EXHIBIT A

COUNTY CERTIFICATION
MHSA FY 2009/10 ANNUAL UPDATE

County Name: ___San Joaquin County__

County Mental Health Director	Project Lead
Name: Vic Singh, LCSW **Telephone Number:** 209-468-8750 **E-mail:** vsingh@sjcbhs.org	**Name:** Becky Gould **Telephone Number:** 209-468-8859 **E-mail:** bgould@sjcbhs.org
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I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Annual Update. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and California Code of Regulations (CCR), Title 9, Section 3410, Non-Supplant.

This Annual Update has been developed with the participation of stakeholders, in accordance with CCR, Title 9, Sections 3300, 3310(d) and 3315(a). The draft FY 09/10 Annual Update was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate.

All documents in the attached FY 2009/10 Annual Update are true and correct.

_____ _____ _____

Signature Date Title
Local Mental Health Director/Designee

EXHIBIT B

Description of Community Program Planning and Local Review Processes
MHSA FY 2009/10 ANNUAL UPDATE

County Name: San Joaquin County

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.

1. Briefly describe the Community Program Planning Process for development of the FY 2009/10 Annual Update. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)

San Joaquin County initiated a multi-faceted process for gaining stakeholder input into the FY2009/10 Annual Update. This process built upon the successes of previous MHSA planning process and included 1) a set of workshops addressing the different CSS components; 2) questionnaires regarding services which were distributed to consumers, family members, service providers and other key stakeholders; and 3) presentations and solicitation of comments at two public meetings.

The planning process was directed by Vic Singh, Director of San Joaquin County Behavioral Health Services with support by Resource Development Associates. The planning process was also reviewed and approved by the Planning Stakeholder Steering Committee. The Planning Stakeholder Steering Committee includes the following members:

Cary Martin	Chair, Mental Health Board
Cynthia Gustafson	Mental Health Board, family advocate
Stephanie Bays	Deputy Chief Probation Officer
Ken Cohen	Director, Health Care Services
Mary Ellen Cranston-Bennett	NAMI Representative/Parent Advocate
Mick Founts	Deputy Superintendent, Office of Education
Kathleen Gutierrez	BHS Employee/Labor Representative
Robert Hart	Medical Director, Behavioral Health Services
Monica Madrigal	BHS Outreach Worker Trainee & Recovery Coach
Jennie Montoya	NAMI Representative/ BHS Outreach Worker
Jane Riddle	BHS Outreach Worker/Family Advocate
Chris Rose	Senior Deputy, County Administrator's Office
Daphne Shaw	Older Adult Advocate
Vic Singh	Director, Behavioral Health Services
John Solis	Executive Director, WorkNet
Margaret Szczepaniak	Assistant Director, Health Care Services
Cheryl Torres	BHS Consumer Outreach Coordinator
Curt Willems	Lead Manager, Substance Abuse Services
Stella Williams	Children's Advocate

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2. Identify the stakeholder entities involved in the Community Program Planning Process.

The following entities participated in the Community Program Planning Process:

Asian Pacific Self-Development and Residential Assc. (APSARA)
BHS Alcohol & Drug Alternative Program (ADAP)
BHS Children and Youth Services (CYS)
BHS Community Adult Treatment Services (CATS)
BHS Crisis Community Response Team (CCRT)
BHS La Familia
BHS Older Adult Services (OAS) / Gaining Older Adult Life Skills (GOALS)
BHS Southeast Asian Recovery Services (SEARS)
BHS Transcultural Clinic (TCC)
BHS Wellness Center
BHS Black Awareness Community Outreach Program & Multicultural Services (BACOP/MC)
CA Network of Mental Health Clients
Casa del Sol In-Home Care
Central Valley Low Income Housing Corp (CVLIHC)
Community Behavioral Intervention Services (CBIS)
Community Partnership for Families of San Joaquin(CPFSJ)
El Concilio: The council for the Spanish-Speaking
Family Resource & Referral Center
Fresh Beginning
Gipson Center, University of the Pacific Community Re-entry Program (CRP)
Head Start Community Development Center
Lao Family of Stockton
Mary Magdalene Community Services
National Alliance on Mental Illness (NAMI) - San Joaquin
Native Directions, Inc. Three Rivers Indian Lodge
San Joaquin AIDS Foundation (SJAF)
San Joaquin County Aging and Adult Services
San Joaquin County Health Care Services (HCS) Agency
San Joaquin County Mental Health Board (MHB)
San Joaquin County Probation Deptartment
Stockton Unified School District
Vietnamese Voluntary Foundation, Inc. (VIVO)
Women's Center of San Joaquin County
Unaffiliated Consumers

EXHIBIT B

3. Describe how the information provided by DMH and any additional information provided by the County regarding the implementation of the Community Services and Supports (CSS) component was shared with stakeholders.

Ongoing Communication with Stakeholders

Information regarding the planning process is routinely shared through the MHSA Planning Stakeholder Steering Committee meetings, which meets monthly, on the second Tuesday of each month. Summaries for these meetings, as well as all planning documents related to the CSS, are available to the public at http://sjmhsa.net

Updates regarding MHSA program requirements or information about the core objectives are shared through regularly scheduled meetings with all BHS contractors. For example there are monthly meetings with all children's services providers and with all contractors who are participating in the full service partnerships and system development programs.

During the monthly Mental Health Board Meetings there are standing MHSA reports that are given which include a summary of all new DMH updates and an overview on the progress implementing the CSS component.

All meetings are open to the public and interested participants and service providers are encouraged to join our dialogue.

Communication for the CSS Planning Process

A discussion of the intent to conduct a community planning process for this Annual Update was first discussed at a meeting of the Mental Health Board. Subsequently e-mail invitations to participate in a two-day public meeting were submitted to all stakeholders that had participated in any of the three previous MHSA planning processes, a distribution list that includes several hundred individuals. Notices and invitations to participate in the meetings were also posted at the Gipson Center, the Wellness Center, throughout the BHS campus, and at other mental health serving organizations.

Meeting invitations included a notice that translators were available in multiple languages upon request.

The two day workshop consisted of an initial presentation providing information on CSS program implementation, the mission of the upcoming planning process, and an overview of the day's agenda and activities. To aid in this overview all workshop participants received a packet that included the Executive Summary of the CSS Plan. In addition program summaries and key strategies for each of the CSS components were provided to re-familiarize stakeholders with the different component areas. Also a more detailed visual and verbal overview of the CSS component was provided at the beginning of each of the workshop sessions. These smaller group discussions were also used to answer any questions about the program implementation or the MHSA planning process.

At the end of each day meeting participants were informed of the "next steps" in the planning process, provided with instructions on how to submit additional comments, and given contact information on how to ask more questions. All participants were also asked to take questionnaires back to their respective communities or provider agencies and distribute them amongst their friends, family members, or colleagues in the hopes of soliciting more information on the planning process.

