SAN JOAQUIN COUNTY
BEHAVIORAL HEALTH SERVICES

MENTAL HEALTH SERVICES ACT

COMMUNITY SERVICES AND SUPPORTS
IMPLEMENTATION PROGRESS REPORT
JANUARY-DECEMBER 2007

July 2008

Introduction

On October 27, 2006, San Joaquin County Behavioral Health Services (BHS) received approval of the Mental Health Services Act (MHSA) Community Services and Supports (CSS) plan from the California State Department of Mental Health (DMH). This followed a comprehensive community planning process involving over 5,000 participants, and approval by the San Joaquin County Board of Supervisors in June 2006 to submit the plan. The long planning process involved contracted community-based organizations and the community at large. Although this was invaluable in gathering information from and beginning a partnership with the community, it did delay plan submission and program implementation.

On January 16, 2007, the San Joaquin County Board of Supervisors authorized the implementation by approving the agreement with the DMH for the MHSA three-year program and expenditure plan, authorizing the establishment of the MHSA Trust Fund, approving the 2006-07 budget appropriations for the MHSA Trust Fund, approving the revised 2006-07 budget appropriations for the Mental Health Services budget, and approving the allocation of 45 new positions to Mental Health Services.

BHS began agency reorganization in March 2007, with the anticipated addition of the MHSA programs, and changes in the Senior Management team. In 2007 recruitment and initial hiring for staffing began, sites were located and leases approved, remodel teams met, seven (7) Request for Proposals (RFP) for contractors were developed and late 2007- early 2008, thirteen (13) agreements were approved by the Board of Supervisors.

Twelve (12) programs were approved in the San Joaquin County CSS Plan, including six (6) Full Service Partnerships (FSP) and six (6) General System Development (SD) programs. No Outreach and Engagement (OE) programs were specifically developed, as outreach and engagement services were embedded into all 6 FSPs and the Wellness Center System Development program.

San Joaquin County planned to contract with community- based organizations in 2007 and 2008 to partner with county providers in the implementation of the CSS plan. Two are housing and employment programs to provide supports to enrollees of the six full service partnership programs. Nine of these community-based organizations will have agreements specifically to increase access to mental health care to ethnic and priority populations with outreach and services. The nine priority populations for San Joaquin County in the CSS plan include the following communities: African-American, Cambodian, Gay, Lesbian, Bisexual and Transgender, Hmong, Latino, Laotian, Muslim/Middle Eastern Native American and Vietnamese.

This report will focus on the progress towards implementation from January-December 2007, in accordance with DMH Information Notice #08-08.

A. Program/Services Implementation

1) The County is to briefly report by Work Plan on how implementation of the approved program/services is proceeding, including a) whether implementation activities are generally proceeding as described in the County's approved Plan and identifying any key differences if not; b) what percent of anticipated clients have been enrolled in each FSP work plan; c) what percent of anticipated clients have received the indicated program or service in each General System Development work plan; and d) the major implementation challenges that the County has encountered.

Full Service Partnership Programs

For each of the six full service partnership programs, implementation activities are generally proceeding as described in the approved Plan. The six FSPs began hiring the county staff allocated to the programs, and were waiting in 2007 for the completion of the RFP process and contracts with the community-based organizations to complement the program with the culturally focused outreach and case management components. There were delays in the initial RFP timeline, with some county procedural changes.

There were no clients enrolled in 2007, but there were Outreach and Engagement and System Development activities, as reported on Exhibit 6 (Three Year Plan- Quarterly Progress Goals and Report).

FSP-1 Child and Youth Full Service Partnership

The goal of this program is to serve at least 60 children, receiving referrals primarily from Human Services Agency's Intake and Assessment Unit and the Immediate Response Team, and the Juvenile Justice System. All children must have a Serious Emotional Disturbance (SED) and be impacted by the child welfare foster care system or the juvenile justice system formally or informally. The goal is to reduce the need for either system to remove SED children and youth from their homes.

In the year 2007, BHS conducted meetings to introduce the MHSA Children and Youth Services (CYS) programs to the Juvenile Court Judges, Juvenile Probation, the Public Defenders Office, District Attorney's Office, the Human Services Agency, community programs, families, and consumers in the form of work groups. Periodic updates were given to the various agencies that CYS MHSA would have a collaborative relationship with. Contact was maintained with parents who hoped that the MHSA program would soon become available to assist them in the management of their children. CYS MHSA staff continued to attend the scheduled MHSA general and specific meetings during the 2007 year.

