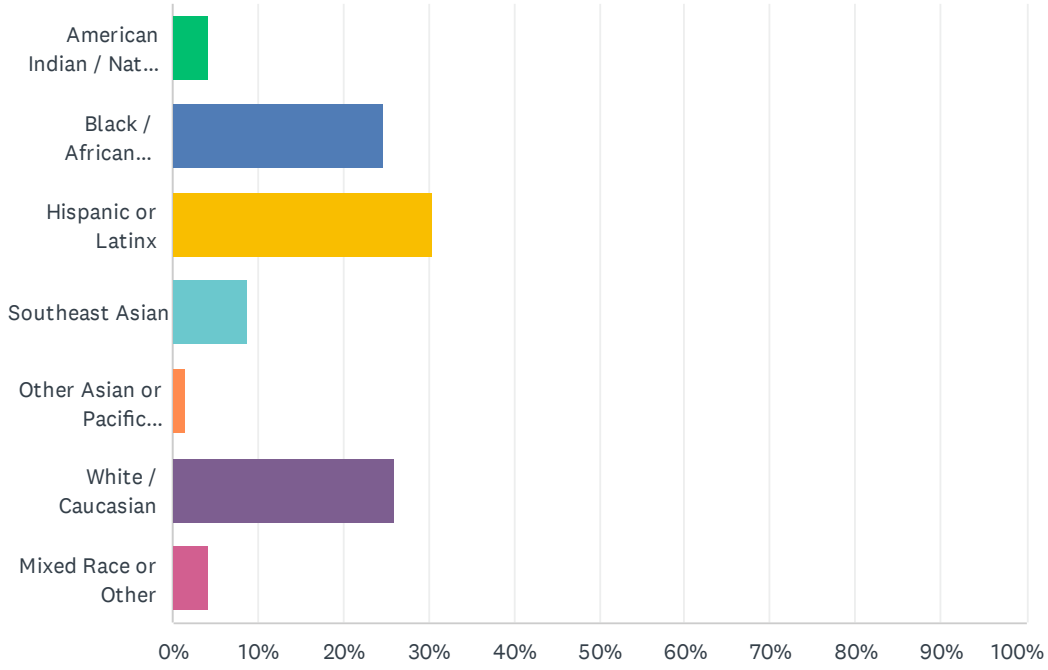


ANSWER CHOICES	RESPONSES	
English	84.06%	58
Spanish	10.14%	7
Other (please specify)	5.80%	4
TOTAL		69

#	OTHER (PLEASE SPECIFY)	DATE
1	Vietnamese	11/3/2023 9:44 AM
2	Vietnamese	11/2/2023 9:37 AM
3	Cambodian	10/30/2023 3:39 PM
4	Vietnamese	10/30/2023 3:38 PM

Q5 What is your race or ethnicity?

Answered: 69 Skipped: 0

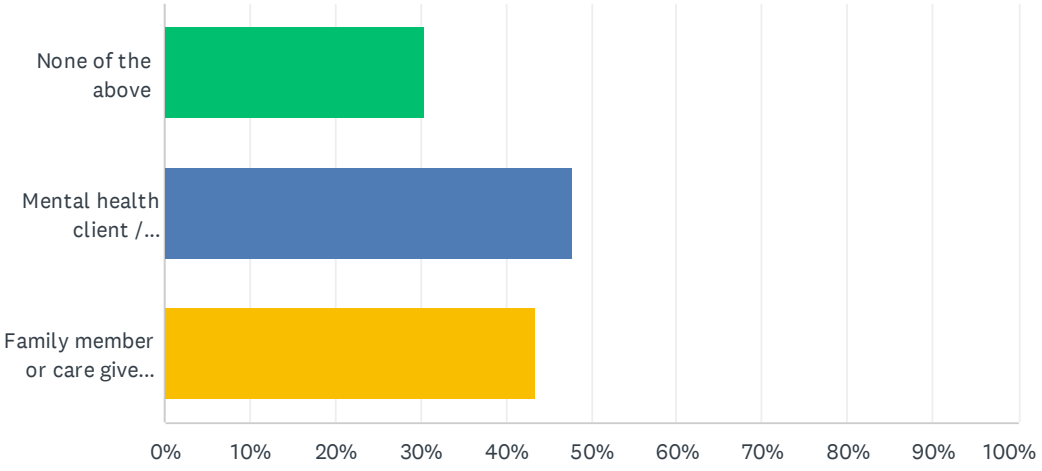


ANSWER CHOICES	RESPONSES	
American Indian / Native American / First Nations (including Hawaiian and Alaskan Native)	4.35%	3
Black / African American	24.64%	17
Hispanic or Latinx	30.43%	21
Southeast Asian	8.70%	6
Other Asian or Pacific Islander	1.45%	1
White / Caucasian	26.09%	18
Mixed Race or Other	4.35%	3
TOTAL		69

#	MIXED RACE OR OTHER	DATE
1	White, Asian, Hispanic	11/2/2023 9:41 AM
2	Black & White	10/31/2023 3:17 PM
3	decline to state	10/31/2023 10:10 AM

Q6 Consumer Affiliation (if applicable)

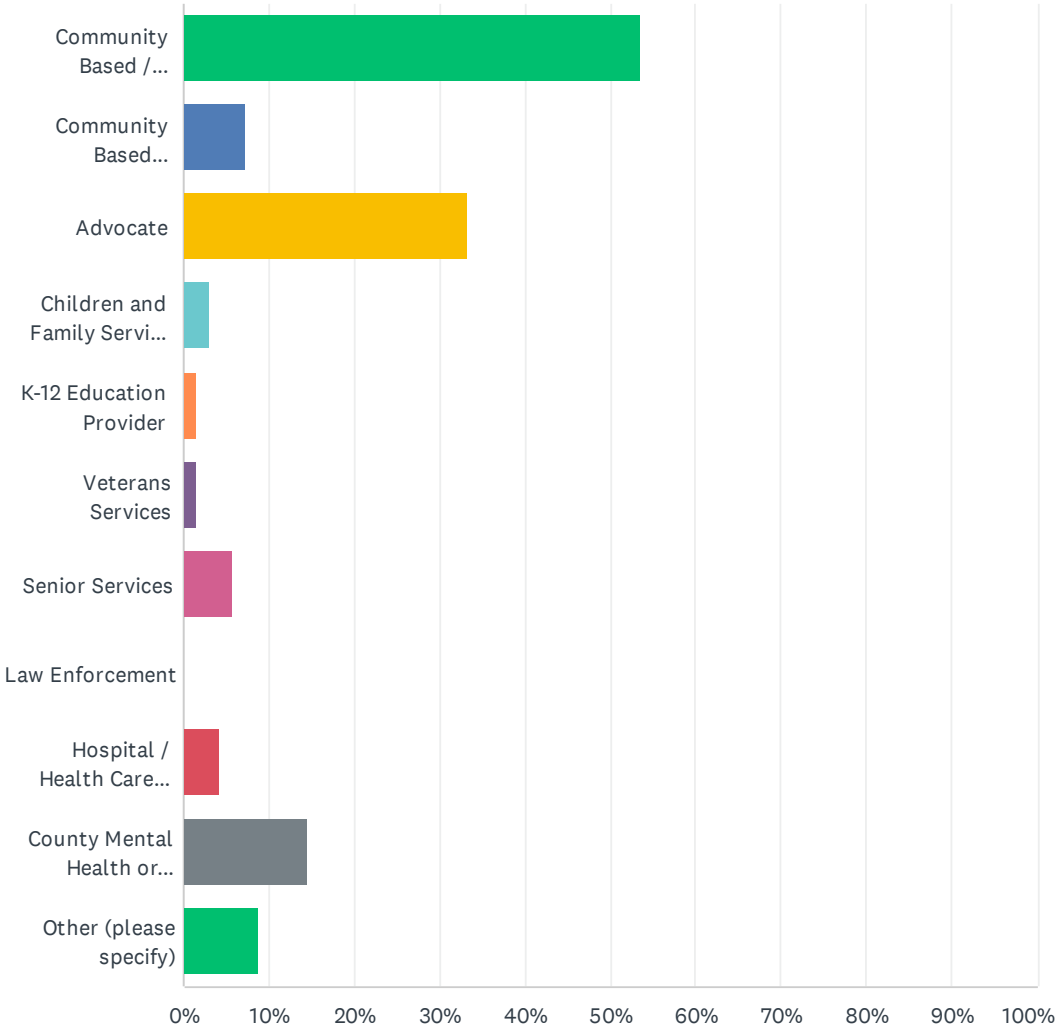
Answered: 69 Skipped: 0



ANSWER CHOICES	RESPONSES	
None of the above	30.43%	21
Mental health client / Consumer	47.83%	33
Family member or care giver of a mental health consumer	43.48%	30
Total Respondents: 69		

Q7 Stakeholder Affiliation (check all that apply)

Answered: 69 Skipped: 0

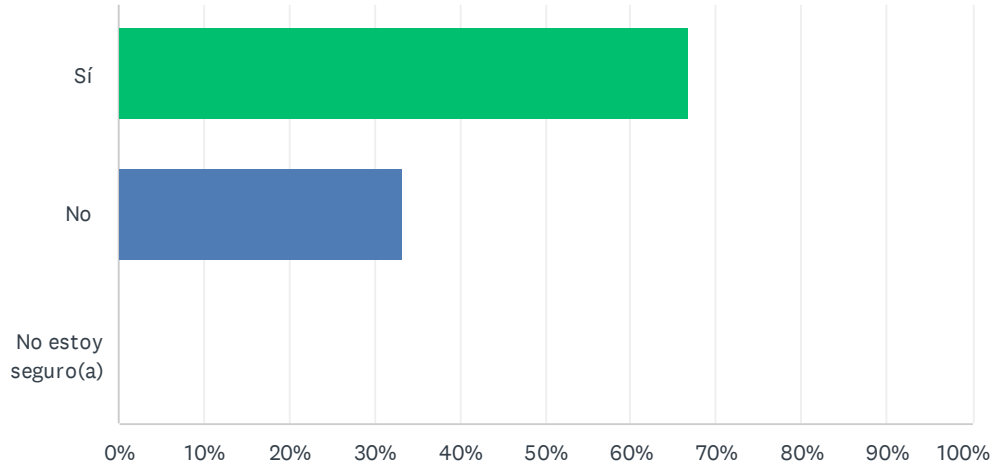


ANSWER CHOICES	RESPONSES	
Community Based / Non-Profit Mental Health Services Provider	53.62%	37
Community Based Organization (Not-Mental Health Services Provider)	7.25%	5
Advocate	33.33%	23
Children and Family Service Provider	2.90%	2
K-12 Education Provider	1.45%	1
Veterans Services	1.45%	1
Senior Services	5.80%	4
Law Enforcement	0.00%	0
Hospital / Health Care Provider	4.35%	3
County Mental Health or Substance Abuse Services Staff	14.49%	10
Other (please specify)	8.70%	6
Total Respondents: 69		

#	OTHER (PLEASE SPECIFY)	DATE
1	Disability Rights Advocate	11/2/2023 9:39 AM
2	Student	11/2/2023 9:36 AM
3	BHAB Board Member	10/30/2023 4:03 PM
4	other	10/30/2023 4:02 PM
5	other	10/30/2023 4:00 PM
6	Local City Government	10/30/2023 3:41 PM

Q1 ¿Se identifica como alguien quien esté recibiendo, o quien necesite, servicios de tratamiento de salud mental?

Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	66.67%	2
No	33.33%	1
No estoy seguro(a)	0.00%	0
TOTAL		3

Q2 ¿Cómo calificaría la ubicación de donde proveemos nuestros servicios?