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4. Attach substantive comments received about the CSS implementation information and responses to those comments. Indicate if none received.

The CSS workshops occurred over two days and addressed the Full-Service Partnership and six System Development initiatives funded by the MHSA. These workshops were held March 4-5, 2009 at the San Joaquin BHS offices at 1212 N. California Street in Stockton, CA. The workshops provided a facilitated setting in which to discuss implementation successes, challenges and recommendations. Sixty-five people attended the first day of workshops, and forty-two people attended on the second day. Participants included BHS staff, representatives of Community-Based Organizations (CBOs) and consumers and their family members.

Community members were also invited to submit feedback on programs and services provided through CSS. Questionnaires were posted on the SJMHSA website, distributed to all community stakeholders on our e-mail distribution list, and made available to consumers and family members at all mental health serving agencies in the county. Sixty-four questionnaires were received with nearly 60% from consumers and/or family members.

The public planning process was structured into workshops, which were facilitated using a collaborative model. Participants were encouraged to share freely during the discussion on program strengths, challenges, and recommendations. Groups were encouraged to reach consensus on the most significant comments in each category, and based on that, workshop feedback was summarized to include the following:

Strengths

1. Success in implementing outreach strategies to unserved, underserved, and inappropriately served populations
2. New collaborations achieved through MHSA planning process, and extended through implementation
3. Success in employing consumers/family members

Challenges

1. Providing sufficient/supportive housing, employment and transportation to MHSA consumers/family members
2. Providing appropriate treatment to consumers with co-occurring disorders given current policy restrictions
3. Lack of capacity in core services to treat all referred consumers
4. Continued challenges in adequately serving underserved populations, exacerbated by challenges noted in 1 and 3 above
5. Building ongoing sustainability into programs, given above challenges

Recommendations

1. The Consortium (contractor meetings under the auspices of System Development funding) has successfully built on the collaborative, problem-solving progress built during the MHSA planning phase. As such, it's become a good venue for working groups to address ongoing challenges outlined above, with particular attention to ongoing sustainability; housing, employment and transportation; and the appropriate treatment of those with co-occurring disorders.
2. Work to improve linkages between BHS and the CSS programs and school districts, Child Protective Services and the criminal justice system.
3. Improve the transportation infrastructure for those seeking services; explore innovative methods of providing transportation, especially for young children and older adults.

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In addition, participants were invited to submit personal comments. Most participants amplified one or two of the points above, but the following unique comments were also shared:

- This is "a different, more responsive way of providing services."
- We did not anticipate core services losing funding
- Better engagement is needed between core staff and the broader community
- Keep refining the training model, so that people have time off to get training

At the conclusion of the workshops, participants were asked to complete a feedback form; the vast majority of participants rated the workshops and materials as Good to Excellent. Specific comments include:

- "Open, frank discussion"
- "Smaller group format gave more opportunity to discuss materials"
- "It would have been helpful to have the questions to be discussed before the meeting"
- Meeting "enhanced communication about progress, needs and what needs to be worked on."

5. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.

The public presentation was made on March 18, 2009 at a meeting of the Mental Health Board. A presentation was given of the public planning process and major themes that emerged from community input. The draft CSS annual update was reviewed and members of the public were encouraged to ask questions, provide feedback and suggestions, and to share their experiences participating in the public planning sessions.

The written public comment period begins on March 20, 2009 and ends on April 19, 2009.

The public hearing will be held on Monday April 20, 2009.

A description of substantive comments received during the stakeholder review and public hearing will be added to this document after the public hearing on April 20th.

EXHIBIT C

Report on FY 2007/08 Community Services and Supports Activities
MHSA FY 2009/10 ANNUAL UPDATE

County Name: _San Joaquin__

Provide a brief narrative description of progress in providing services through the MHSA Community Services and Supports (CSS) component to unserved and underserved populations, with emphasis on reducing racial/ethnic service disparities. (suggested length – one-half page)

San Joaquin County has made gains in identifying and serving previously unserved, underserved, and inappropriately served populations, including ethnic and special populations, through innovative partnerships between community-based organizations (CBOs) and core, or traditional, mental health service providers. Community stakeholders who participated in the community meetings were proud of the efforts that had been made through the Full-Service Partnerships to provide better communication, outreach and improved service delivery with San Joaquin County's diverse communities. However the short implementation time was noted by most participants, with nearly everyone agreeing that though culturally-appropriate strides had been made, there was more work to be done.

CBOs have been trained in mental health identification and delivery and have proven successful in identifying those needing services and working within cultural norms, extended families and perceptions of stigma to move consumers into treatment. In particular community meeting participants noted the importance of the cross training that has started to occur between the different full service partnership members. Community members talked about the importance of ensuring that all programs were able to support any individual who walked through the door.

The next phase of work in this area includes increased cross-training between CBO staff and service providers in order to streamline and improve the transition to care. In addition, San Joaquin County will continue to emphasize language- and culturally-appropriate services to the Hispanic, Native American, African American, Muslim, and Southeast Asian communities. For example in the Southeast Asian Community, geographic isolation and language complexity make these populations more challenging to reach. Outreach work in cultural communities has yielded referrals in greater numbers, and the County will continue to build on this success.

Behavioral Health Services is committed to listening deeply to ethnic and special populations (Gay, Lesbian, Bisexual, Transgender) communities to strengthen and improve service delivery strategies to unserved and underserved and inappropriately served populations. In particular the County has committed to a capacity building project that will help promote federally recommended Culturally and Linguistically Accessible Service (CLAS) standards throughout organizations serving the mental health needs of San Joaquin County residents.

San Joaquin County Behavioral Health
Unique Client Count Populations Comparison
Ethnicity 07--08

	SJCBHS System of Care		SJC Medic-Cal		SJCBHS Medi-Cal Eligibility	
Ethnicity	**Client Count**	**Percent**	**Client Count**	**Percent**	**Client Count**	**Percent**
African American	2,250	16.68%	19,462	12.72%	1,796	18.07%
Asian	1,629	12.08%	24,423	15.96%	1,443	14.52%
Hispanic	2,643	19.60%	68,515	44.78%	1,821	18.33%
Native American	463	3.43%	563	0.37%	329	3.31%
Other	256	1.90%	5,974	3.90%	199	2.00%
Pacific Islander	30	0.22%	512	0.33%	21	0.21%
White	6,217	46.09%	33,544	21.93%	4,328	43.55%
Total	***13,488***	***100.00%***	***152,993***	***100.00%***	***9,937***	***100.00%***

San Joaquin County Behavioral Health
Unique Client Count Populations Comparison
Language 07--08