There was a lot of time and effort during the year spent in meeting with our partnering agencies and with the community planning and determining how to best run the FSP. Everyone had their own ideas and there were many different levels of experience which

both complicated and enhanced the process. Fortunately CYS has a long history of working with community based organizations and partner agencies together to serve youth and their families in our other programs. These relationships have enabled us to draw from the multitude of experience that CYS has gained in partnering with the community to give us an idea of where to start. CYS Managers representing both Juvenile Justice and Child Welfare were able to attend all the planning meetings, and in June of 2007 hired a Clinical Supervisor with previous experience working with a Wraparound that would be hands on with the Juvenile Justice and the Child Welfare focus. Preparations were made in fall 2007 to prepare for the hiring of county clinical staff in early 2008. Contractor staff to focus on outreach and case management to the Latino, African-American and Southeast Asian communities will be added in 2008 once contracts are completed.

FSP-2 Black Awareness Community Outreach Program/Multicultural Services (BACOP/MC) Full Service Partnership

The Black Awareness Community Outreach Program/ Multicultural Services program (BACOP/MC) has particular focus on improving access to specialty mental health services to African-American, Native American, Muslim/Middle Eastern and Gay, Lesbian, Bisexual and Transgender (GLBT) persons in the county. For the African-American component there is an additional focus on individuals who use intensive services (Crisis, Inpatient) but do not use other supportive services within mental health and those who are currently receiving services yet continue to use intensive services at a high rate. San Joaquin County completed an exceptional outreach and engagement process that facilitated an in-depth community and support services plan. BHS dug deep into those communities that have been identified as being underserved, unserved and inappropriately served. This was achieved by multiple community meetings in various community meeting venues and non traditional gathering places. This was continued in 2007 with the BACOP/MC implementation subcommittee meeting regularly, and comprised of community-based organizations, county staff, consumers and family members.

In 2007, initial staff was hired for BACOP/MC, including the Program Manager, Clinical Supervisor and case management staff. A program site was determined, the lease was negotiated, and plans made for building changes, furniture, computers and other supplies needed to accommodate a mental health program with a planned move to the new site in spring 2008.

The First 90 Days Model of intensive support was developed by BACOP/MC as a service delivery model to ensure the early contacts with the mental health system are positive, supportive and move towards continued appropriate participation in the system, moving towards independence and recovery.

FSP-3 La Familia Full Service Partnership

The La Familia program has particular focus on increasing the penetration rate for Latinos receiving specialty mental health services. Data indicates that Latinos in San Joaquin County are underserved at all points of service. The La Familia program strives to develop trust and respect between the Latino community and mental health services.

There was a decision made by BHS and stakeholders to utilize contracts through the RFP process with culturally focused community-based organizations to provide staff to facilitate outreach, cultural and language consultation. The RFP and contract process for the FSP was not completed in 2007. Bilingual and bicultural county staff also is to be assigned to the program.

In April 2007 the first La Familia FSP Implementation Sub-Committee met. This group was developed to gain stakeholder input into all aspects of the proposed program. The group consisted of consumers, family members, existing County staff, Community-based Organization staff, and community members. The group initially met weekly, then every other week through July 2007. Meeting minutes were taken and distributed to all committee members and other interested parties, including BHS Management. Minutes and agenda were done in both English and Spanish and Interpreters were utilized as the group facilitator was monolingual for English. The process initially involved brainstorming general program areas that the group identified as important treatment/recovery areas. The next step was to list more specific issues within each of the areas, and finally to suggest possible interventions, strategies, and/or ideas about how these areas could best be addressed. The general areas identified are: Assessment, Money/Financial Needs, Spiritual Needs, Housing/Transitions, Drugs and Alcohol, Collaboration, "Crisis Prevention", Facility/Site Issues, Mental Health Treatment, Aftercare, Outcomes/Evaluation, and Outreach.

A La Familia program site was determined, the lease negotiated and plans were made for building changes needed to accommodate a mental health program, with a planned move to the new site in 2008.

FSP-4 Southeast Asian Recovery Services (SEARS) Full Service Partnership

The SEARS program focuses on services to the Southeast Asian community to address the myriad of psychosocial barriers to ongoing wellness. The primary communities of focus are Cambodian, Hmong, Laotian and Vietnamese.

In April 2007 the first Southeast Asian Recovery Services (SEARS) Implementation Sub-Committee met. This group was developed to gain stakeholder input into all aspects of the proposed program. The group consisted of consumers, existing County staff, Community-based Organization staff, and community members. The group initially met weekly, then weekly or bi-weekly through July 2007. Meeting minutes were taken and distributed to all committee members and other interested parties, including BHS Management. While all the committee represented different cultures and languages, all

were bilingual, although interpreter staff were readily available. The process involved initially developing a Mission Statement representing the focus and philosophy of the program. The statement reads: "The SEARS Full Service Partnership will provide whatever it takes to stabilize individuals and to initiate recovery and movement towards self-sufficiency". Meetings initially addressed proposed program philosophy structure and Legislative requirements. The group then generated a list of services, needs, concepts, interventions, and culturally congruent approaches to consumers. This list of "thoughts, ideas, and concepts" was then organized into a number of "program component categories", including outreach and outcomes in addition to direct service issues.