Answered: 3 Skipped: 0

4.0★
average rating

	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	0.00% 0	0.00% 0	33.33% 1	33.33% 1	33.33% 1	3	4.00

Q3 ¿Cómo calificaría la duración para recibir una cita?

Answered: 2 Skipped: 1

4.5★
average rating

	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	0.00% 0	0.00% 0	0.00% 0	50.00% 1	50.00% 1	2	4.50

Q4 ¿Cómo calificaría los tipos de intervención en grupo o individual que son ofrecidos?

Answered: 3 Skipped: 0

2.7★
average rating

	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	33.33% 1	33.33% 1	0.00% 0	0.00% 0	33.33% 1	3	2.67

#	SI SELECCIONÓ “NECESITA MEJORAR”: ¿QUÉ TIPOS DE INTERVENCIONES INDIVIDUALES O EN GRUPO LE GUSTARÍA VER?	DATE
1	Preventivo	10/9/2023 3:23 PM

Q5 ¿Cómo calificaría la rigurosidad de los servicios proporcionados?

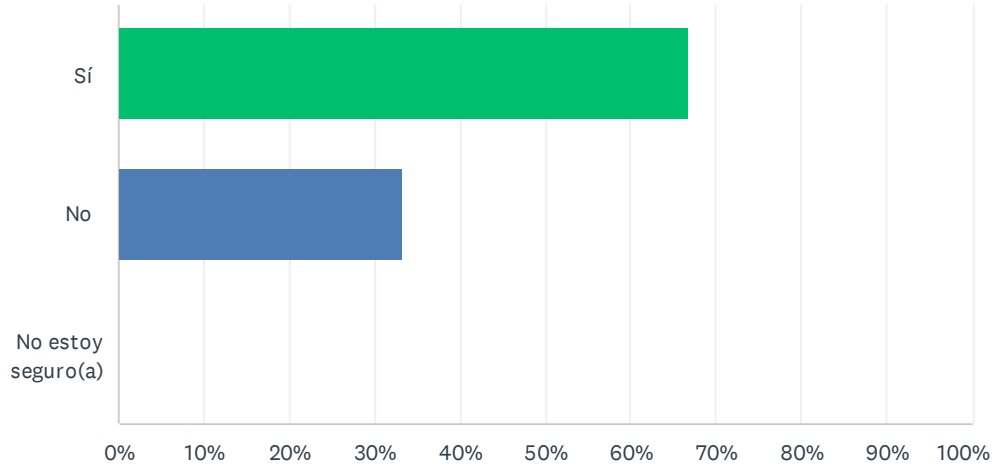
Answered: 3 Skipped: 0

3.3★
average rating

	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	33.33% 1	0.00% 0	0.00% 0	33.33% 1	33.33% 1	3	3.33

Q6 ¿Recomendaría nuestros servicios a gente que necesite ayuda por una preocupación relacionada a la salud mental o consumo de sustancias?

Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	66.67%	2
No	33.33%	1
No estoy seguro(a)	0.00%	0
TOTAL		3

Q7 ¿Qué servicios o apoyos necesitan el mayor mejoramiento y qué puede hacer BHS para mejorarlos?

Answered: 3 Skipped: 0

#	RESPONSES	DATE
1	Mas Parking	10/9/2023 3:25 PM
2	Promover Servicios en espanol	10/9/2023 3:23 PM
3	Mas intervecion para ninos	10/5/2023 4:54 PM

Q8 Por favor déjenos saber si piensa que los servicios del programa BHS están satisfaciendo las necesidades culturales y lingüísticas de la comunidad.¿Las áreas de la recepción son amigables y cálidas?

Answered: 3 Skipped: 0

1.7★
average rating

	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	66.67% 2	0.00% 0	33.33% 1	0.00% 0	3	1.67

Q9 ¿Los empleados de BHS son amables y profesionales?

Answered: 3 Skipped: 0

2.0★
average rating

	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	66.67% 2	0.00% 0	0.00% 0	33.33% 1	3	2.00

Q10 ¿Los empleados de BHS son respetuosos de su patrimonio cultural?

Answered: 3 Skipped: 0

1.3★
average rating

	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	66.67% 2	33.33% 1	0.00% 0	0.00% 0	3	1.33

Q11 ¿Los empleados de BHS explican las cosas de una manera que le gusta y endiente?

Answered: 3 Skipped: 0

1.7★
average rating

	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	66.67% 2	0.00% 0	33.33% 1	0.00% 0	3	1.67

Q12 ¿Los programas de BHS son útiles para muchos tipos de gente?

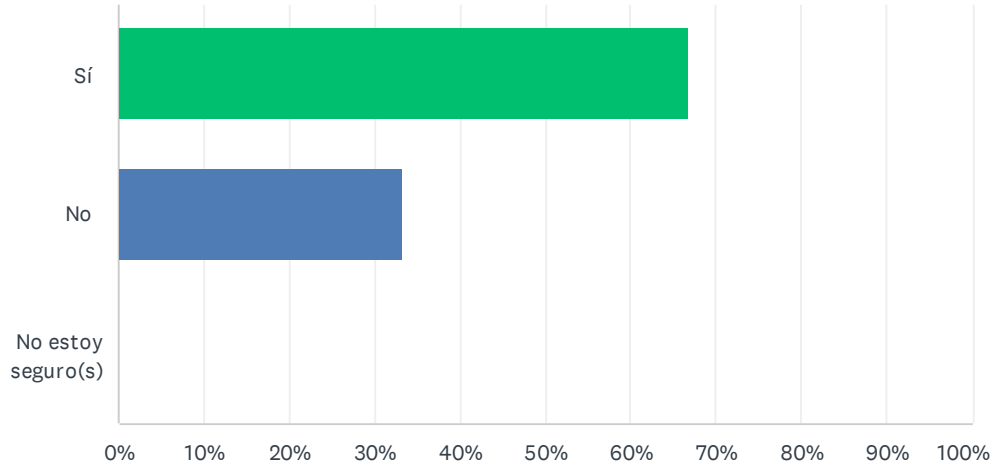
Answered: 3 Skipped: 0

1.7★
average rating

	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	66.67% 2	0.00% 0	33.33% 1	0.00% 0	3	1.67

Q13 ¿Usted o algún familiar ha usado los servicios de interpretación de BHS?

Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	66.67%	2
No	33.33%	1
No estoy seguro(s)	0.00%	0
TOTAL		3

Q14 Si ha usados los servicios de interpretación de BHS, ¿cómo describiría la calidad de los servicios de interpretación?

Answered: 3 Skipped: 0

3.7★
average rating

	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	33.33% 1	0.00% 0	0.00% 0	0.00% 0	66.67% 2	3	3.67

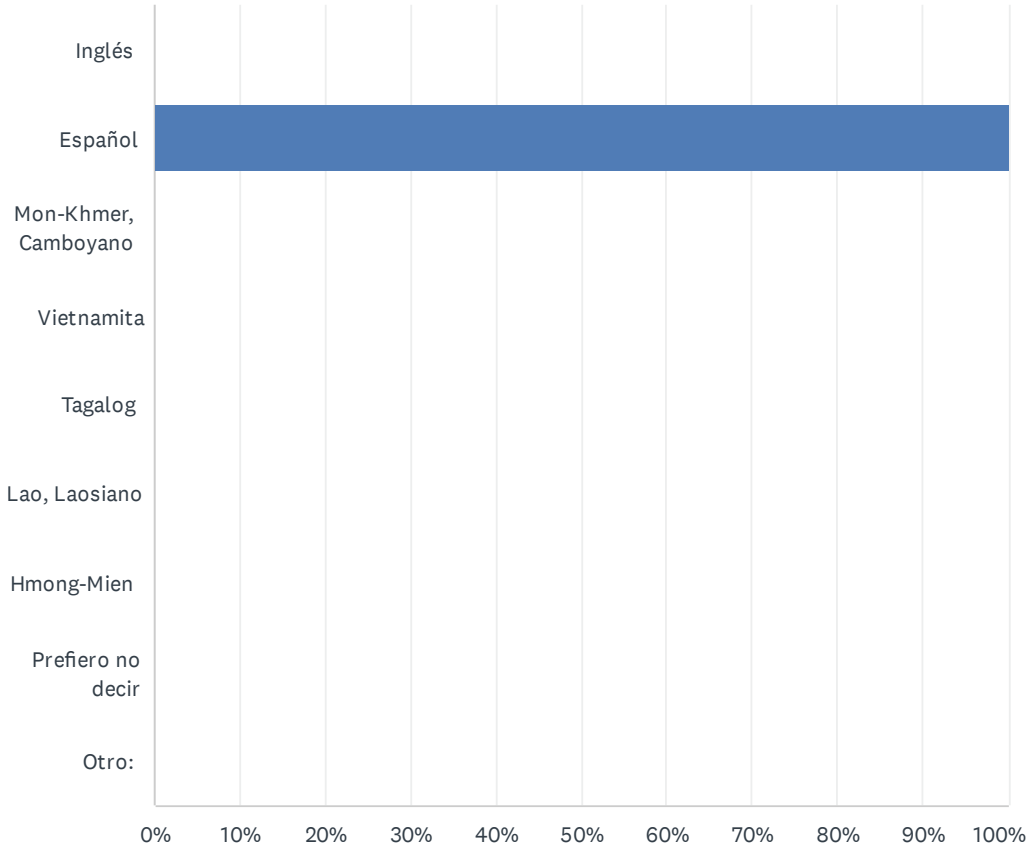
Q15 ¿Cuál es el factor MÁS importante que contribuye al bienestar y recuperación?

Answered: 2 Skipped: 1

#	RESPONSES	DATE
1	servicios de terapistas	10/9/2023 3:23 PM
2	CARES programa	10/5/2023 4:54 PM

Q16 Por favor indique el idioma que se habla con más frecuencia en su hogar (por favor elija solo uno):

Answered: 3 Skipped: 0



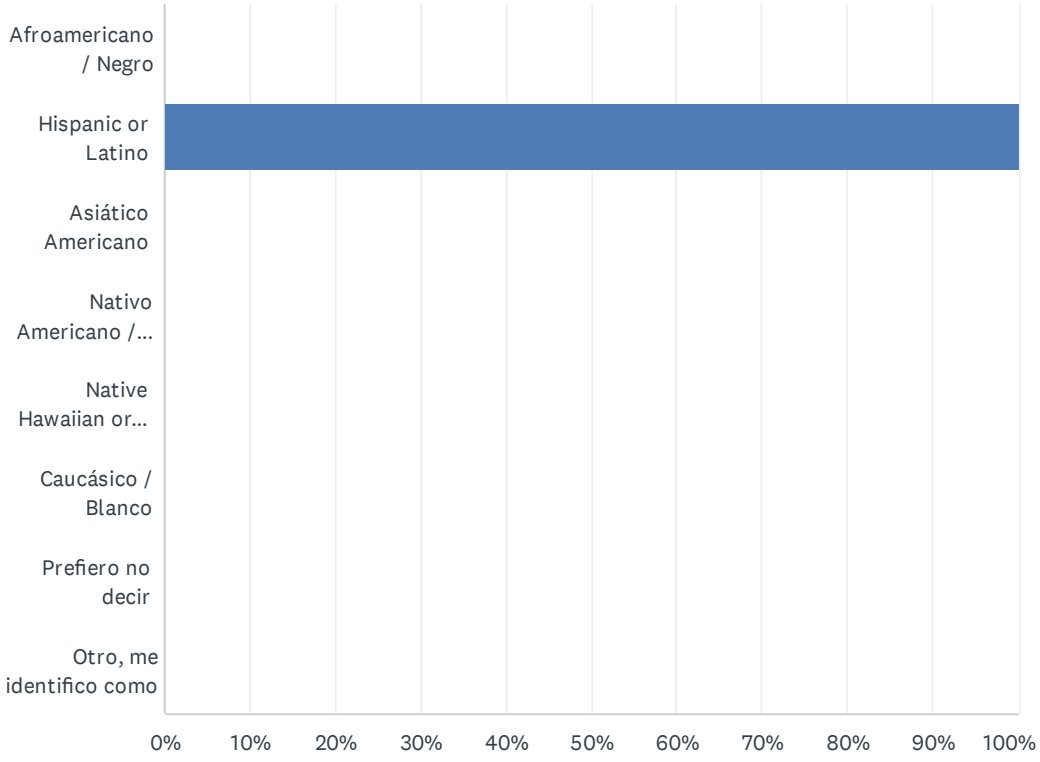
ANSWER CHOICES	RESPONSES	
Inglés	0.00%	0
Español	100.00%	3
Mon-Khmer, Camboyano	0.00%	0
Vietnamita	0.00%	0
Tagalog	0.00%	0
Lao, Laosiano	0.00%	0
Hmong-Mien	0.00%	0
Prefiero no decir	0.00%	0
Otro:	0.00%	0
TOTAL		3

#	OTRO:	DATE

There are no responses.