	SJCBHS System		SJC Medic-Cal		SJCBHS Medi-	
Language	**Client Count**	**Percent**	**Client Count**	**Percent**	**Client Count**	**Percent**
Asian/Pacific Island	965	7.15%	9,720	6.35%	887	8.93%
English	11,224	83.21%	96,308	62.95%	8,118	81.69%
Indo European	24	0.18%	80	0.05%	18	0.18%
Other or Unspecified	593	4.40%	8,302	5.43%	500	5.03%
Sign	6	0.04%	23	0.02%	5	0.05%
Spanish	676	5.01%	38,560	25.20%	409	4.12%
Total	***13,488***	***100.00%***	***152,993***	***100.00%***	***9,937***	***100.00%***

Unique Client Count Populations Comparison
Gender by Age group 07-08

Age Group	SJCBHS System of Care					SJC Medic-Cal					SJC BHS Medi-Cal Eligibility				
	Female	Percent	Male	Percent	Total	Female	Percent	Male	Percent	Total	Female	Percent	Male	Percent	Total
Adult (18-59)	5,264	72.58%	3,880	60.49%	9,144	38,391	44.55%	21,657	32.41%	60,048	3,990	70.78%	2,480	55.79%	6,470
Children (0-17)	1,255	17.30%	2,053	32.01%	3,308	37,380	43.38%	38,687	57.90%	76,067	1,062	18.84%	1,612	36.27%	2,674
Older Adult (60+)	734	10.12%	481	7.50%	1,215	10,404	12.07%	6,474	9.69%	16,878	585	10.38%	353	7.94%	938
Total	***7,253***	***100.00%***	***6,414***	***100.00%***	***13,667***	***86,175***	***100.00%***	***66,818***	***100.00%***	***152,993***	**5,637**	***100.00%***	**4,445**	***100.00%***	***10,082***

San Joaquin County Behavioral Health
Total Medi-Cal Clients - Penetration Rates
2007-2008

	Medi-Cal Beneficiaries Served By SJCBHS	*Total Medi-Cal Beneficiary Population*	*Penetration Rate*
TOTAL			
	9,937	***152,993***	***6.50%***
RACE/ETHNICITY			
African American	1,796	19,462	9.23%
Asian	1,443	24,423	5.91%
Hispanic	1,821	68,515	2.66%
Native American	329	563	58.44%
Other	199	5,974	3.33%
Pacific Islander	21	512	4.10%
White	4,328	33,544	12.90%
AGE GROUP			
Adult (18-59)	6,470	60,048	10.77%
Children (0-17)	2,674	76,067	3.52%
Older Adult (60+)	938	16,878	5.56%
GENDER			
Female	5,637	86,175	6.54%
Male	4,445	66,818	6.65%
Language			
Asian/Pacific Island	887	9,720	9.13%
English	8,118	96,308	8.43%
Indo European	18	80	22.50%
Other or Unspecified	500	8,302	6.02%
Sign	5	23	21.74%
Spanish	409	38,560	1.06%

San Joaquin County Behavioral Health
Total Number Served with County Population-Penetration Rates
2007-2008

	Total Number Served by BHS	*County Population (Census 2000)*	*Penetration Rate*
TOTAL			
	13,488	***563,598***	***2.39%***
RACE/ETHNICITY			
African American	2,250	36,139	6.23%
Asian	1,629	62,126	2.62%
Hispanic	2,643	172,073	1.54%
Native American	463	3,531	13.11%
Other	256	21,103	1.21%
Pacific Islander	30	1,624	1.85%
White	6,217	267,002	2.33%
AGE GROUP			
Adult (18-59)	9,144	310,959	2.94%
Children (0-17)	3,308	174,569	1.89%
Older Adult (60+)	1,215	78,070	1.56%
GENDER			
Female	7,253	281,991	2.57%
Male	6,414	281,627	2.28%

Behavioral Health Services Retention of New Clients

(Clients who received their first service during the 2007-2008 and 2006-2007 fiscal year.)

	All Clients										MediCal Clients									
	Retained		Not Retained		Total Clients		Percent Retained		Percent not Retained		Retained		Not Retained		Total Clients		Percent Retained		Percent not Retained	
	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07
Ethnicity																				
African American	445	359	255	162	700	521	63.6%	68.9%	36.4%	31.1%	353	251	191	98	544	349	64.9%	71.9%	35.1%	28.1%
Asian	175	158	89	95	264	253	66.3%	62.5%	33.7%	37.5%	135	115	61	53	196	168	68.9%	68.5%	31.1%	31.5%
Latino	584	520	479	292	1,063	812	54.9%	64.0%	45.1%	36.0%	401	363	274	132	675	495	59.4%	73.3%	40.6%	26.7%
Native American	56	58	20	18	76	76	73.7%	76.3%	26.3%	23.7%	28	23	10	9	38	32	73.7%	71.9%	26.3%	28.1%
Other	50	80	33	73	83	153	60.2%	52.3%	39.8%	47.7%	37	66	19	42	56	108	66.1%	61.1%	33.9%	38.9%
Pacific Islander	4	3	1	-	5	3	80.0%	100.0%	20.0%	0.0%	4	2	-	-	4	2	100.0%	100.0%	0.0%	0.0%
White	1,025	948	613	547	1,638	1,495	62.6%	63.4%	37.4%	36.6%	649	571	306	236	955	807	68.0%	70.8%	32.0%	29.2%
Total	**2,339**	**2,126**	**1,490**	**1,187**	**3,829**	**3,313**	**61.1%**	**64.2%**	**38.9%**	**35.8%**	**1,607**	**1,391**	**861**	**570**	**2,468**	**1,961**	**65.1%**	**70.9%**	**34.9%**	**29.1%**
	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07
Age at time of first service																				
0-5	167	90	31	11	198	101	84.3%	89.1%	15.7%	10.9%	166	88	29	11	195	99	85.1%	88.9%	14.9%	11.1%
6-17	812	660	792	264	1,604	924	50.6%	71.4%	49.4%	28.6%	685	558	348	158	1,033	716	66.3%	77.9%	33.7%	22.1%
18-59	1,272	1,302	573	796	1,845	2,098	68.9%	62.1%	31.1%	37.9%	706	696	428	339	1,134	1,035	62.3%	67.2%	37.7%	32.8%
60+	88	74	94	116	182	190	48.4%	38.9%	51.6%	61.1%	50	48	56	62	106	110	47.2%	43.6%	52.8%	56.4%
Total	**2,339**	**2,126**	**1,490**	**1,187**	**3,829**	**3,313**	**61.1%**	**64.2%**	**38.9%**	**35.8%**	**1,607**	**1,390**	**861**	**570**	**2,468**	**1,960**	**65.1%**	**70.9%**	**34.9%**	**29.1%**
	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07
Language																				
Asian/Pacific Island	113	94	33	37	146	131	77.4%	71.8%	22.6%	28.2%	86	69	24	24	110	93	78.2%	74.2%	21.8%	25.8%
English	2,022	1,776	1,325	996	3,347	2,772	60.4%	64.1%	39.6%	35.9%	1,405	1,166	762	484	2,167	1,650	64.8%	70.7%	35.2%	29.3%
Indo European	5	4	-	2	5	6	100.0%	66.7%	0.0%	33.3%	4	2	-	2	4	4	100.0%	50.0%	0.0%	50.0%
Other or Unspecified	27	78	22	46	49	124	55.1%	62.9%	44.9%	37.1%	15	61	12	25	27	86	55.6%	70.9%	44.4%	29.1%
Sign	2	1	1	2	3	3	66.7%	33.3%	33.3%	66.7%	2	1	1	1	3	2	66.7%	50.0%	33.3%	50.0%
Spanish	170	173	109	104	279	277	60.9%	62.5%	39.1%	37.5%	95	91	62	34	157	125	60.5%	72.8%	39.5%	27.2%
Total	**2,339**	**2,126**	**1,490**	**1,187**	**3,829**	**3,313**	**61.1%**	**64.2%**	**38.9%**	**35.8%**	**1,607**	**1,390**	**861**	**570**	**2,468**	**1,960**	**65.1%**	**70.9%**	**34.9%**	**29.1%**
	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07	07-08	06-07
Diagnosis																				
Adjustment Disorder	428	330	312	164	740	494	57.8%	66.8%	42.2%	33.2%	348	256	192	76	540	332	64.4%	77.1%	35.6%	22.9%
Anxiety Disorder	335	324	209	168	544	492	61.6%	65.9%	38.4%	34.1%	244	229	118	98	362	327	67.4%	70.0%	32.6%	30.0%
Behavioral Disorder	218	173	134	48	352	221	61.9%	78.3%	38.1%	21.7%	164	138	72	31	236	169	69.5%	81.7%	30.5%	18.3%
Mood Disorder	975	939	598	508	1,573	1,447	62.0%	64.9%	38.0%	35.1%	604	557	342	239	946	796	63.8%	70.0%	36.2%	30.0%
Other	176	148	187	231	363	379	48.5%	39.1%	51.5%	60.9%	140	95	102	95	242	190	57.9%	50.0%	42.1%	50.0%
Schizophrenic	207	212	50	68	257	280	80.5%	75.7%	19.5%	24.3%	107	115	35	31	142	146	75.4%	78.8%	24.6%	21.2%
Total	***2,339***	***2,126***	***1,490***	***1,187***	***3,829***	***3,313***	***61.1%***	***64.2%***	***38.9%***	***35.8%***	***1,607***	***1,390***	***861***	***570***	***2,468***	***1,960***	***65.1%***	***70.9%***	***34.9%***	***29.1%***