The new program required adding an additional suite, furniture, and computers to the existing Transcultural Clinic site, to accommodate the FSP. County interpreters and staff have been assigned, but the contracts were not in place in 2007 with the culturally focused community-based organizations to provide staff to facilitate outreach, cultural and language consultation.

FSP-5 Adult Forensic Court Full Service Partnership

When the community identified Forensic and the adult mentally ill offender as a target need under MHSA services there were several key factors to address, especially how MHSA would work with the Superior Court system. A Forensic advisory sub committee was formed consisting of consumers and family members, mental health staff, court employees, justice of the peace, attorneys and other interested community leaders and citizens. The subcommittee met during the months of January through August. This committee came to consensus with definite goals for program planning and implementation. Consensus included definition of the population to served, criteria for services and descriptions of the service delivery model.

Once the Forensic advisory sub-committee came to consensus it was time to plan and organize with the court system just how the MHSA Court Program could be implemented and interact with the court process. Planning meetings included judges, attorneys and court staff and were held to begin planning the court calendar and to determine how the mentally ill offender would progress in the court system. Each mentally ill offender's case is addressed on a case by case basis and progress is monitored by the court.

The program manager was hired in April and one case manager was hired during the month of June. Additional staffing would be provided by Community Based Organizations once (RFP) proposals were received, reviewed and awarded a contract (in 2008).

Outreach and engagement began in August which proved to be beneficial to the court system and to mentally ill offenders. Persons who meet the criteria as unserved, underserved or not appropriately served were among those contacted. There is a positive working relationship between the Superior Courts, Criminal Justice System, consumers and Family Members and the community. Due to the fact the RFP process was pending,

service delivery was limited in 2007. Contractor staff to focus on outreach and case management to the Latino, African-American and Southeast Asian communities will be added in 2008 once contracts are completed.

FSP-6 Gaining Older Adult Life Skills (GOALS) Full Service Partnership

The GOALS program is to address the needs of persons aged 60 and over who have a serious mental illness. A range of services and treatment options will utilize both county and community agencies. The program manager was assigned in January and the clinical supervisor of GOALS was hired in July 2007. Initially, GOALS was housed at the Older Adult Services building. Plans for renovating a larger building were finalized by November, with improvements beginning in December 2007. The GOALS Implementation subcommittee, comprised of county staff, consumers and family members met to review the GOALS approved plan and involve stakeholders in implementation progress. Contractor staff to focus on outreach and case management to the Latino, African-American and Southeast Asian communities will be added in 2008 once contracts are completed. No clients were opened to GOALS during this initial phase of the program.

General System Development Programs

SD-1 The Wellness Center

San Joaquin County Behavioral Health Services (SJCBHS) is implementing a Wellness Center as a system development service of the CSS plan. This is designed to move towards a program that will be organized and run by consumer peers. A 2006-07 contract with Central Valley Low Income Housing Corporation (CVLIHC) was modified to include the responsibility of hiring the consumer outreach staff to provide services at The Wellness Center and to take the lead role in developing and creating a consumer/family member organization that would eventually assume full operation and control of the Wellness Center. By the end of the calendar year, CVLIHC was ready to proceed with intensive staff training and opening of the Wellness Center. During 2007 steps taken to facilitate the creation of the Wellness Center included: Development of collaborative processes between CVLIHC and BHS regarding oversight and employee management, continuing participation in the Wellness Center Implementation Sub-Committee, development of job descriptions for consumer positions, educational presentations regarding the scope and nature of Wellness Center program and activities, recruitment of potential Wellness Center staff, interviews and identification of Wellness Center staff, preliminary work schedules, preliminary support group and class schedule and topics and development of implementation schedule.

A new Consumer Outreach Coordinator civil service position was created in 2007, working with County Human Resources and the Civil Service Commission, and approved by the County Board of Supervisors. Interviews were held, and an offer made in December 2007 with a start date of January 2008. This position is in the career track of Outreach Worker Trainee and Outreach Worker. The Coordinator is assigned primarily

with the Wellness Center, but also with responsibilities related to the promotion of consumer and family member participation in all of BHS.

The original plan of the Wellness Center was based on a remodel of conference rooms and kitchen at the main BHS campus to transform into a peer run center. Due to the fact that our CSS plan was submitted late, the initial remodel plan was unable to be completed during the fiscal year. An interim site was reviewed in 2007 and leased for the Wellness Center that is close to the main campus. The Wellness Center was not officially open in 2007 to provide service delivery, but began other complementary services, including providing a Cooling Center during a heat wave and Wellness Recovery Action Plan (WRAP) peer groups.