Q17 ¿Cuál es su raza?

Answered: 3 Skipped: 0

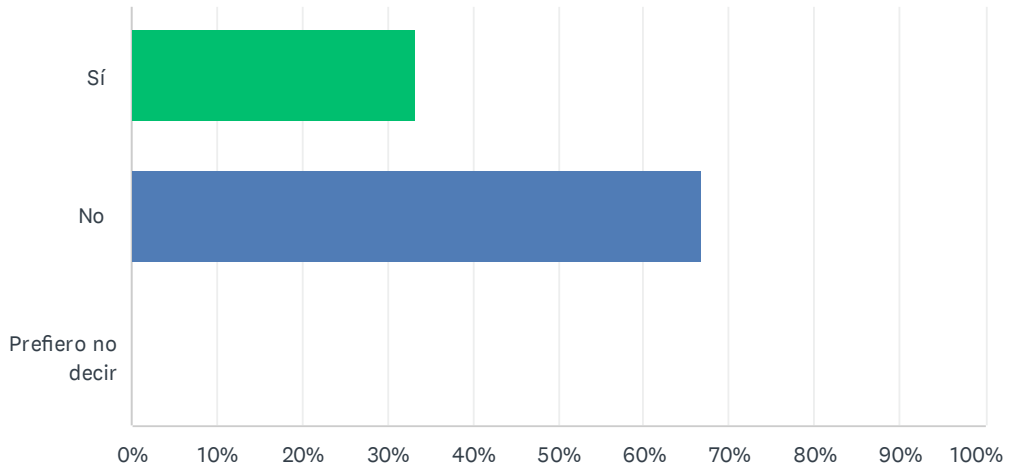


ANSWER CHOICES	RESPONSES	
Afroamericano / Negro	0.00%	0
Hispanic or Latino	100.00%	3
Asiático Americano	0.00%	0
Nativo Americano / Primeras Naciones (incluyendo Hawaiano o Natal de Alaska)	0.00%	0
Native Hawaiian or other Pacific Islander	0.00%	0
Caucásico / Blanco	0.00%	0
Prefiero no decir	0.00%	0
Otro, me identifico como	0.00%	0
TOTAL		3

#	OTRO, ME IDENTIFICO COMO	DATE
	There are no responses.	

Q18 ¿Actualmente está desamparado o en riesgo de estar desamparado?

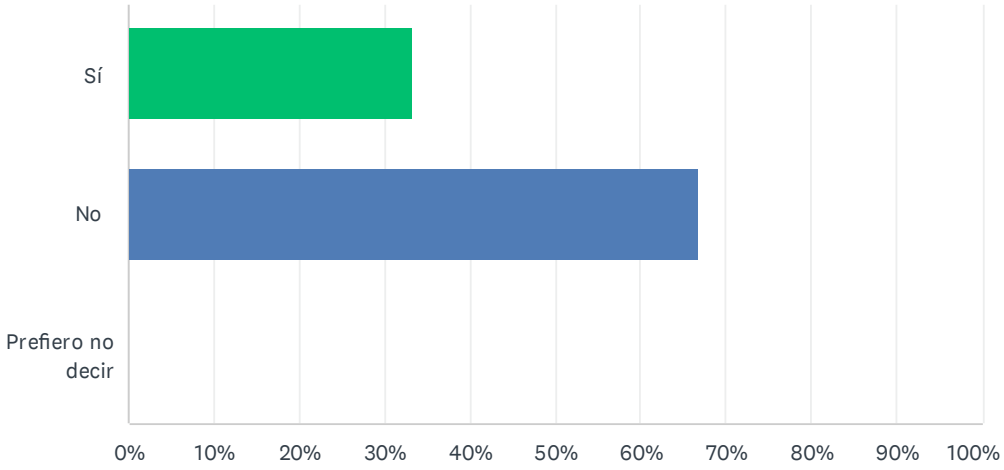
Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	33.33%	1
No	66.67%	2
Prefiero no decir	0.00%	0
TOTAL		3

Q19 ¿En los últimos tres años ha estado desamparado por más de un año o ha experimentado estar desamparado más de cuatro veces?

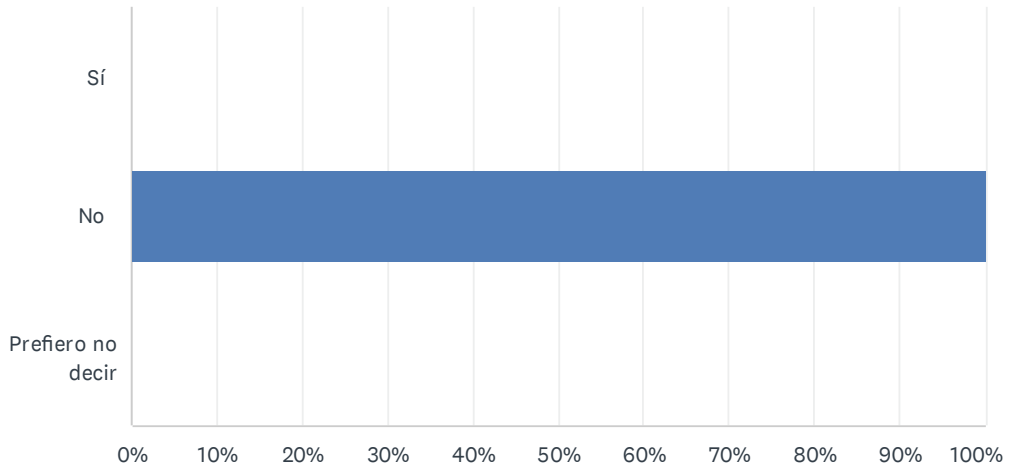
Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	33.33%	1
No	66.67%	2
Prefiero no decir	0.00%	0
TOTAL		3

Q20 ¿Ha sido arrestado(a) o detenido(a) por la policía?

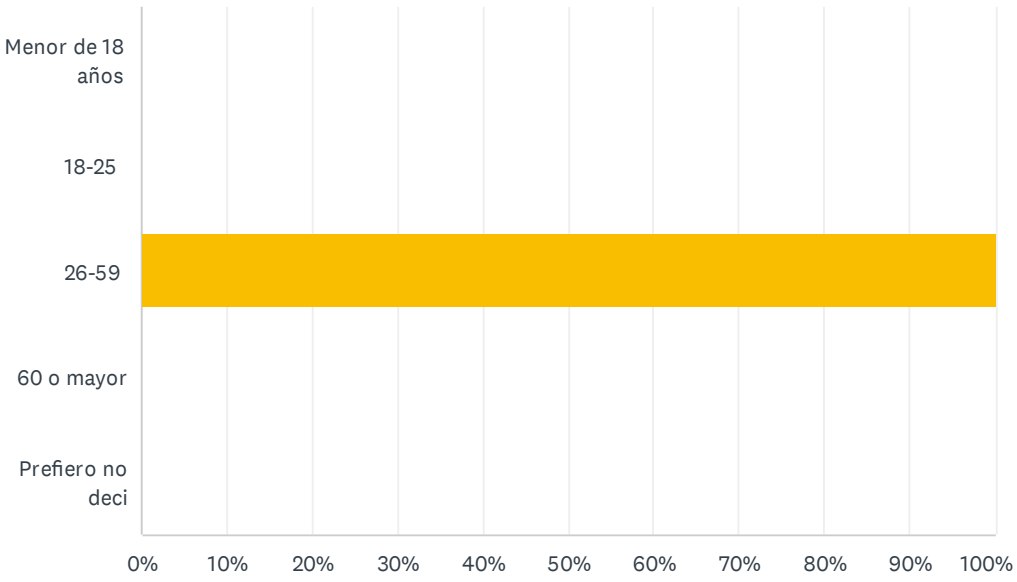
Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	0.00%	0
No	100.00%	3
Prefiero no decir	0.00%	0
TOTAL		3

Q21 Por favor indique su edad:

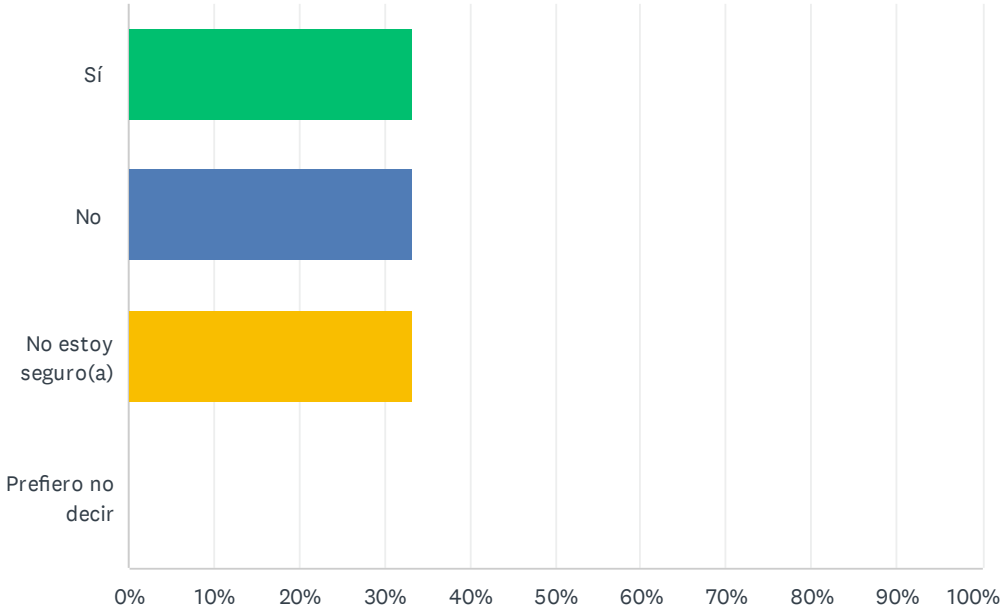
Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Menor de 18 años	0.00%	0
18-25	0.00%	0
26-59	100.00%	3
60 o mayor	0.00%	0
Prefiero no deci	0.00%	0
TOTAL		3

Q22 ¿Es padre o a punto de ser padre?