All New Clients				
	Clients		*Percent*	
# of Services	**07-08**	**06-07**	**07-08**	**06-07**
1	870	699	22.7%	21.1%
2	617	487	16.1%	14.7%
3	437	282	11.4%	8.5%
4	303	221	7.9%	6.7%
5 to 15	1,157	890	30.2%	26.9%
15+	445	734	11.6%	22.2%
Total	***3,829***	***3,313***	***100.0%***	***100.0%***

New MediCal Clients			
Clients		*Percent*	
07-08	**06-07**	**07-08**	**06-07**
479	326	19.4%	16.6%
379	244	15.4%	12.4%
264	157	10.7%	8.0%
198	135	8.0%	6.9%
812	568	32.9%	29.0%
336	531	13.6%	27.1%
2,468	***1,961***	***100.0%***	***100.0%***

Mental Health Services Act–Work Plan Description (EXHIBIT D)

County Name

San Joaquin County

Work Plan Title

San Joaquin Full Service Partnership

Population to Be Served

- Children (3-15)
- Transitional Age Youth (16 -25)
- Adults (26 - 59)
- Older adults (60+)
- Youth in the Juvenile Justice System who are on probation formally or informally
- Youth in the Child Welfare system
- Adult Mentally ill offenders
- African-American, Latino, Cambodian, Vietnamese, Laotian, Hmong, Native American, Muslim/Middle Eastern, Gay, Lesbian, Bisexual, Transgender communities who are unserved or are currently in the system are inappropriately served or underserved
- Homeless or at risk of homelessness
- At risk of involuntary hospitalization or institutionalization
- First episode of serious mental illness
- Frequent users of hospital or emergency room services for mental health treatment
- Persons with Co-Occurring disorders

COMMUNITY SERVICES AND SUPPORTS

Annual Number of Clients to Be Served

__700_ Total

Number of Clients By Funding Category

___700_ Full Service Partnerships

_____ System Development

_____ Outreach & Engagement

PREVENTION AND EARLY INTERVENTION

Annual Number to Be Served

_____ Total

Number of Clients By Type of Prevention

_____ Early Intervention

_____ Indicated/Selected

_____ Universal

Project Description and Work Plan

The Full Service Partnership programs provide intensive community based services using a multi-disciplinary approach, including case management, individual and family therapy, psychiatric services, rehabilitation services, group therapy, specific behavioral interventions, 24/7 support, employment and housing linkage and "whatever it takes" supports. The Full Service Partnership programs are diverse in location, cultural focus, age focus, and criminal justice focus, allowing increased accessibility and consumer preference.

The programs provide developmentally appropriate services that encourage independence and recovery, resulting improvement in quality of life. Outreach and "case-finding" will be done to identify previously unserved and underserved individuals. Staffing includes county and contract staff, in partnerships with contract community-based organizations to focus on priority ethnic and cultural communities. The multi-disciplinary programs include psychiatrists, nurses, psychiatric technicians, mental health specialists, and outreach workers/recovery coaches.

Work plans were developed based on input from consumers, family members, and service providers during the Annual Update community planning process. Anticipated activities for the upcoming year are included on the following page.

Community Feedback and Recommendations

Major Program Strengths:

- New outreach to underserved populations with much better attention to the needs of diverse communities.
- Mode of service delivery is more responsive to consumer needs and is resulting in enhanced collaboration and partnerships.
- Permission to do "whatever it takes" has both increased our options for services and supports and has led to far more trust with consumers and family members as we work with them to address all of their needs.

Major Program Challenges

- The capacity of the core mental health system is stretched very thin.
- Participating in the MHSA Full Service Partnership is a new way of doing business and staff are still learning how to interpret eligibility guidelines, make qualifying referrals, and meet administrative requirements.
- Transportation challenges remain a major barrier for consumers to consistently make their appointments.
- Meaningful employment remains a major challenge for participants.

Actions and Next Steps

The anticipated budget shortfall for 2010/11 and 2011/12 has led BHS to be prudent in filling vacant positions to ensure that we can sustain our hiring commitments as funding for both MHSA programs and core services decreases. However at this time aggressive recruitment efforts are underway for key clinical positions. It is anticipated that over the next year more positions will be filled, easing capacity constraints.