A Wellness Center subcommittee comprised of BHS staff, CBO, consumers and family members met in 2007. This subcommittee provided meetings for planning and consumer input in 2007. These 22 meetings were attended by 167 consumers/family members and stakeholders from various ethnic groups. The Wellness Center worked closely with consumers and family members to establish a good working relationship with stakeholders. Strategies to reach unserved, underserved and inappropriately served populations were discussed.

SD-2 Community MHSA Consortium

The Community Consortium was a recommendation of a consumer who wanted to continue to support the community collaboration that had occurred during the CSS planning process. The idea was adopted and the consortium was formed in spring 2007. The Consortium is made up of many shareholders including consumers/family members, faith and tribal based communities, community based organizations and the community-at-large. The Consortium's mission statement is as follows:

"We are a group of Community Providers, Consumer/Family Members and Stakeholders. Our purpose is to form a collaborative partnership to transform and support the implementation and evaluation of the Mental Health Services Act process. Through networking we will find a common ground to support the recovery model and the sharing of resources. We will learn from and about each other to develop greater cultural understanding. Our mission is to meet the needs of the Mental Health Consumer/Family members that are served by San Joaquin County Behavioral Health services that have serve mental illness and emotional disturbances."

The Consortium is a system development program that does not provide direct service delivery to consumers. Community-Based Organizations (CBOs) are members of the Consortium which provide direct service delivery to consumers and family members. The CBOs, as well as other stakeholders, bring a unique ethnic and cultural focus that is implemented in service delivery.

During 2007, the Consortium was meeting on a bi-monthly basis to assist in defining our mission, role, and purpose. The meetings were on hold during the RFP process, to

eliminate any concern that CBOs who attended would receive information related to the proposals outside of the formal Bidder's Conference. The Consortium utilized a consultant who assisted in strategizing on how to reach unserved populations.

The Consortium developed a schedule of culture and practice focused trainings which began in 2007, but primarily will be held in April- June 2008 after contractor staff have been hired.

SD-3 Housing Empowerment and Employment

Two organizations went through the RFP process with intents to award announced in October 2007 to provide Housing and Employment support services to enrollees in the Full Service Partnerships. The Central Valley Low Income Housing Corporation (CVLIHC) will provide housing supports through a program identified as Creating Housing Opportunities In a Community Environment (CHOICE).
The University of the Pacific (UOP) Community Re-Entry Program (CRP) will provide the employment supports, with the contracts effective January 2008. Goals and objectives necessary for the contracts with CRP and CVLIHC were developed consistent with the intent of the MHSA and recovery principles and the agreed upon county plan.

CVLIHC had played a significant role in the original development of the housing plan that was made part of the new Full Service Partnerships, and continued to provide consulting services, support and educational information within the context of the Housing Work Group and implementation meetings. CVLIHC identified and recruited necessary staff, began staff training, developed preliminary models of how the housing component would work in conjunction with the Full Service Partnerships, and developed initial work plans for program implementation.

CRP management was actively involved in the MHSA planning and implementation process in 2007, participating in subcommittees related to employment, Full Service Partnerships and MHSA implementation.

SD-4 Community Behavioral Intervention Services (CBIS)

The Request for Proposal process was completed through a BHS contract with Moss Adams in fall 2007, with intent to award announced in September 2007. The contract agreement to Human Services Project, Inc. was approved in November by the County Board of Supervisors for the term of December 2007-June 2009. The implementation activities are anticipated to proceed as described in the approved Plan. No clients received services in 2007 due to the contract beginning in December, and staff recruitment following.

SD-5 Community Response Team

Crisis Intervention Services (CIS) proposed to expand the current core behavioral health response services already coordinated with seven hospital emergency room programs and

nine law enforcement agencies in San Joaquin County. There were specific target items that were to be addressed to facilitate the transformation of the current system. The target items and progress towards completion is reviewed below:

1. *Increased mobile community crisis response for assessment and intervention services 24/7/365*. MHSA Implementation Sub-Committee Meetings were conducted to gather input from mental health consumers, community members and BHS staff. During April, 2007 the MHSA Implementation Subcommittee member applications reviewed and sub-committee members selected. Four Crisis Community Response Team (CCRT) Implementation Subcommittee meetings occurred between May-July 2007, with BHS staff, consumers and family members participating.

   The Crisis Community Response Team (CCRT) began operations on July 1, 2007. Initially, due to staffing limitations the hours of operation were limited to Monday through Friday, 7:00AM to 12AM. Beginning September 1st the hours of operation was expanded to include weekend availability for telephone assessment and field response to both board and care facilities and protected housing between the hours of 7AM and 12AM. Between October 1st and December 31st, the CCRT made 101 field calls, 85 of which were initial responses and the balance follow-up calls. Approximately 18% of the referrals that resulted in CCRT field calls were generated by law enforcement agencies.