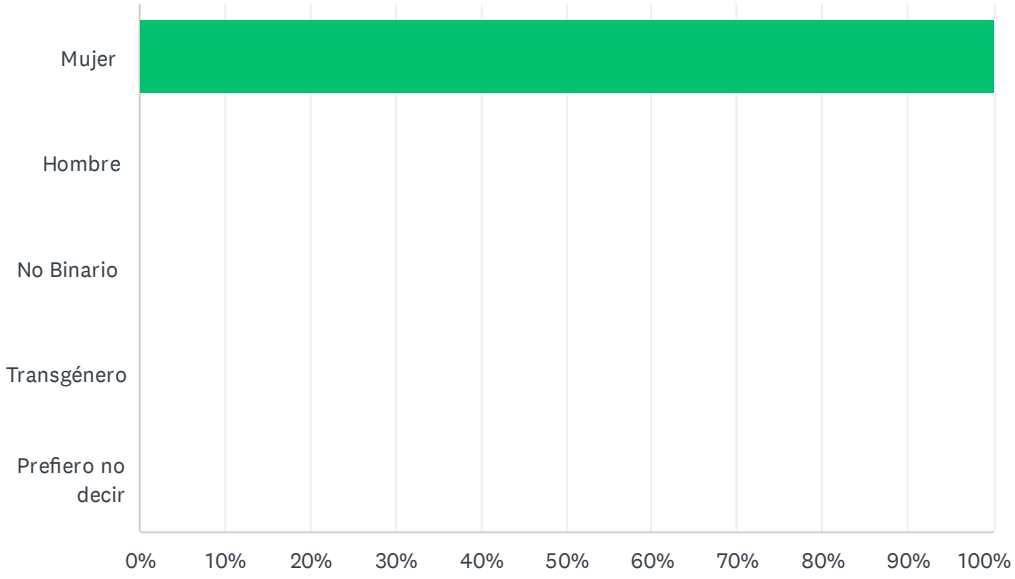
Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	33.33%	1
No	33.33%	1
No estoy seguro(a)	33.33%	1
Prefiero no decir	0.00%	0
TOTAL		3

Q23 Por favor indique su género

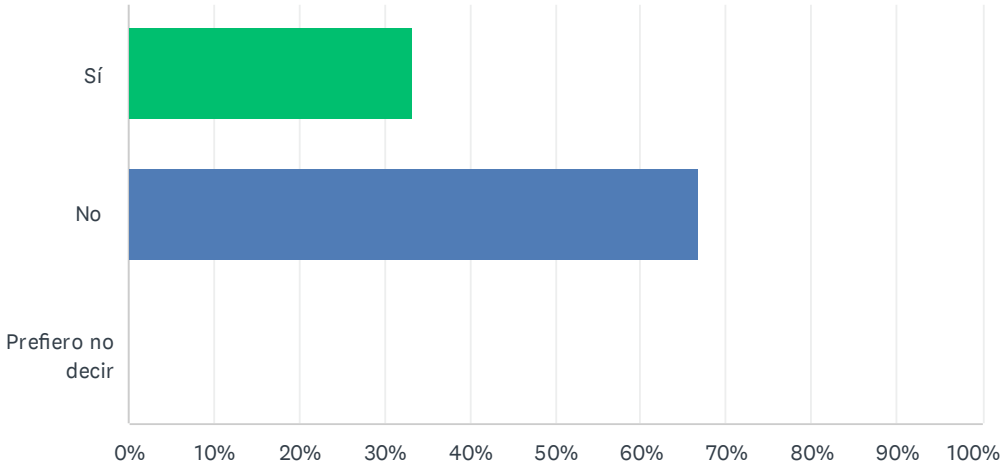
Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Mujer	100.00%	3
Hombre	0.00%	0
No Binario	0.00%	0
Transgénero	0.00%	0
Prefiero no decir	0.00%	0
TOTAL		3

Q24 ¿Usted se identifica como alguien con una discapacidad física o del desarrollo?

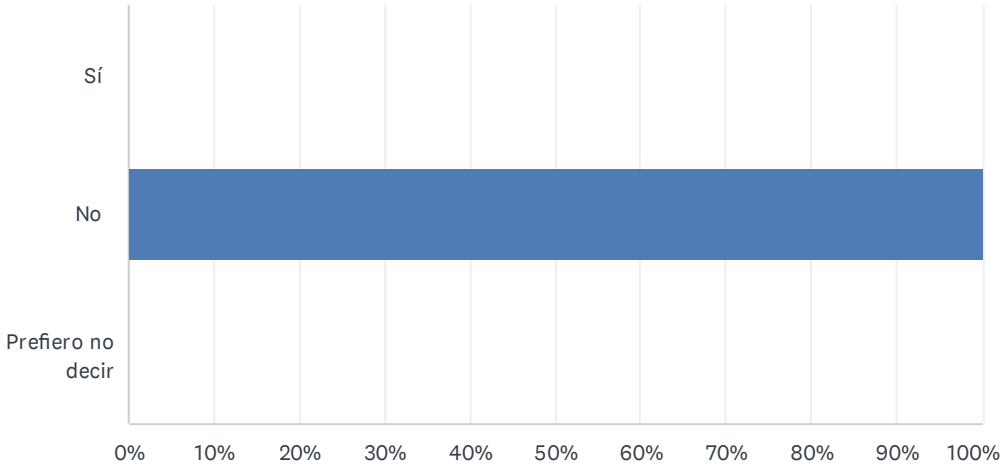
Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	33.33%	1
No	66.67%	2
Prefiero no decir	0.00%	0
TOTAL		3

Q25 Si es un adulto, ¿es un Veterano Militar Estadunidense, Naval, Marina, Fuerza Aérea o Guardacostas?

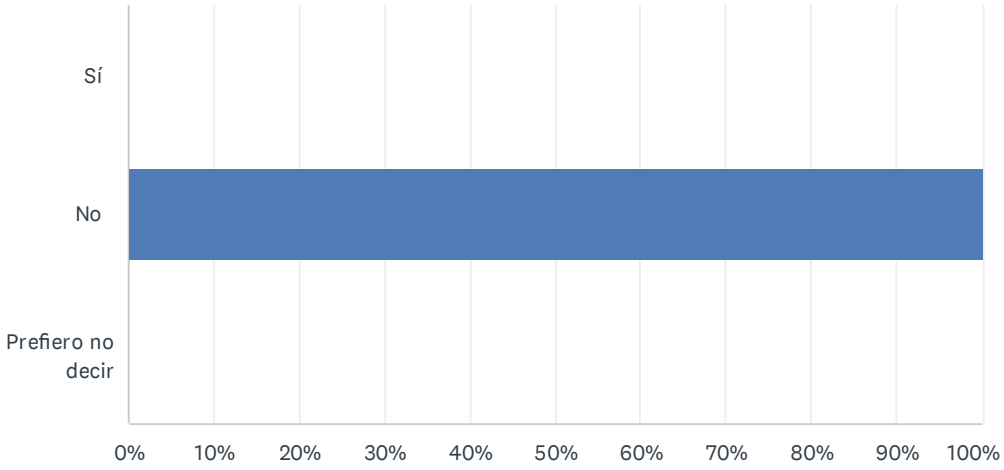
Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	0.00%	0
No	100.00%	3
Prefiero no decir	0.00%	0
TOTAL		3

Q26 ¿Usted se identifica como Lesbiana, Gay, Bisexual, Transgénero, u Homosexual/Cuestionándose (LGBTQ)?

Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	0.00%	0
No	100.00%	3
Prefiero no decir	0.00%	0
TOTAL		3

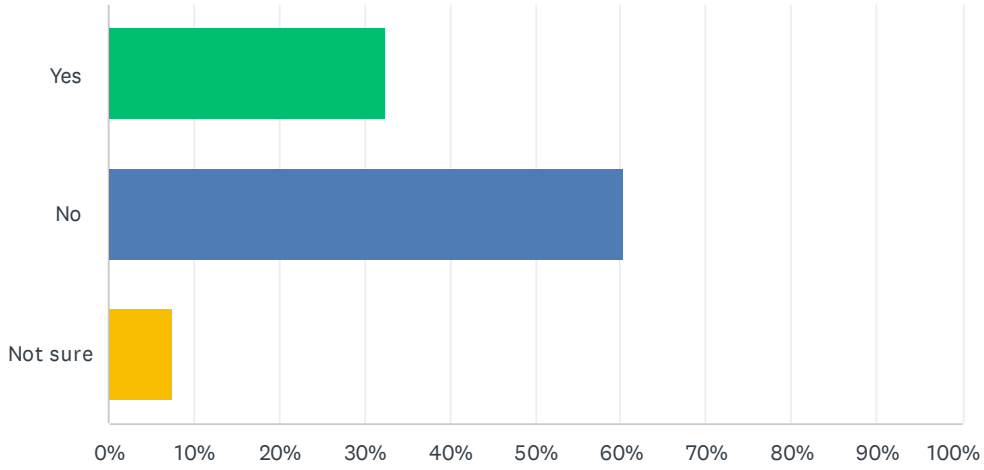
Q27 ¿Hay alguna otra cosa que quisiera compartir sobre qué se necesitaría para apoyar de mejor manera su bienestar y recuperación?

Answered: 3 Skipped: 0

#	RESPONSES	DATE
1	No utilice la palabra "latin/x" porque es una palabra offensivo	10/9/2023 3:25 PM
2	servicios preventivos y para el brenestor	10/9/2023 3:23 PM
3	Excelente trabajo el programa de CARES	10/5/2023 4:54 PM

Q1 Do you identify as someone who is receiving, or who needs, mental health treatment services?

Answered: 297 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	32.32%	96
No	60.27%	179
Not sure	7.41%	22
TOTAL		297

Q2 How would you rate the location where our services are provided?

Answered: 293 Skipped: 5

3.6★
average rating

	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	2.39% 7	11.60% 34	31.40% 92	31.74% 93	22.87% 67	293	3.61

Q3 How would you rate the length of time it takes to get an appointment?

Answered: 287 Skipped: 11

3.2★
average rating

	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	5.57% 16	20.21% 58	38.68% 111	24.04% 69	11.50% 33	287	3.16

Q4 How would you rate the types of individual or group interventions that are offered?

Answered: 286 Skipped: 12

3.5★
average rating

	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	2.45% 7	11.89% 34	38.81% 111	30.42% 87	16.43% 47	286	3.47

Q5 How would you rate the thoroughness of the services that are provided?

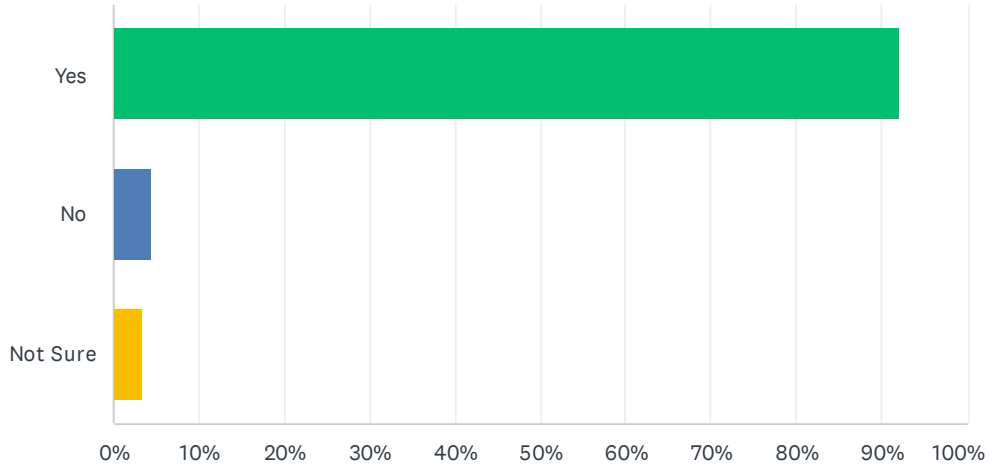
Answered: 290 Skipped: 8

3.5★
average rating

	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	1.03% 3	10.69% 31	37.93% 110	33.79% 98	16.55% 48	290	3.54

Q6 Would you recommend our services to people who need help for a mental health or substance use concern?