Ongoing consortium and contractor meetings are will continue to be used as a venue to discuss training issues and administrative requirements. BHS will also investigate our current training model to determine the barriers for our CBO partner staff to participate in scheduled mental health trainings. The new WET coordinator will also help deliver core mental health trainings to all appropriate staff within the contracted service providers.

San Joaquin County has limited public transit options with time consuming options for individuals trying to come into Stockton from other county communities. Transportation is being addressed in various manners. The Wellness Center has initiated regular weekly pick-up times in Lodi, Tracy, Escalon, and Three Rivers Indian Lodge in Manteca. Through PEI funding some programs will be given one-time start-up costs that can be used to purchase vehicles. BHS will continue to advocate for better public transit options and seek funding for better transit solutions.

The economic crisis has hit San Joaquin County very hard. Extremely high unemployment rates (15.1% in January 2009) are making competition for scarce jobs quite severe. In this climate BHS will continue to develop new job and employment training opportunities for consumers. The new WET coordinator will play a pivotal role in this task.

Mental Health Services Act–Work Plan Description (EXHIBIT D)

County Name

San Joaquin County

Work Plan Title

Community Behavioral Intervention Services

Population to Be Served

Community behavioral intervention service (CBIS) provides quality behavioral interventions to at-risk unserved and underserved mentally ill persons. This Wraparound service will reduce or prevent first time hospitalization, relapses, and psychiatric readmissions. Emphasis will be on recovery and fostering resiliency through specialized behavioral interventions for transitional age youth (18-25), adults (26-59), and older adults (60+).

COMMUNITY SERVICES AND SUPPORTS

Annual Number of Clients to Be Served

__240__ Total

Number of Clients By Funding Category

_____ Full Service Partnerships

__240__ System Development

_____ Outreach & Engagement

PREVENTION AND EARLY INTERVENTION

Annual Number to Be Served

_____ Total

Number of Clients By Type of Prevention

_____ Early Intervention

_____ Indicated/Selected

_____ Universal

Project Description and Work Plan

Community Behavioral Intervention Services (CBIS)

The program is projected to serve 60 clients per quarter, or 240 clients per year. This number includes clients who have been successfully closed during the year for meeting a particular target goal; however, the client may be re-referred for additional services during the year. The population served by CBIS is clients from the age of 18 through Older Adult.

CBIS is a System Development program which provides individualized interventions for specific behaviors that inhibit a client from transitioning to either a less restrictive environment, or a lower level of clinical care.

CBIS is a contract organizational provider which employs a clinician, behavioral specialists, and Recovery Coaches. Recovery Coaches consist of consumers/family members who have become recovery coaches. They have been trained in the Wellness Recovery Action Plan. This has assisted clients enrolled in CBIS with additional support toward their recovery even after they are discharged from CBIS services.

Work plans were developed based on input from consumers, family members, and service providers during the Annual Update community planning process. Anticipated activities for the upcoming year are included on the following page.

Community Feedback and Recommendations

Major Program Strengths:

- Qualified, well trained and culturally competent and diverse peer based staff.
- Approximately 3-5 consumers receive intensive services on a weekly basis.
- Services are reaching targeted underserved populations “very well” according to community input received.

Major Program Challenges

- Shortages of psychiatric staff.
- Getting referrals from full-service partnerships. Referrals tend to be only the most severe cases though this is now expanding.

Actions and Next Steps

Ongoing consortium and contractor meetings are ideal opportunities to discuss referral opportunities. In the coming year we intend to develop communication systems and strategies around how to better integrate with the full service partnership, looking at what needs to be developed in order for us to share client information and develop team-decision making protocols. These meetings will also be ongoing opportunities to share successes and challenges and make sure all programs are aware of when and how to make appropriate referrals or simply to get advice or input on appropriate strategies for patient treatments.

Through both WET and PEI funding for community based *Mental Health 101,* lectures we are also looking forward to the opportunity to engage the larger community in a discussion of what services are available through BHS and how we can support individuals and families prior to, during, and after a mental health crisis.

Mental Health Services Act-Work Plan Description (EXHIBIT D)

County Name

San Joaquin County

Consortium

Population to Be Served

Consumers, family members, contractors, and BHS staff meet together monthly in the consortium and in topic-specific subcommittees. No direct services provided to clients. Contractors include CBOs representing the ethnic and cultural communities.

COMMUNITY SERVICES AND SUPPORTS

Annual Number of Clients to Be Served

____0__ Total

Number of Clients By Funding Category

_____ Full Service Partnerships

___0__ System Development

_____ Outreach & Engagement

PREVENTION AND EARLY INTERVENTION

Annual Number to Be Served

_____ Total

Number of Clients By Type of Prevention

_____ Early Intervention

_____ Indicated/Selected

_____ Universal

Project Description and Work Plan

Consortium:

The Consortium is a means to continue the inclusiveness and transparency that was started by the MHSA process. Additionally, the Consortium assists Behavioral Health Services in rolling out the approved mental health programs and in evaluating evidence-based practices. The Consortium provides a means to continue the partnership and trust that has developed.

The initial goal of the first year was to assist Behavioral Heath Services in rolling out the Mental Health Services Act programs. A goal of the Consortium is to develop partnership and trust with ethnic and cultural communities thru Community Based Organizations (CBO). These initial goals of the Consortium has been met with the successful establishment of Full Service Partnership programs that are meeting the special needs of unserved, underserved and inappropriately served populations including Gay, Lesbian, Bisexual, Transgender (GLBT) communities.

Educational efforts of year one were to learn the unique services of each CBO and education on the cultural community it serves. Additionally, the Consortium provided training on mental illness and dual-diagnosis encompassed in a 24/7 training for the Case Managers of the Full Service Partnerships (FSP).

The second year goals of FY 2009/2010 are to further evaluation efforts and to research evidenced based practices that are effective with unserved, underserved and inappropriately served populations. Evaluation will include addressing cultural, racial, ethnic and linguistic disparities including penetration and retention rates. Goals are to improve each CBO program's linguistic competency by providing services in the language of the consumer's choice. Improve documentation and evaluation of culture specific and specialized outreach efforts of each CBO, and continue community collaboration and improve service delivery to all consumer and family members, additionally addressing homelessness and factors that contribute to homelessness.

Work plans were developed based on input from consumers, family members, and service providers during the Annual Update community planning process. Anticipated activities for the upcoming year are included on the following page.