2. One of target items to be addressed included the ability for *joint response of mental health staff with law enforcement to reduce incarcerations and inappropriate use of hospital emergency rooms*. Additionally, another related target item is *to increase our response capability with the development of mobile, multidisciplinary response teams 24/7/365.* When CCRT operation started on July 1st, the availability to law enforcement agencies was for telephone consultation and to accept referrals for CCRT follow-up and field responses for sub-5150 contacts. This gradually expanded so that by October 1st, the CCRT was available for limited immediate or scheduled joint response with Stockton PD and San Joaquin County Sheriffs Department on a Monday through Friday basis. A major milestone proposed to occur during 2008 will be to expand the availability of the CCRT to 7 days a week full operation between the hours of 7AM and 11PM. Ultimately, and possibly during 2008 the CCRT will be able to implement response capability on a 24 hour basis reaching the goal of *"services 24/7/365"*. Of the field calls made during October 1st through December 31st, 15 were referrals from SJ County law enforcement agencies. A goal for 2008 will be to increase both the number and percentage of law enforcement referrals for CCRT response.

3. A major outcome of the CCRT activity is to provide not only intervention, but also, *prevention services to reduce use of law enforcement agencies for intervention in a crisis*. The CCRT started making contacts and presentation to San Joaquin County law enforcement and community agencies. During 2007 the

CCRT made presentations about the CCRT and encouraged referrals to be made by law enforcement and community agencies. The CCRT is encouraging law enforcement to provide notification to CCRT of individuals they are arresting for jail that they believe have mental illness. The CCRT is coordinating with S.J. County Jail Medical Unit staff for "interception" of the mentally ill at release to foster rapid assessment and intervention if needed. A goal for 2008 is to make presentations or send information to all law enforcement agencies, BHS departments and many community agencies within SJ County that would be major referral sources for the CCRT.

4. Another target item for CCRT implementation was the *coordination with the consumer-operated Wellness Center, developing peer support and assistance through the use of volunteer and/or employed consumer/family members, as included members of the multi-disciplinary crisis teams*, and, *develop an integrated career ladder allowing a path from volunteer to mental health specialist.* The employment of consumer/family members' item is being addressed with the development of the Mental Health Outreach Worker (MHOW) and Mental Health Outreach Worker Trainee (MHOWT) positions. The first Mental Health Outreach Worker applicants were interviewed and two staff hired during October and November. The MHOW's have become an integral addition to the CCRT. They provide support to mental health consumers and family of consumers both on the BHS campus and in the community. The numbers of MHOW and MHOW Trainees will expand during 2008 with the projected implementation of the Consumer Support Warm-line and expanded CCRT operational hours and referrals. The employment of MHOW's and their integration into the CCRT and activities within the existing Crisis department functions have assisted on system transformation and maintaining the focus on recovery and resiliency at all stages and levels of services.

5. A major MHSA program goal for mental health system transformation and services expansion is to *increase hot and warm-line capabilities available 24/7/365.* Crisis emergency hotline capability on a 24/7/365 basis has been in place for many years at BHS. The proposed expansion to include both dedicated hotline, and also, consumer support warm-line capability on a 24/7/365 basis requires adequate staffing levels and also staff training and equipment installation. The ongoing hiring of MHOW and MHOW-Trainee's who will staff the warm-line will continue, with the goal of implementing 24/7/365 warm-line operation during 2008. It is anticipated that planned increased CIS staffing levels will allow for a staff dedicated to Crisis hotline response, and not multi-tasking with other CIS functions. Specifically, it is planned that CIS staff be scheduled to answer the Crisis hotline between midnight and 7AM and not have that function transferred to PHF staff during night hours.

6. Input from mental health consumers and community members was provided at the MHSA Implementation Sub-Committee Meetings demonstrating a need for outreach and support to decrease consumers distress and isolation, not only out in

the community, but also, *on-site* in the BHS main lobby and Crisis waiting areas. Additionally, an ongoing goal for Crisis Intervention Services (CIS) has been to reduce wait times. Therefore, the MHSA CIS Triage Component (CTC) has been implemented to *assist and support consumers coming to Crisis*, and is a process to more rapidly identify those consumers in urgent need of behavioral health services, provide support and also redirection to other agencies or more appropriate services. The CTC was implemented September 2007, and CIS Triage staff have had over 600 billed consumer contacts through December 31st. Additionally, the MHOW staff have made numerous unbilled consumer contacts in the Crisis waiting areas, providing support, advocacy and reassurance.

SD-6 Co-Occurring Treatment Program

The Co-Occurring Treatment Program is a collaborative between San Joaquin County Office of Education (COE), Probation, the Courts, and Behavioral Health Services. The approved plan included funds for remodel of the program/treatment portion of the building that was to be purchased by COE. As COE searched for a viable site, a first choice arose, but was not realized. By the end of the 2007 calendar year, a site had not been secured, though the search was in full pursuit. A second choice became viable, and the pursuits were successful. The site was finalized by COE, with the support of the partner agencies listed above, and the remodel was completed within the time frame, though after the period of this Progress Report.