Answered: 294 Skipped: 4



ANSWER CHOICES	RESPONSES	
Yes	92.18%	271
No	4.42%	13
Not Sure	3.40%	10
TOTAL		294

Q7 What services or supports need the most improvement and what should BHS do to make them better?

Answered: 160 Skipped: 138

Q8 From a cultural and linguistic perspective, are the BHS lobby and reception areas friendly and welcoming?

Answered: 290 Skipped: 8

1.6★
average rating

	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	54.48% 158	34.83% 101	4.14% 12	6.55% 19	290	1.63

Q9 Are BHS staff members courteous and professional?

Answered: 292 Skipped: 6

1.5★
average rating

	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	61.64% 180	30.82% 90	4.11% 12	3.42% 10	292	1.49

Q10 Are BHS staff members respectful of your cultural heritage and provide cultural responsive services?

Answered: 291 Skipped: 7

1.5★
average rating

	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	62.54% 182	31.27% 91	2.06% 6	4.12% 12	291	1.48

Q11 Do BHS staff members explain things in a way that you like and understand?

Answered: 293 Skipped: 5

1.5★
average rating

	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	60.41% 177	33.11% 97	3.41% 10	3.07% 9	293	1.49

Q12 Are BHS programs helpful for many different types of people?

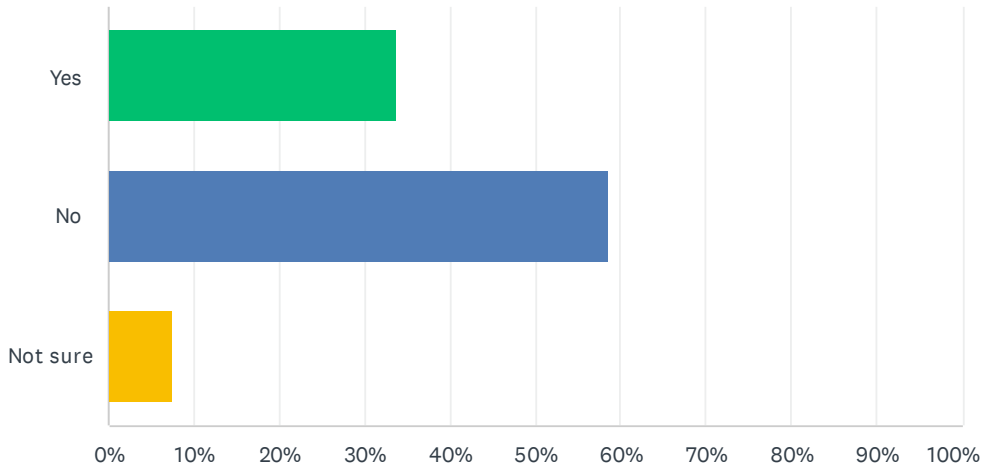
Answered: 293 Skipped: 5

1.5★
average rating

	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	62.80% 184	31.74% 93	1.71% 5	3.75% 11	293	1.46

Q13 Have you or a family member ever used BHS interpretation services?

Answered: 293 Skipped: 5



ANSWER CHOICES	RESPONSES	
Yes	33.79%	99
No	58.70%	172
Not sure	7.51%	22
TOTAL		293

Q14 If you've used BHS interpretation services, how would you describe the quality of the interpretation services?

Answered: 209 Skipped: 89

3.4★
average rating

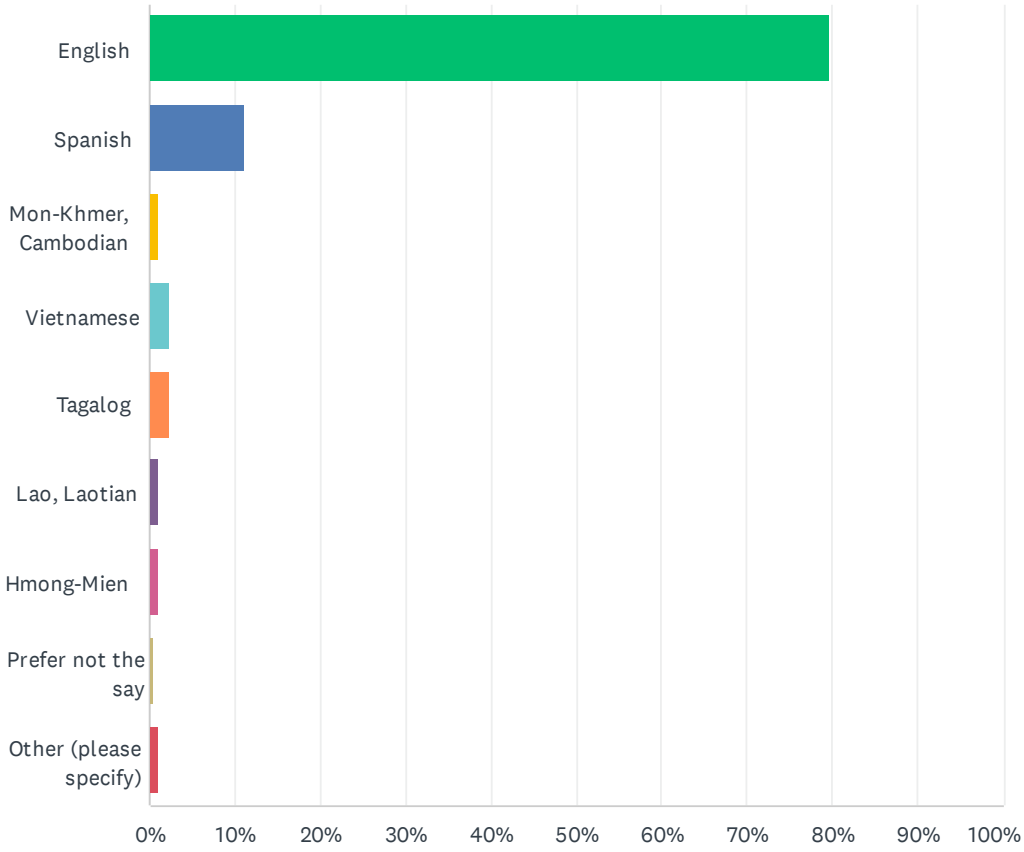
	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	2.39% 5	14.35% 30	39.71% 83	24.40% 51	19.14% 40	209	3.44

Q15 What is the MOST important factor that contributes to wellness and recovery?

Answered: 171 Skipped: 127

Q16 Please indicate the language that is most frequently spoken in your home (please choose only one).

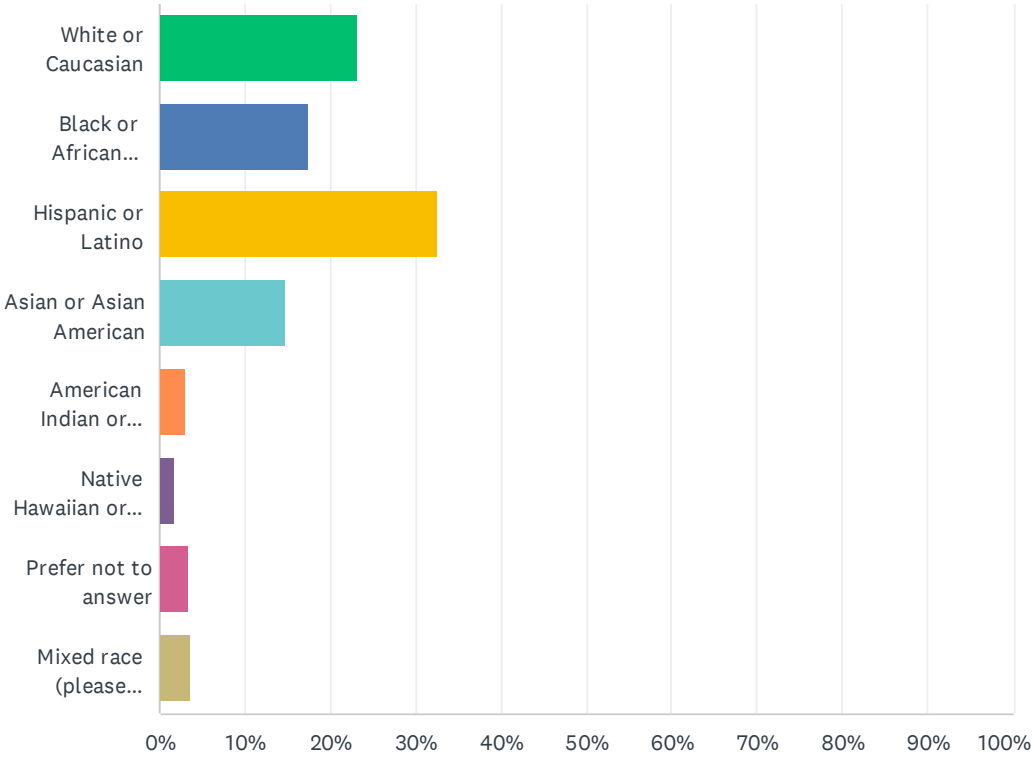
Answered: 297 Skipped: 1



ANSWER CHOICES	RESPONSES	
English	79.80%	237
Spanish	11.11%	33
Mon-Khmer, Cambodian	1.01%	3
Vietnamese	2.36%	7
Tagalog	2.36%	7
Lao, Laotian	1.01%	3
Hmong-Mien	1.01%	3
Prefer not the say	0.34%	1
Other (please specify)	1.01%	3
TOTAL		297

Q17 What is your race?

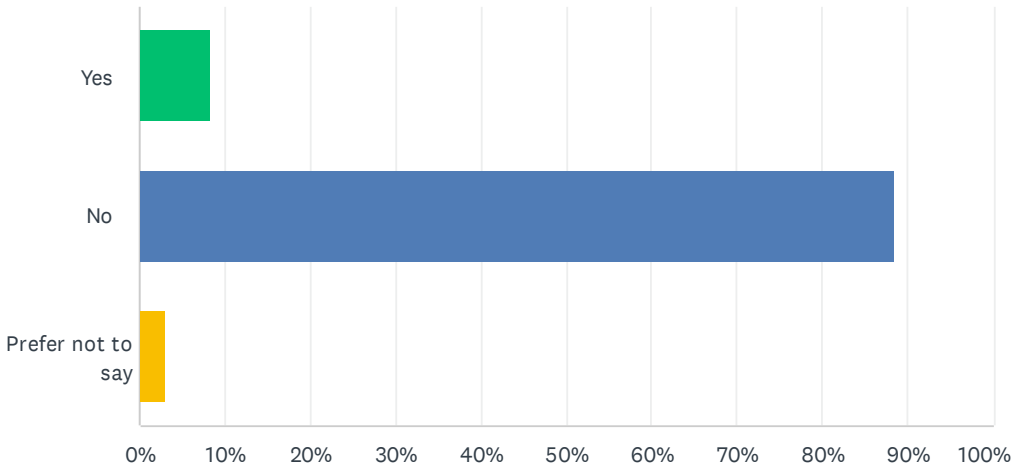
Answered: 297 Skipped: 1



ANSWER CHOICES	RESPONSES	
White or Caucasian	23.23%	69
Black or African American	17.51%	52
Hispanic or Latino	32.66%	97
Asian or Asian American	14.81%	44
American Indian or Alaska Native	3.03%	9
Native Hawaiian or other Pacific Islander	1.68%	5
Prefer not to answer	3.37%	10
Mixed race (please specify)	3.70%	11
TOTAL		297

Q18 Are you currently homeless or at risk of homelessness?

