

MHSA COUNTY COMPLIANCE CERTIFICATION

County: **SAN BENITO**

- Three-Year Program and Expenditure Plan
 Annual Update

Local Mental Health Director	Program Lead
Name: Alan Yamamoto	Name: Alan Yamamoto
Telephone Number: 831-636-4020	Telephone Number: 831-636-4020
E-mail: alan@sbcmh.org	E-mail: alan@sbcmh.org
Local Mental Health Mailing Address: 1131 San Felipe Road Hollister, CA 95023	

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

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on NOV. 4, 2014

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

All documents in the attached annual update are true and correct.

Alan Yamamoto
Mental Health Director (PRINT)

[Signature]
Signature

11/12/2014
Date

AGENDA ITEM TRANSMITTAL		Agenda Time Estimates: Minutes or <input checked="" type="checkbox"/> Consent	Leave Blank: 810	Date/Time Rec'd: 10/24/14
TO: BOARD OF SUPERVISORS		CONTACT FOR INFORMATION: Name: Alan Yamamoto Phone No: 831-636-4020		NUMBER OF CERTIFIED COPIES REQUIRED:
FROM: Alan Yamamoto Behavioral Health Department				

MEETING DATE: Nov. 04, 2014	(1) SUBJECT: Request for Board of Supervisors Approval of the FY 2014-15-16-17 Mental Health Services Act (MHSA), 3-Year Plan
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(2) BACKGROUND INFORMATION (If not summarized within this space provide a staff report instead, noting attachment):

The State Dept. of Health Care Services (DHCS), Mental Health Division requires local Board of Supervisors approval of the County Behavioral Health Departments MHSA Plans and the MHSA Oversight and Accountability Commission approval of the Innovation MHSA Plan component to access the available funding for the entire MHSA program components included in the plan. The current annual plan update includes a combined submission of the MHSA, Community Services and Supports (CSS), Prevention and Early Intervention (PEI) and Innovative Programs (INN) components into one plan submission. The State DMH originally approved the first San Benito County MHSA Plan and funding request in June 2006, the PEI component of the County's MHSA Plan and funding request in May 2009 and INN component of the MHSA Plan and funding request in May 2011.

(3) OTHER AGENCY INVOLVEMENT:

Some Community Based Agencies provide services for components of the County's MHSA Plan as contractors on behalf of County Behavioral Health.

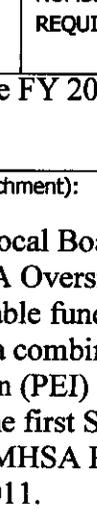
(4) SUPPORTIVE DOCUMENTS RELATIVE TO THIS ITEM: <input type="checkbox"/> Contract <input type="checkbox"/> Ordinance <input type="checkbox"/> Resolution <input checked="" type="checkbox"/> 3 Year Plan	(5) PREVIOUS RELEVANT BOARD ACTIONS ON THIS SPECIFIC ITEM: Previous MHSA Annual Plans Approved
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(6) FUNDING SOURCE(S): MHSA Funds from State income tax revenue	(7) CURRENT YEAR COST: \$ 2,988,363	(8) ANNUAL OR PROJECT COST: \$9,444,565 3-yr est	(9) BUDGETED: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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(10) WILL PROPOSAL REQUIRE ADDITIONAL PERSONNEL? YES NO If YES, STATE NUMBER: _____
Permanent Limited Term

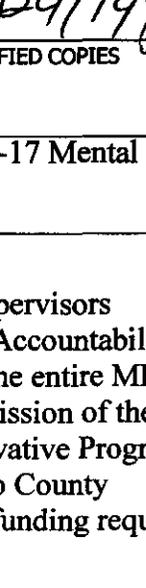
(11) RECOMMENDED ACTION(S):

- Board of Supervisors approval of the County Behavioral Health Department's FY 2014-15-16-17 MHSA, 3 Year Plan and submission to the Mental Health Services Act Oversight and Accountability Commission and;
- Authorize the County Behavioral Health Director to sign the FY 2014-15-16-17 MHSA, 3 Year Plan County Certifications and;
- Authorize the County Auditor upon Auditors approval signing of the MHSA Plan Auditor's Fiscal Certification .

SIGNATURE OF AGENCY OR DEPARTMENT AUTHORIZED REPRESENTATIVE 	DATE Oct. 24, 2014
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CLERK'S USE ONLY

<input checked="" type="checkbox"/> APPROVED	<input type="checkbox"/> DENIED	<input type="checkbox"/> ADOPTED	<input type="checkbox"/> CONTINUED TO _____
<input type="checkbox"/> ACKNOWLEDGED	<input type="checkbox"/> ACCEPTED	<input type="checkbox"/> RESOLUTION NO. _____	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> SET PUBLIC HEARING	<input type="checkbox"/> APPOINTED	<input type="checkbox"/> ORDINANCE NO. _____	<input type="checkbox"/> NO ACTION TAKEN _____

BY:  Deputy Clerk of the Board	DATE: 11/4/14
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COPY ROUTING: ORIGINATING DEPT. - AUDITOR - COUNTY COUNSEL