2) **For each of the six general standards in California Code of Regulations, Title 9, Section 3320, very briefly describe one example of a successful activity, strategy or program implemented through CSS funding and why you think it is an example of success e.g. what was the result of your activity. Please be specific.**

a. Community collaboration between the mental health system and other community agencies, services, ethnic communities etc.

The Co-Occurring Treatment program is an excellent collaboration between County Office of Education (COE), Juvenile Probation, Juvenile Justice Bench, and Behavioral Health Services which includes both Mental Health and Substance Abuse Services. Without these agencies partnering together this program design would not be possible; each component is inter-related. Youth must be in school—COE; the targeted youth are the Juvenile Offenders—Probation and the Juvenile Bench; and they have Co-Occurring treatment needs of serious emotional disturbance and substance abuse—Behavioral Health Services.

b. Cultural competence

A successful implementation strategy was to contract with ethnic specific CBOs that are connected and trusted by communities of color. This enabled San Joaquin County Behavioral Health Services to reach out to individuals that have not been reached in the past and to penetrate deeper into cultural, faith and tribal based communities.

San Joaquin County has broken new ground in the Central Valley for developing full service partnership programs dedicated to improving access to specialty mental health services for African Americans, Native Americans, Muslim / Middle Eastern Americans, Gay, Lesbian, Bisexual and Transgender individuals. Just as with the La Familia and SEARS programs, the BACOP/MC full service partnership plans for county and contractor staff to reflect and represent the ethnic, cultural and linguistic diversity of the consumers. The BACOP/MC program was developed in collaboration with community stakeholders, including community and faith based organizations, consumers, family members and BHS staff.

During 2007, the Consortium provided education to itself on Recovery Concepts and Ethnic specific models of service delivery. This included the "First 90 day model" develop by the Black Awareness Community Outreach Program (BACOP). The "first 90" is an intensive upfront ethnic specific matched service designed to assist the unserved, underserved and inappropriately served populations. This "first 90" model has been able to be implemented to different cultural groups since it can be adapted to any target ethnic group.

c. Client/family driven mental health system

Client and family driven services is a major focus of the peer provided Wellness Center. The fiscal challenge was funding an interim facility while renovation plans are underway for a final location to be completed within the next year. A current focus is in contacting other Wellness Centers, in neighboring counties, to compare service delivery models and program evaluation instruments.

Throughout the year 2007, consumers and family members were recruited, encouraged and supported to be ongoing participations in committees, workgroups and program operations. Each individual's participation was positive and very meaningful for implementation success. The level of concern shared by consumers and family members empowered a level of awareness that would not have been achieved in their absence. Successful transformation and reaching the goals of MHSA certainly were strengthening with consumer and family input.

Consumers, family members and community stakeholders participated at every level of this process. To encourage consumers and family members, stipends and incentives were provided throughout the process. The National Alliance of the Mentally Ill (NAMI) local chapter also participated in an active manner.

d. Wellness/recovery/resiliency focus

Substance abuse services have for years held true to the wellness recovery focus, with the resiliency of youth an integral part of the treatment. Co-Occurring mental health services, by design, requires the whole family to participate; a vital element for the success of programs. Wellness, recovery, and resiliency have been major concepts in instituting MHSA with BHS and our contractors. The core values of wellness, recovery and resiliency are incorporated into each program. This county also developed new strategies to meet the needs of the consumers, the "whatever it takes approach". BHS continues to transform and move towards integrated recovery focus among Mental Health Services (MHS) core programs, MHSA programs and Substance Abuse Services (SAS) programs, all of which comprise Behavioral Health Services.

e. Integrated services experience for clients and families: changes in services that result in services being seamless or coordinated so that all necessary services are easily accessible to clients and families

Due to staffing shortages, not all programs have psychiatric coverage or other multi-disciplinary services. BHS staff worked together to acquire needed services between programs and teams, including MHS core, MHSA and SAS to increase the ease of access to needed services for consumers. This is an ongoing challenge for 2008, but staff are determined to decrease the impact to consumers and families.

3) **For the Full Service Partnership category:**
   a. **If BHS has not implemented the SB 163 Wraparound, please describe the progress that has been made.**

BHS has implemented SB 163 Wraparound.

   b. **Please provide the total amount of MHSA funding approved as Full Service Partnership funds that was used for short-term acute inpatient services.**

BHS did not use any MHSA Full Service Partnership funds for short-term acute inpatient services.