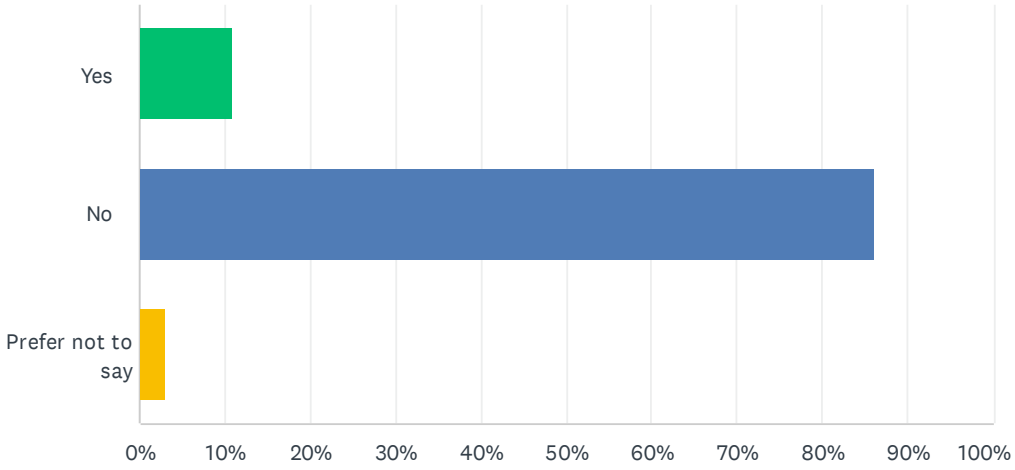
Answered: 297 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	8.42%	25
No	88.55%	263
Prefer not to say	3.03%	9
TOTAL		297

Q19 In the past three years, have you been homeless for more than a year or have you experienced homelessness for more than four times?

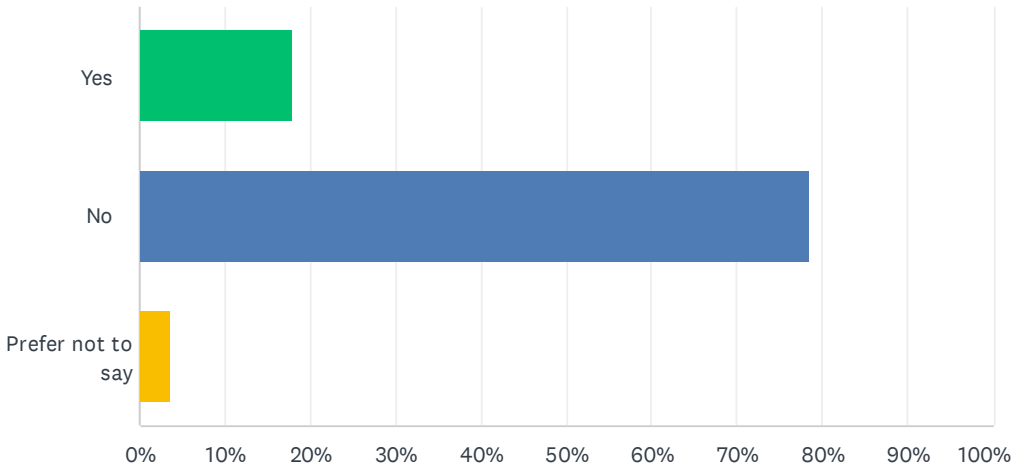
Answered: 296 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes	10.81%	32
No	86.15%	255
Prefer not to say	3.04%	9
TOTAL		296

Q20 Have you ever been arrested or detained by the police?

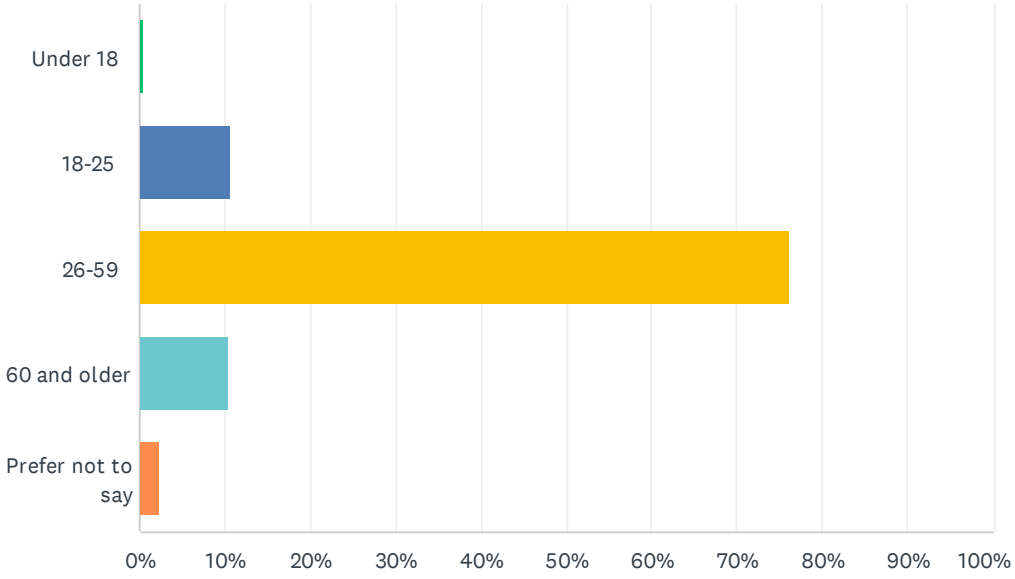
Answered: 297 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	17.85%	53
No	78.45%	233
Prefer not to say	3.70%	11
TOTAL		297

Q21 Please indicate your age

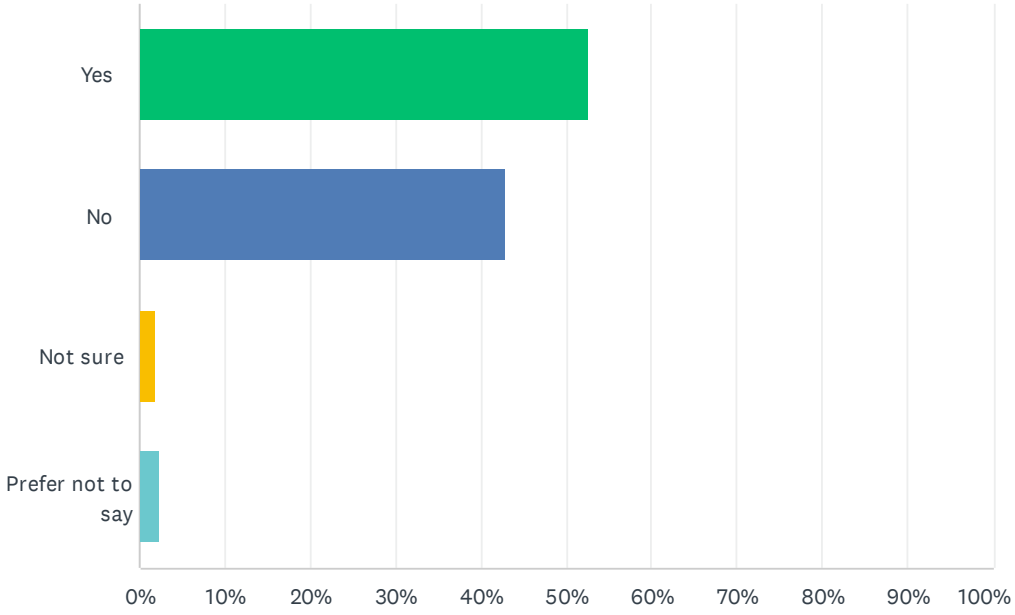
Answered: 298 Skipped: 0



ANSWER CHOICES	RESPONSES	
Under 18	0.34%	1
18-25	10.74%	32
26-59	76.17%	227
60 and older	10.40%	31
Prefer not to say	2.35%	7
TOTAL		298

Q22 Are you a parent or are you about to be a parent?

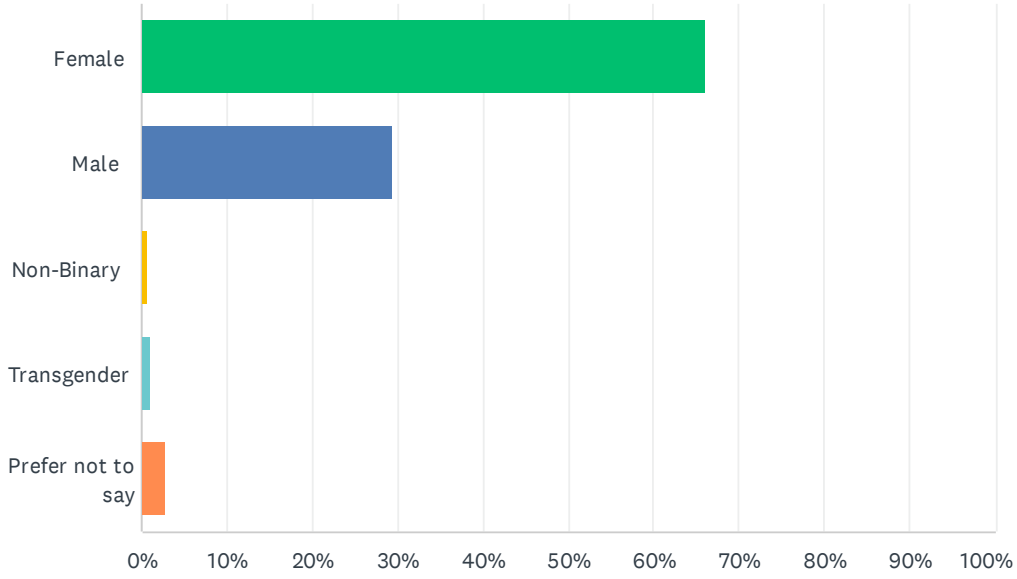
Answered: 298 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	52.68%	157
No	42.95%	128
Not sure	2.01%	6
Prefer not to say	2.35%	7
TOTAL		298

Q23 Please indicate your gender

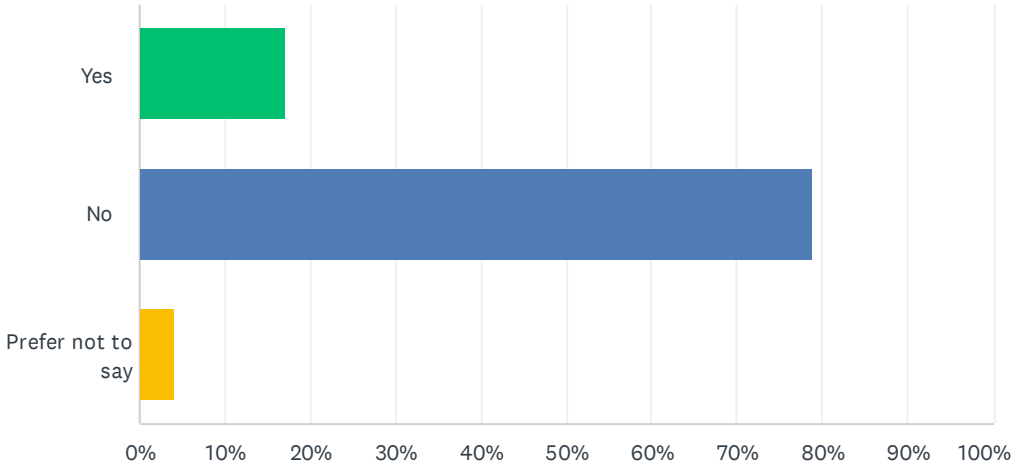
Answered: 298 Skipped: 0



ANSWER CHOICES	RESPONSES	
Female	66.11%	197
Male	29.53%	88
Non-Binary	0.67%	2
Transgender	1.01%	3
Prefer not to say	2.68%	8
TOTAL		298

Q24 Do you self-identify as someone with a physical or developmental disability?