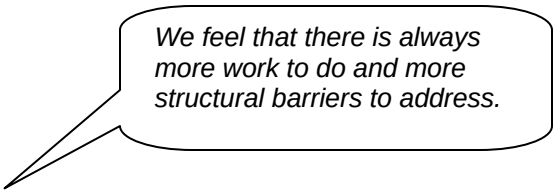
Community Feedback and Recommendations

Major Program Strengths:

- Together we have collectively shaped an ongoing, positive commitment to diversity and openness.
- Working together we have developed a comprehensive plan addressing service access for all San Joaquin county residents regardless of age, gender, race/ethnicity or language.
- Services are reaching targeted underserved populations "somewhat well" according to community input received.

Major Program Challenges

- The system does not handle individuals with co-occurring disorders well.
- Some people referred for services end up being deemed ineligible due to two concerns, first that referrals are not adequately documented according to BHS needs and second because at times referrals are made for individuals who do not meet clinical criteria.



Actions and Next Steps

Through the PEI planning process funding has been allocated to improve Behavioral Health's ability to respond to individuals with co-occurring disorders. Scheduled for use of anticipated 2009-2010 funds is the anticipated creation of a Transitional Age Youth (TAY) co-occurring disorders program. Also through Training, Technical Assistance, and Planning funding BHS will undergo a comprehensive organizational assessment process to identify internal processes and opportunities to strengthen services for individuals with co-occurring disorders. WET funding supports these efforts with funding reserved for an all staff training in co-occurring disorders.

During the community planning process consortium members agreed to use a portion of their consortium meeting time to address training issues regarding the documentation that is included with the referrals to ensure that individuals in need of services are better able to access more comprehensive services.

Through programs funded by prevention and early intervention funding, new programs will be developed that help address individuals who may not meet a diagnosis criteria for mental health treatment services. The new PEI plan includes funding for adults and seniors to receive short-term, counseling services through the family practice clinic at San Joaquin General Hospital for individuals suffering from depression, anxiety, anger, etc who may not qualify for treatment interventions. The PEI plan also provides funding for support groups, anger management classes, and recovery programs for adults and seniors who need ongoing community supports to help prevent mental health issues from developing into a full mental illness.

Mental Health Services Act-Work Plan Description (EXHIBIT D)

County Name

San Joaquin County

Work Plan Title

Co-Occurring Residential Treatment Program

Population to Be Served

This program serves 18 youth in Juvenile Probation's Placement Unit. All the targeted youth have serious emotional disturbance and a co-occurring substance abuse problem, and will receive mental health and substance abuse services

COMMUNITY SERVICES AND SUPPORTS

Annual Number of Clients to Be Served

__18____ Total

Number of Clients By Funding Category

_____ Full Service Partnerships

__18___ System Development

_____ Outreach & Engagement

PREVENTION AND EARLY INTERVENTION

Annual Number to Be Served

_____ Total

Number of Clients By Type of Prevention

_____ Early Intervention

_____ Indicated/Selected

_____ Universal

Project Description and Work Plan

Co-Occurring Residential Treatment Program

The operation of the Co-Occurring Residential Treatment Program will be a collaborative effort between several San Joaquin County agencies; to include Behavioral Health Services (BHS), Substance Abuse Services (SAS), Probation, Superior Courts, County Office of Education (COE) and the Human Services Agency (HSA). This project is still in its implementation phase. Phase I of the project, preparing a school site and completing renovations on the facility, has been completed. A vendor will be solicited in the coming year to manage the residential and treatment components of the program (Phase II).

The program is designed to serve youth that present with mental health disorders and co-occurring substance abuse problems. Each youth will be provided with mental health and substance abuse services. On-site public educational services will be provided to include services to special education students when required.
A collaborative approach such as this continues be a missing but necessary service to this population of youth in San Joaquin County. Residential services provided locally allow the family component of the services to occur. Thus resulting in more positive outcomes and may meet the objective of reducing recidivism, substance abuse and the amelioration of the mental health symptoms that affect the well-being of the youth and family.

The intent of the Co-Occurring Residential Treatment Program is to offer a comprehensive treatment diversionary alternative to the substance abusing youth with co-occurring mental health disorders for the purpose of diverting these youth from out-of-county and out-of-state residential placements and Department of Juvenile Justice incarcerations. Furthermore, with the participation of Behavioral Health Services, Substance Abuse Services, County Office of Education, Juvenile Probation and Health Services Agency on-site, this residential program is variedly unique as it allows easy access to the availability of treatment and other services offered to the youth, located at one venue.

Work plans continue to align with those described in the Community Services and Supports Plan. Community input regarding the co-occurring residential treatment program was not solicited during the recent community planning process, as services have yet to be provided.

Mental Health Services Act–Work Plan Description (EXHIBIT D)

County Name

San Joaquin County

Work Plan Title

Crisis Community Response Team (aka CCRT)

Population to Be Served

The priority populations for Crisis Community Response Team (CCRT) are adults and older adults with serious mental illness (SMI), children and youth with serious emotional disability (SED), and family and friends of SED and SMI consumers seeking information, education, assistance and support. CCRT proposes to expand our current core behavioral health response services to provide an array of enhancements to mental health crisis response.

COMMUNITY SERVICES AND SUPPORTS

Annual Number of Clients to Be Served

__3000_ Total

Number of Clients By Funding Category

_____ Full Service Partnerships

_3000__ System Development

_____ Outreach & Engagement

PREVENTION AND EARLY INTERVENTION

Annual Number to Be Served

_____ Total

Number of Clients By Type of Prevention

_____ Early Intervention

_____ Indicated/Selected

_____ Universal

Project Description and Workplan

1. Crisis Community Response Team / Consumer Support Warm-line
2. The CCRT makes approximately 2 follow-up home contacts for every initial contact making efforts to engage consumers that have been hesitant to agree to mental health services.
3. The population to be served includes all persons regardless of race/ethnicity, language or situation. The multi-disciplinary response team that contacts consumers consists of staff, including consumer staff, who are best equipped to assist the consumer in terms or language, culture, age, medical, substance abuse or mental health need.

Consumer Support Warm-line

The Consumer Support Warm-line provides peer support for consumers, family members, and the community. The Consumer Support Warm-line is a consumer-staffed friendly phone line through which consumers of mental health services receive support, share concerns, obtain referrals, and talk with a peer who generally understands their perspective and is willing to listen and talk with them. The integration of the warm and hotlines enhances early identification and intervention in crisis situations, promote community education, decreases stigma, fosters social support and improve community functioning for consumers who are in recovery.

Crisis Community Response Team (CCRT)

This mobile multi-disciplinary crisis team provides community adult mental health outreach, early intervention and joint field response with law enforcement for crisis 5150 detention evaluations. The CCRT responds in the community to provide mental health outreach to unserved & underserved, linkage to services, risk reduction, crisis intervention, crisis residential housing and 5150 evaluations. The Crisis Community Response Team (CCRT) is currently available 16/7/365 from 7:00AM to 11:00PM to respond to calls from mental health consumers, family members of consumers and the community, in addition to law enforcement, community agencies and hospitals. Emphasis is on early intervention and education to decrease the necessity of emergency calls for police and emergency medical response. The CCRT is the point of contact for law enforcement agency referrals and joint field evaluations. At the optimum, with an informed community and consumers comfortable in requesting mental health assistance, the CCRT will assist to decrease involvement by law enforcement, reduce psychiatric hospitalizations, incarcerations, and the frequent use of emergency rooms as mental health facilities.