4) **General System Development Category only: Briefly describe how the implementation of the General System Development programs have strengthened or changed the County's overall public mental health system. If applicable, provide an update on any progress made towards addressing any conditions that may have been specified in your DMH approval letter.**

The Wellness Center has not formally opened it doors but it is having an impact on the current mental heath system through the sharing and support of recovery concepts. The Consumer Outreach Coordinator brings a wellness and recovery focus to meetings addressing core services and quality assurance activities. The Consumer Outreach Coordinator is on the Cultural Competency Committee and encourages consumer

participation at all levels of the organization. Consumers are becoming more empowered to address personal treatment options and in the planning of the Wellness Center.

The Consortium is a general system development program that is supporting our integration in the San Joaquin County Community. The Consortium is comprised of stakeholders from unserved, underserved and inappropriately served ethnic communities. This system development program is giving ethnic communities a voice into service delivery of the public mental health system. It is supporting a partnership between diverse stakeholders to find commonality and to celebrate diversity.

The Crisis Community Response Team has strengthened the overall BHS system with increased triage, mobile response and peer support. This program has had a number of positive newspaper articles regarding it, which has raised the community's awareness of mental health services and response.

B. Efforts to Address Disparities

1) Briefly describe one or two successful current efforts to address disparities in access and quality of services to unserved or underserved populations targeted in the CSS component of your Plan. If possible, include results of the effort/strategy.

San Joaquin County made a conscious effort to present the MHSA plan to the community by using a diverse team of facilitators. That was useful in opening up the dialogue with communities that had issues with trust and past broken promises. Each program had a separate subcommittee that involved staff, consumers, family and interested stakeholders. The specialized groups started to identify areas of similarity that resulted in stronger networking across ethnic and cultural lines. San Joaquin County also developed RFPs to contract with community based organizations to help access persons in the 9 priority communities- African American, Native American, Muslim/ Middle Eastern, Cambodian, Hmong, Laotian, Vietnamese, Latino and Gay, Lesbian Bisexual and Transgender in this county. When communities feel empowered and invested to make changes in their communities, the outcomes are more positive. These communities felt validated by the MHSA process. The BHS decision to contract with culturally based and competent community based organization(s) with expertise in and access to the nine priority populations was part of an overall strategy to address disparities.

One successful effort was been outreach at cultural specific events that in the past has not resulted in direct referrals. Due to ethnic and cultural matching, communities of color have been more receptive to cultural specific outreach. The CBOs have brought a level of community trust that has allowed individuals to come for services who would not have come to our agency in the past. Unserved and inappropriately served populations are willing to try new or return for services largely due to the involvement of ethnic specific CBOs. This partnering of services has developed trust with ethnic communities and special populations.

2) **Briefly describe one challenge you faced in implementing efforts/strategies to overcome disparities, including where appropriate what you have done to overcome the challenge.**

During the planning phase, a delicate balance needed to be maintained to ensure that all groups had a voice and participation in program development. This allowed specialized groups to be able to communicate and discuss strategies that maintained service delivery for all populations. Each ethnic or cultural group was advocating for the special needs of their group. Implementation teams were developed comprised of BHS staff, Community Based Organizations and consumers and family members of various ethnic and special populations.

One of the unique challenges for the implementation of the SEARS program is the diversity within the Southeast Asian population; really being comprised of at least four distinct languages and cultures. While there are similarities within these cultures, there were also significant differences.

3) **Indicate the number of Native American organizations or tribal communities that have been funded to provide services under the MHSA and what results you are seeing to date if any.**

There were at least two different tribal groups that showed interest in the MHSA process. No organizations were funded in 2007. Three Rivers Indian Lodge, a part of Native Directions, Inc., was selected in 2008 as the contracted agency to outreach and case management to Native Americans in this county. A position, occupied by a Native American staff member, is funded to reach out to this underserved community. Ethnic matching is an integral part of outreach for those who would feel more comfortable speaking to a Native American staff member. This contract staff member will provide intensive follow-up to assist the Native American Community in accessing and maintaining service delivery to our public mental health system. BHS programs will be able to refer to this specialized service provider and get cultural consultation to address the needs of Native American consumers/family members.

4) **List any policy or system improvements specific to reducing disparities, such as the inclusion of linguistic/cultural competence criteria to procurement documents and/or contracts.**

SJCBHS is addressing disparities by contracting directly with ethnic specific community-based organizations that already have trust with communities of color. This unique relationship of the CBOs with these communities has enabled BHS to reduce disparities by increasing direct service delivery through our community service and supports (CSS) process.

San Joaquin County has continued to engage the community by developing a Consortium for community partners; Community Based Organizations, stakeholders, consumers and families. The Wellness Center will carry this vision into service delivery of cultural

communities. Specialized systems (i.e., ethnic, cultural and GLBT) will be able to provide assistance to the Wellness Center during service delivery to meet the unique needs of each consumer/family member.