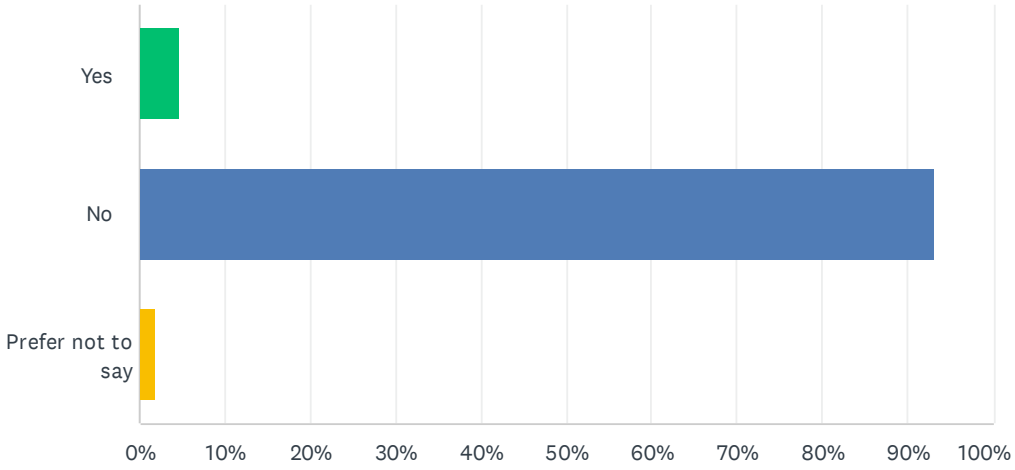
Answered: 298 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	17.11%	51
No	78.86%	235
Prefer not to say	4.03%	12
TOTAL		298

Q25 Are you a U.S. Military Veteran of the Army, Navy, Marines, Air Force, or Coast Guard?

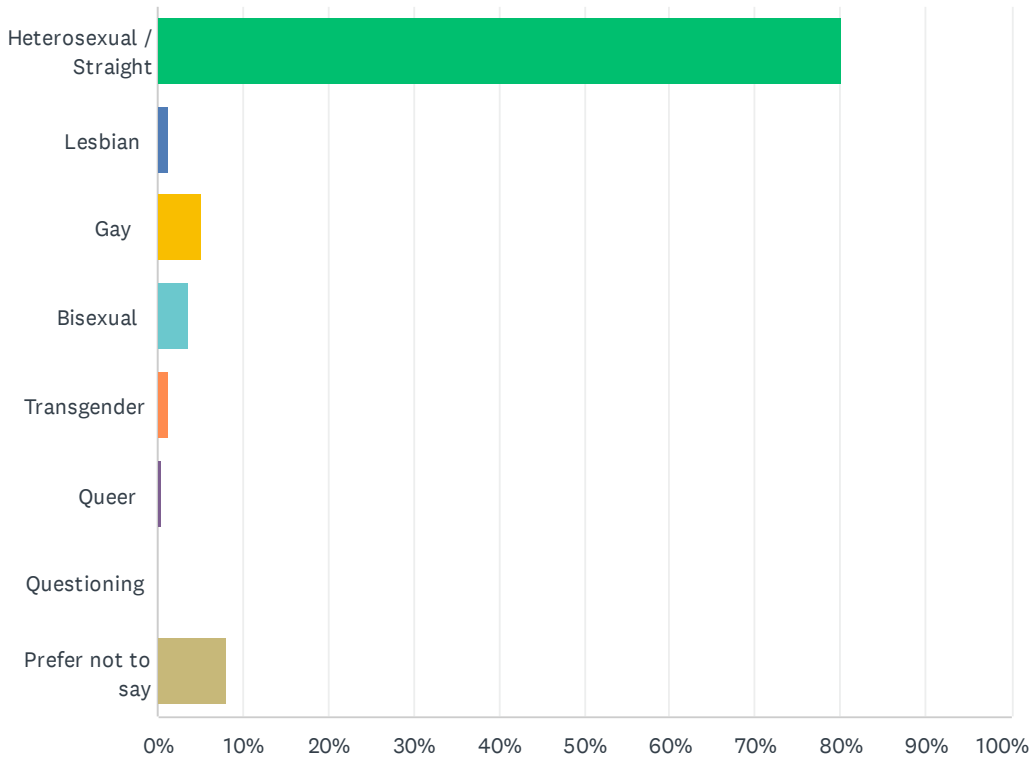
Answered: 297 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	4.71%	14
No	93.27%	277
Prefer not to say	2.02%	6
TOTAL		297

Q26 What is your sexual orientation?

Answered: 298 Skipped: 0



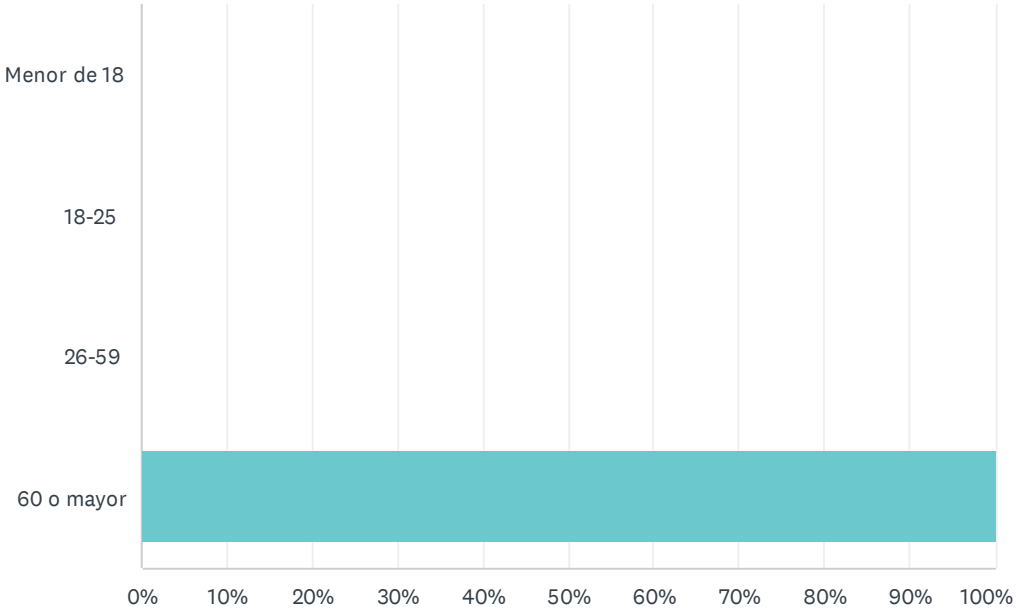
ANSWER CHOICES	RESPONSES	
Heterosexual / Straight	80.20%	239
Lesbian	1.34%	4
Gay	5.03%	15
Bisexual	3.69%	11
Transgender	1.34%	4
Queer	0.34%	1
Questioning	0.00%	0
Prefer not to say	8.05%	24
TOTAL		298

Q27 Is there anything else you want to share about what is needed to better support your wellness and recovery?

Answered: 99 Skipped: 199

Q1 Indique su rango de edad

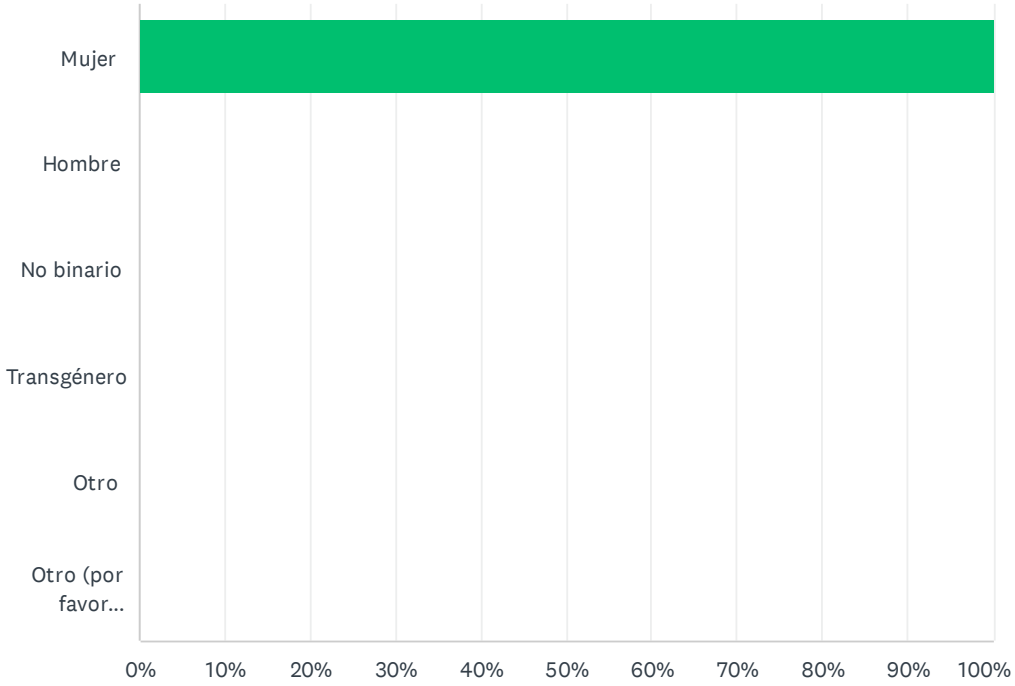
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Menor de 18	0.00%	0
18-25	0.00%	0
26-59	0.00%	0
60 o mayor	100.00%	1
Total Respondents: 1		

Q2 Indique su género

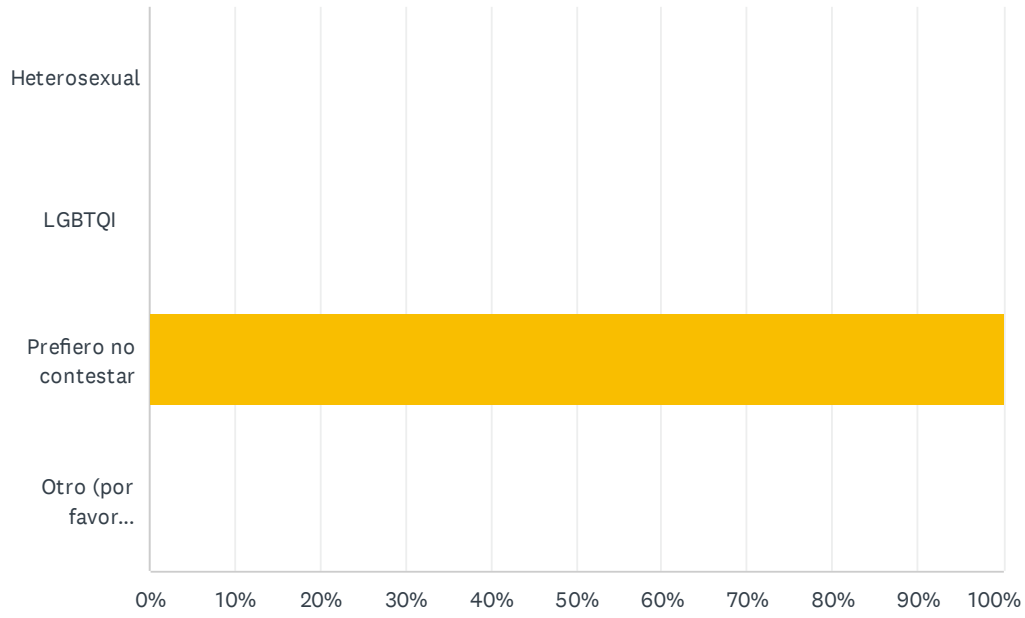
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Mujer	100.00%	1
Hombre	0.00%	0
No binario	0.00%	0
Transgénero	0.00%	0
Otro	0.00%	0
Otro (por favor especifique)	0.00%	0
TOTAL		1

Q3 ¿Cuál es su orientación sexual?