Community Feedback and Recommendations

Major Program Strengths:

- Qualified, well trained and culturally competent and diverse peer based staff.
- Warm line has proven to be exceptionally well utilized.
- Field calls are working well to diffuse crisis situations and to provide a warm welcome to available services.
- Services are reaching targeted underserved populations “very well” according to community input received.

Major Program Challenges

- Shortages of psychiatric staff.
- Strategies to work with individuals with co-occurring disorders, particularly those requiring detoxification from substances.

Actions and Next Steps

Through strategies initiated through the WET planning process and ongoing recruitment and retention practices BHS is looking to increase its clinical staff over the next six months. In addition to the recruitment and retention strategies the WET plan has also developed a career pathways initiative and an incentive program to help enable individuals to pursue education to advance their counseling and clinical skills.

Through the PEI planning process funding has been allocated to improve Behavioral Health’s ability to respond to individuals with co-occurring disorders. Scheduled for use of anticipated 2009-2010 funds is the anticipated creation of a TAY co-occurring disorders program. Also through Training, Technical Assistance, and Planning funding BHS will undergo a comprehensive organizational assessment process to identify internal processes and opportunities to strengthen services for individuals with co-occurring disorders. WET funding supports these efforts with funding reserved for an all staff training in co-occurring disorders.

Mental Health Services Act–Work Plan Description (EXHIBIT D)

County Name

San Joaquin County

Work Plan Title

Housing Empowerment and Employment Recovery Services

Population to Be Served

Population to be served- Seriously Mentally Ill adult and older adult enrollees of Full Service Partnership; unserved, underserved and inappropriately served persons, focus on African-American, Latino, Native American, Muslim/Middle Eastern, Southeast Asian and Gay, Lesbian, Bisexual and Transgender communities.

COMMUNITY SERVICES AND SUPPORTS

Annual Number of Clients to Be Served

_____ Total

Number of Clients By Funding Category

_____ Full Service Partnerships

_____ System Development

_____ Outreach & Engagement

PREVENTION AND EARLY INTERVENTION

Annual Number to Be Served

_____ Total

Number of Clients By Type of Prevention

_____ Early Intervention

_____ Indicated/Selected

_____ Universal

Work Plan Description

Housing Empowerment and Employment Recovery Services

The Housing Empowerment and Employment Recovery Services program proposes specific services that will increase stable, safe, affordable, permanent housing for people recovering from symptoms of severe mental illness. Through employment services, individual goals for security and personal identity will be identified and supported.

A stable home and meaningful work activity are important aspects of recovery. Community based housing and employment specialist programs provide supports to persons enrolled in Full Service Partnership (FSP). The Creating Housing Opportunities in Community Environments (CHOICE) assists consumers in locating and maintaining stable, safe, affordable, transitional or permanent housing. The Recovery Employment Services assists with individual goals for education and employment.

Housing is currently provided through crisis housing, satellite housing, and shelters. In the next year we anticipate enhanced housing options through new affordable housing.

This systems development project operates in strong partnership with the Full Service Partnership. Behavioral Health Services is responsible for project coordination and the development of new housing and employment opportunities. Contracted programs participating in San Joaquin County's Full Service Partnership subsequently link consumers to these housing or employment opportunities. Program strengths, challenges, and recommended actions were discussed by participants of the Full Service Partnership work group.

Mental Health Services Act–Work Plan Description (EXHIBIT D)

County Name

San Joaquin County

Work Plan Title

The Wellness Center

Population to Be Served

The target population is all consumers (Adults 18+) with emotional or psychiatric concerns with a special emphasis on the unserved, underserved, and inappropriately served ethnic and cultural populations. These populations include faith and tribal based communities, as well as Transition Age Youth (TAY) and Gay, Lesbian, Bisexual, Transgender (GLBT)

COMMUNITY SERVICES AND SUPPORTS

Annual Number of Clients to Be Served

__300__ Total

Number of Clients By Funding Category

_____ Full Service Partnerships

__300__ System Development

_____ Outreach & Engagement

PREVENTION AND EARLY INTERVENTION

Annual Number to Be Served

_____ Total

Number of Clients By Type of Prevention

_____ Early Intervention

_____ Indicated/Selected

_____ Universal

Project Description and Work Plan

The Wellness Center

The Wellness Center is a program designed, organized and run by people who have or have had mental health problems. The Center is based the concept of a consumer-run and self-help program. The Wellness Center functions as a General System Development program by outreaching to peers, assisting peers develop life skills and coping skills; and reducing isolation and stigma by reaching out to staff and the community to be a partner in transformation.

One of the main goals of The Wellness Center is to provide a consumer-run center based on the concepts of recovery and wellness. The Wellness Center will provide peer advocacy and skill based classes in a variety of topics. The Center will coordinate and make referrals to programs for additional treatment and supports.

A second year goal is to provide leadership training and possible opportunities for Wellness Center participants to volunteer and provide leadership through co-facilitation of skill based and peer-support groups. Opportunities for consumer leadership will be explored through the Power N Support team and special projects, like the bulletin board project, that are designed to be an instrument for consumer voice and education. As Wellness Center participants advance through the four levels of classes, opportunities of mentorship will be explored to foster and enhance leadership and advocacy skills.

Work plans were developed based on input from consumers, family members, and service providers during the Annual Update community planning process. Anticipated activities for the upcoming year are included on the following page.

Community Feedback and Recommendations

Major Program Strengths:

- The Wellness Center has done a good job of linking people to the community services that they need.
- The Wellness Center has really contributed to consumer empowerment. It has strong direction and input from consumers and it has done a good job of employing consumers or providing incentives for consumers to continue with their education.
- Services are reaching targeted underserved populations "well" according to community input received.

> *We are reaching people with no previous contact with the mental health system.*

Major Program Challenges

- Reaching out to family members, particularly in underserved communities.
- Knowing all the best community services to refer people to.

Actions and Next Steps

Volunteer cultural brokers (similar to the *promotores* model) will be recruited and trained through prevention and early intervention efforts. Cultural brokers will be existing community leaders, such as ministers, elders, shamans, imams, medicine men and women and others who have a deep connection to the diverse cultural communities of San Joaquin County. We anticipate that these cultural brokers will help us make better connections to family members and others who are integrally involved in consumers' treatment and well-being.