C. Stakeholder Involvement

As counties have moved from planning to implementation many have found a need to alter in some ways their Community Program Planning and local review processes. Provide summary description of any changes you have made during the time period covered by this report in your Community Program Planning Process. This would include things like addition/deletion/alteration of steering committees or workgroups, changes in roles and responsibilities of stakeholder groups, new or altered mechanisms for keeping stakeholders informed about implementation, new or altered stakeholder training efforts. Please indicate the reason you made these changes.

BHS has an active local Mental Health Board that meets monthly, to keep informed on MHSA and other BHS programs and activities.

The CSS Plan MHSA Planning Stakeholder Steering Committee had been very active during the earlier planning phase of CSS. The MHSA Planning Stakeholder Steering Committee did not meet in 2007, as restructuring through the Mental Health Board was in process and BHS was in Implementation phase rather than planning phase, with plans for it to reconvene in 2008 with the planning phases of the next MHSA components.

An Implementation Committee was established in February 2007, which was initially held weekly to review the implementation of the CSS plan, and then continued twice monthly through 2007. This meeting was open to all stakeholders, and has included consumers, family members, county staff, contractor staff and other interested community-based organization representatives, including from the specified 9 priority populations for San Joaquin County. An MHSA Executive Committee was established in March 2007, which includes Senior Management, the Ethnic Services Manager, a consumer (currently the Consumer Outreach Coordinator), and a NAMI representative. This committee met twice monthly through 2007.

Implementation subcommittees were formed for each of the 12 programs beginning in April 2007. These were comprised of consumers, family members, managers and staff, to continue to engage stakeholder participation and input in moving from the planning phase to the implementation phase and to address community concerns regarding the CSS component.

Consumers and family members who participated in the MHSA Implementation Committees and program subcommittees received a stipend to reimburse for time and travel expenses and encourage participation. Consumers/family members represented a wide variety of ethnic and cultural populations.

The MHSA Coordinator gave presentations or represented information on MHSA at groups as invited, included the San Joaquin National Association of Mental Illness (NAMI), Lathrop Sunrise Rotary, San Joaquin County Office of Education DATE Coordinators, and Hamilton Elementary School.

A BHS Newsletter was initiated for the BHS workforce in March 2007, which has included periodic articles on MHSA and CSS implementation. MHSA "Brown Bag Lunch" gatherings were initiated on a monthly basis in October 2007, to give an opportunity for interested staff members to bring questions or comments regarding MHSA in an informal setting.

SJCBHS' consumer and family members attended many Oversight and Accountability Commission meetings that enabled our consumers to have a stronger voice in the Wellness Center implementation process. Additionally, The California Network of Mental Health Clients was very active in San Joaquin County that resulted in more consumer participation in Wellness Center planning meetings.

Staff, consumers and family members and interested stakeholders were involved from the very beginning to ensure a transparent process. There were areas of concerns brought forth from these meetings; some of those were access to treatment, cultural sensitive services, crisis response, transportation, housing and employment and collaboration with substance abuse services.

The Consortium's initial planning was addressing community penetration, at large. The Consortium realized that it needed to alter its focus to be more culturally and special population specific. This specialized approach of being culturally specific assisted each CBO in planning and in providing service delivery to targeted stakeholders and community groups. The CBOs were able to build upon the relationships they already had with communities of color and to enhance service delivery to reduce disparities to the unserved, underserved and inappropriately served populations.

D. <u>Public Review and Hearing</u>

Provide a brief description of how the County circulated this Implementation Progress Report for a 30-day stakeholder review and comment period, including the date of the public hearing. The statute requires that the update be circulated to stakeholders and anyone who has requested a copy. This section should include the following information:

1) **The dates of the 30-day stakeholder review and comment period, including the date of the public hearing conducted by the local mental health board or commission. (The public hearing may be held at a regularly scheduled meeting of the local mental health board or commission.)**

    - July 16, 2008 at 6 p.m. Mental Health Board and public hearing
      1212 N. California St, Stockton, CA 95202

- July 17-August 16, 2008 Public review and comment period
- August 12, 2008, 12 noon MHSA Planning Stakeholder Steering Committee

2) The methods that the county used to circulate this progress report and the notification of the public comment period and the public hearing to stakeholder representatives and any other interested parties.

The 2007 Implementation Progress Report shall be circulated using the following methods:

- A copy posted on the San Joaquin County MHSA website: www.sjmhsa.net
- Electronic copies sent to all BHS service sites announcing the posting of the notice
- Communication to the Mental Health Board notifying of the beginning of the public review period and how to obtain a copy of the report
- Communication to the Stakeholder Steering Committee notifying of the beginning of the public review period and how to obtain a copy of the report
- Copies to the MHSA Implementation Committee
- Newspapers

3) A summary and analysis of any substantive recommendations or revisions.

This shall be completed following the 30 day public comment and review.