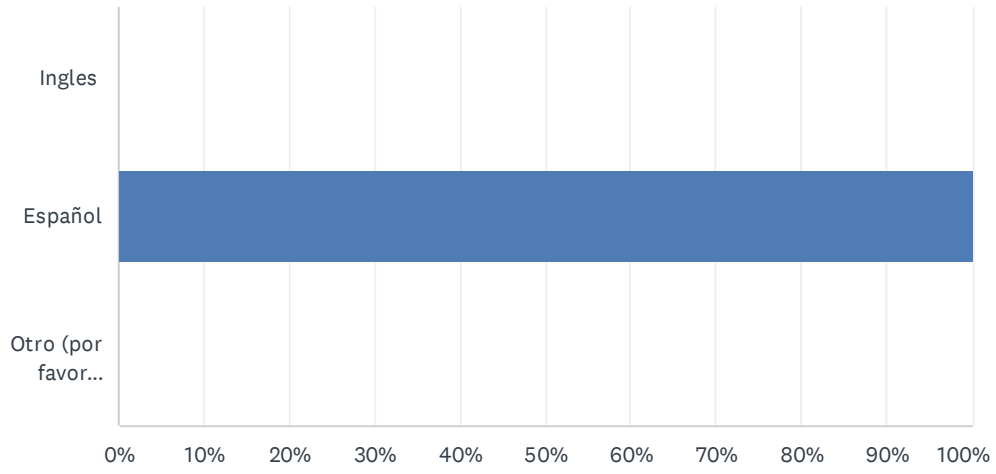
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Heterosexual	0.00%	0
LGBTQI	0.00%	0
Prefiero no contestar	100.00%	1
Otro (por favor especifique)	0.00%	0
TOTAL		1

Q4 Indique el idioma principal que se habla en su hogar

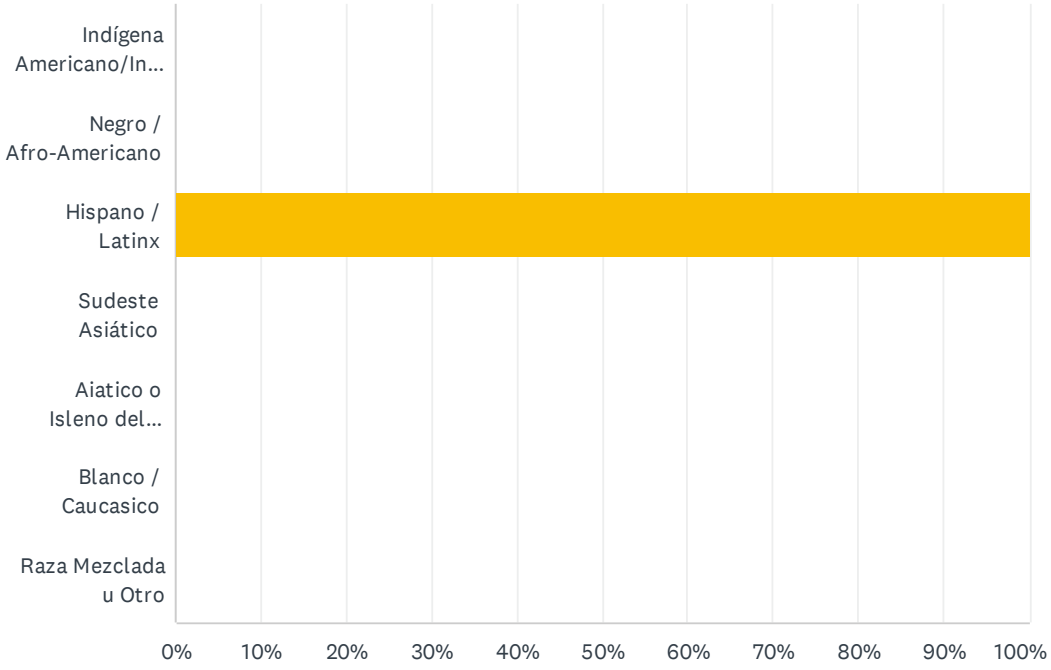
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Ingles	0.00%	0
Español	100.00%	1
Otro (por favor especifique)	0.00%	0
TOTAL		1

Q5 Indique su raza o etnia

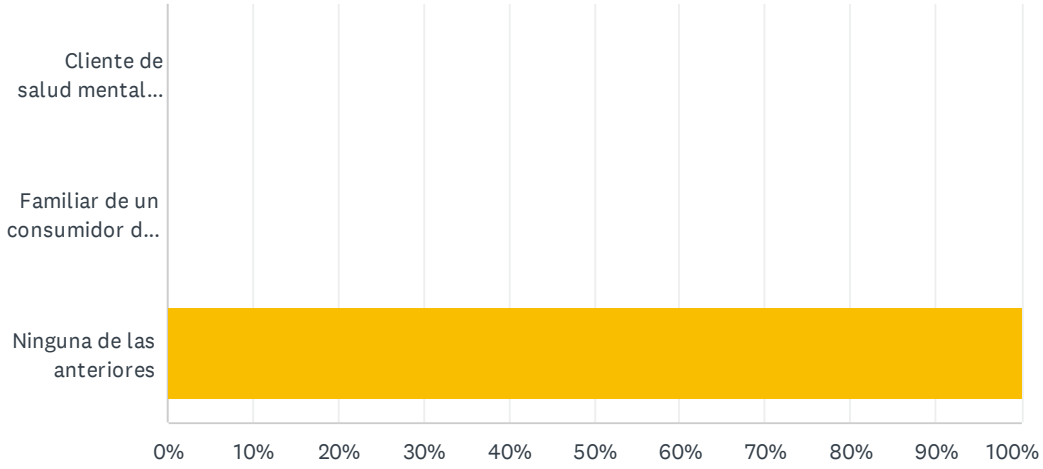
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Indígena Americano/Indio Americano/Primeras Naciones (incluyendo Hawaiano y Nativo)	0.00%	0
Negro / Afro-Americano	0.00%	0
Hispano / Latinx	100.00%	1
Sudeste Asiático	0.00%	0
Aiatico o Isleno del Pacifico	0.00%	0
Blanco / Caucasico	0.00%	0
Raza Mezclada u Otro	0.00%	0
TOTAL		1

Q6 Afiliación de consumidor (si aplica)

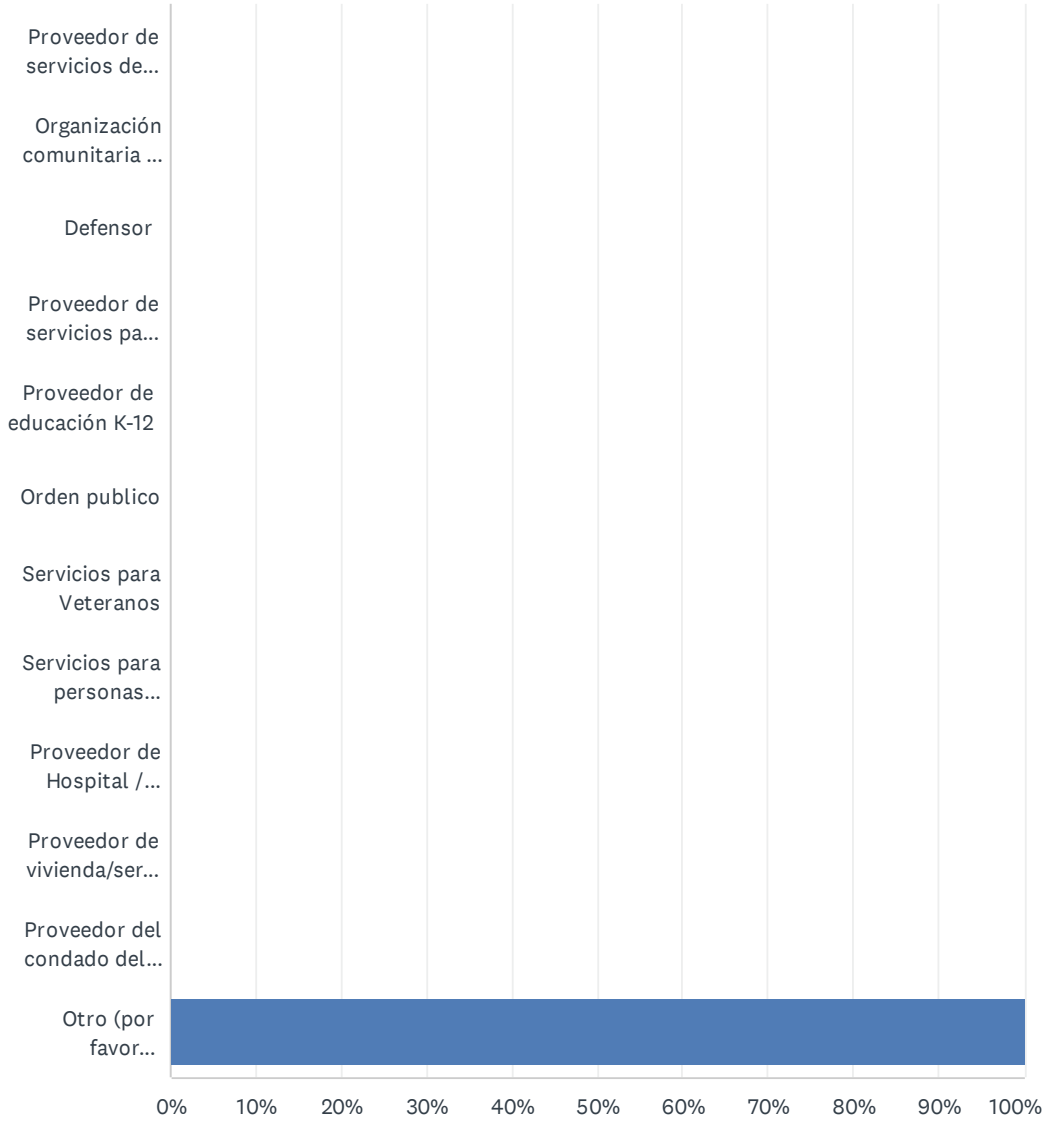
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Cliente de salud mental / consumidor	0.00%	0
Familiar de un consumidor de salud mental	0.00%	0
Ninguna de las anteriores	100.00%	1
Total Respondents: 1		

Q7 Afiliación de intereses (marque todas las que aplican)

Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Proveedor de servicios de salud mental comunitarios / sin fines lucrativos	0.00%	0
Organización comunitaria (no un proveedor de servicios de salud mental)	0.00%	0
Defensor	0.00%	0
Proveedor de servicios para niños y familias	0.00%	0
Proveedor de educación K-12	0.00%	0
Orden publico	0.00%	0
Servicios para Veteranos	0.00%	0
Servicios para personas mayores	0.00%	0
Proveedor de Hospital / cuidado de salud	0.00%	0
Proveedor de vivienda/servicios de vivienda	0.00%	0
Proveedor del condado del departamento de salud mental o de servicios de abuso de sustancias	0.00%	0
Otro (por favor especifique)	100.00%	1
Total Respondents: 1		