Over the short time that the Wellness Center has been operating new connections continue to be forged. Over the next year we look forward to reaching out and learning about the programs and services available throughout the county and further transition to a consumer-run center. The Wellness Center has an open door policy and through the community planning process we have initiated a meeting exchange process where we invite program staff to visit the Wellness Center and we ask for opportunities to come present on the Wellness Center to different programs and services. We look forward to continuing this in the coming year.

EXHIBIT E1-CSS Funding Request

FY 2009/10 Mental Health Services Act
Community Services and Supports Funding Request

County: San Joaquin County

Date: 3/16/2009

CSS Work Plans				FY 09/10 Required MHSA Funding	Estimated MHSA Funds by Service Category				Estimated MHSA Funds by Age Group			
	No.	Name	New (N)/ Approved Existing		Full Service Partnerships (FSP)	System Development	Outreach and Engagement	MHSA Housing Program	Children, Youth, and Their Families	Transition Age Youth	Adult	Older Adult
1.	FSP-1	SJC Full Service Partnership	E	$10,782,555	$10,782,555				$927,627	$625,536	$8,168,279	$1,061,113
2.	SD-1	The Wellness Center	E	$576,234		$576,234					$576,234	
3.	SD-2	Community MHSA Consortium	E	$350,410		$350,410					$350,410	
4.	SD-3	Housing Empowerment & Employmen	E	$1,428,629	$1,028,808	$399,821					$1,428,629	
5.	SD-4	Community Behavioral Intervention Se	E	$666,330		$666,330					$666,330	
6.	SD-5	Community Response Team	E	$1,403,193		$1,403,193				$140,320	$1,122,553	$140,320
7.	SD-6	Co-Occurring Residential	E	$150,000		$150,000			$150,000			
8.												
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22.												
23.												
24.												
25.												
26.	Subtotal: Work Plans[a/]			$15,357,351	$11,811,363	$3,545,988	$0	$0	$1,077,627	$765,856	$12,312,435	$1,201,433
27.	Plus County Administration			$1,770,075								
28.	Plus Optional 10% Operating Reserve			$0								
29.	Plus CSS Prudent Reserve[b/]			$7,645,101								
30.	Total MHSA Funds Required for CSS			$24,772,527								

a/ Majority of funds must be directed towards FSPs (Title 9, California Code of Regulations Section 3620(c)). Percent of Funds directed towards FSPs= 76.91%

b/Transfers to Capital Facilities and Technological Needs, Workforce Education and Training, and Prudent Reserve are subject to limitations of WIC 5892b.

EXHIBIT E-Summary Funding Request

FY 2009/10 Mental Health Services Act
Summary Funding Request

County: San Joaquin County Date: 3/17/2009

	MHSA Component				
	CSS	**CFTN**	**WET**	**PEI**	**Inn**
A. FY 2009/10 Planning Estimates					
1. Published Planning Estimate[a/]					
2. Transfers[b/]					
3. Adjusted Planning Estimates	$0	$0	$0	$0	$0
B. FY 2009/10 Funding Request					
1. Required Funding in FY 2009/10[c/]	$24,772,527				
2. Net Available Unspent Funds					
a. Unspent FY 2007/08 Funds[d/]	$7,019,837				
b. Adjustment for FY 2008/09[e/]					
c. Total Net Available Unspent Funds	$7,019,837	$0	$0	$0	$0
3. Total FY 2009/10 Funding Request	**$17,752,690**	**$0**	**$0**	**$0**	**$0**
C. Funding					
1. Unapproved FY 06/07 Planning Estimates					
2. Unapproved FY 07/08 Planning Estimates					
3. Unapproved FY 08/09 Planning Estimates	**$2,460,090**				
4. Unapproved FY 09/10 Planning Estimates	**$15,292,600**				
5. Total Funding[f/]	**$17,752,690**	**$0**	**$0**	**$0**	**$0**

EXHIBIT F1(a)

Community Services and Supports New Work Plan Narrative
FY 2009/10 Annual Update
Mental Health Services Act

County ____San Joaquin_____

Instructions: Utilizing the following format please provide brief responses. Existing Work Plans that have been previously approved do not need to be included here. List a Work Plan Number and Title. Note: A brief narrative description of the proposed Work Plan and the population to be served as well as the annual number of clients estimated to be served are included as Exhibit D.

Not Applicable: No New Work Plans

a) **Work Plan Number: ___ Title:_____**

b) **Explanation of how the New Work Plan relates to the priorities identified in the Community Planning Process.**

c) **A description of how the proposed Work Plan relates to the General Standards (Title 9, CCR, Section 3320) of the MHSA.**

d) **For project-based housing expenditures using General System Development funding, include a brief description outlining the type of housing (e.g., temporary, respite, transitional, etc.), whether the expenditure will be for master leasing of units, acquisition/rehabilitation of an existing housing structure or construction of new housing and the number of units to be acquired.**

EXHIBIT G

Community Services and Supports Prudent Reserve Plan
FY 2009/10 ANNUAL UPDATE MENTAL HEALTH SERVICES ACT

County San Joaquin County **Date** March 17, 2009

Instructions: Utilizing the following format please provide a plan for achieving and maintaining a prudent reserve.

1. Requested FY 2009/10 CSS Services Funding **$ 15,486,351**
Enter the total funds requested from Exhibit E1 – CSS line 26.

2. Less: Non-Recurring Expenditures **- _____**
Subtract any identified CSS non-recurring expenditures included in #1 above.

3. Plus: CSS Administration **+ 1,641,075**
Enter the total administration funds requested for CSS from Exhibit E1 – CSS line 27.

4. Sub-total **17,127,426**

5. Maximum Prudent Reserve (50%) **8,563,713**
Enter 50%, or one-half, of the line item 4 sub-total. This is the estimated amount the County must achieve and maintain as a prudent reserve by July 1, 2010. If the funding level for CSS services and county administration changes for FY 10/11, the amount of the prudent reserve would also change.

6. Prudent Reserve Balance from Prior Approvals **918,613**
Enter the total amounts previously approved through Plan Updates for the local prudent reserve.

7. Plus: Amount requested to dedicate to Prudent Reserve through this Plan Update **+ 7,645,101**
Enter the amount of funding requested through this Plan update for the local prudent reserve from Exhibit E1 – CSS line 29.

8. Prudent Reserve Balance **8,563,713**
Add lines 6 and 7.

9. Prudent Reserve Shortfall to Achieving 50% **0**
Subtract line 8 from line 5. A positive amount indicates that the County has not dedicated sufficient funding to the local prudent reserve. Please describe below how the County intends to reach the 50% requirement by July 1, 2010; for example indicate future increases in CSS planning estimates that will be dedicated to the prudent reserve before funding any program expansion.

Note: If subtracting line 8 from line 5 results in a negative amount – this indicates that the County is dedicating too much funding to the local prudent reserve, and the prudent reserve funding request will be reduced by DMH to reflect the maximum.