MHSA FY 2014–2017 3 Year Plan FISCAL ACCOUNTABILITY CERTIFICATION¹

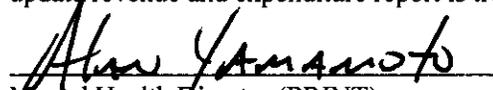
County: **SAN BENITO**

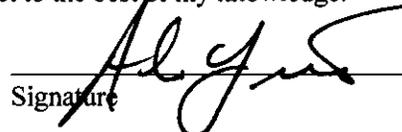
- Three-Year Program and Expenditure Plan
- Annual Update
- Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller
Name: Alan Yamamoto	Name: Joe Paul Gonzalez
Telephone Number: 831-636-4020	Telephone Number: 831-636-4090
E-mail: alan@sbcmh.org	E-mail: jgonzalez@cosb.us
Local Mental Health Department Mailing Address:	
1131 San Felipe Road, Hollister, CA 95023	

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

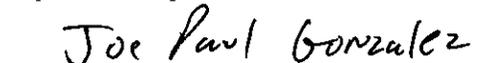
I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.


Mental Health Director (PRINT)

 11/12/2014
Signature Date

I hereby certify that for the fiscal year ended June 30, 2014 the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the fiscal year ended June 30, 2013. I further certify that for the fiscal year ended June 30, 2014, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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


County Auditor-Controller (PRINT)

 10-14-14
Signature Date

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

MHSA Community Program Planning and Local Review Process

County: SAN BENITO 30-day Public Comment period: 08/19/14 - 09/17/14

Date: 08/19/14 Date of Public Hearing: Thursday, 09/18/14

COUNTY DEMOGRAPHICS AND DESCRIPTION

San Benito County is a small, rural county that lies in the Central Coast region of California. It is located at the southern end of the Santa Clara Valley, just south of Silicon Valley, and offers easy access to the metropolitan San Jose area, Monterey, and Santa Cruz. The county's population is 55,269 (*US Census 2010, Demographic Profile*). San Benito County's largest city is Hollister, home to approximately 34,928 residents (*US Census 2010, Demographic Profile*). San Benito County is a racially-diverse county, with the third highest proportion of Latinos in the general county population relative to all other California counties. The County's population is comprised of 57% Latinos, 38% Caucasians, and 5% from Other race/ethnic groups.

All services are sensitive to the client's cultural and linguistic background and delivered in the person's preferred language, which promote a welcoming environment that meets the needs of our population.

The census estimates that 39.2% of the population of San Benito County speaks a language other than English at home. Spanish is the only threshold language in San Benito County. There are 2,646 veterans, which represent 5% of the population. Approximately 7.4% of the population is under 5 years of age, 24.6% are ages 6-19, 58.3% are ages 20-64, and 9.7% are over 65 years of age. Females represent 50.0% of the population.

COMMUNITY PROGRAM PLANNING

Provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this annual update per Title 9 of the California Code of Regulations, Sections 3300 and 3315.

- 1. Briefly describe the Community Program Planning (CPP) Process for development of all components included in the FY 2014-2017 Three Year Plan.*

The San Benito County Behavioral Health (SBCBH) Community Program Planning (CPP) process for the development of the FY 2014/15-2017/18 Three-Year Plan builds upon the initial planning process that started in 2005 for the development of our original Three-Year Plan and our Annual Updates. Over the past several years, this planning process has been comprehensive and has included the input of diverse stakeholders through focus groups, stakeholder meetings, and surveys. Components addressed by the planning process included Community Services and Supports (CSS); Prevention and Early Intervention (PEI); Innovation; Workforce Education and Training (WET); Capital Facilities/Technological Needs (CFTN); and Housing. In addition, we

provided basic education regarding mental health policy; program planning and implementation; monitoring and quality improvement; evaluation; and fiscal and budget components.

For the planning process for the FY 2014/15-2017/18 Three-Year Plan, we conducted focus groups and stakeholder meetings at various locations in the community, including our wellness center (Esperanza Center). In addition, we obtained input from community stakeholders and conducted outreach to the unserved and underserved through collection of MHSA surveys. This outreach included meeting with over 50 Hispanic families (N=52) who completed the MHSA survey. These families meet monthly with a Migrant Education Program and were very interested in learning about our programs and services. We also obtained information from individual school personnel, to obtain their perspective on needs and issues for children and families in our community. Across all stakeholder groups including consumers, we received surveys from 86 individuals. Included in these stakeholder groups were veterans, persons from the LGBTQ community, and persons with lived experience. The survey results are included as Attachment A.

With this information, we were able to determine the unique needs of our community and develop an MHSA program that is well designed for our county. The overall goals of the MHSA are still valid and provide an excellent guide for maintaining and enhancing our MHSA services in FY 14/15-17/18.

We also analyzed data on our Full Service Partnership (FSP) clients to ensure that clients are successfully achieving positive outcomes. Outcome and service utilization data is regularly analyzed and reviewed by management to monitor clients' progress over time. This data has helped us to understand service utilization and evaluate client progress, and has been instrumental in our planning process to continually improve FSP services.

The proposed Three-Year Plan integrates stakeholder, survey, a service utilization data to analyze community needs and determine the most effective way to further meet the needs of our unserved/ underserved populations. In addition, the MHSA Three-Year Plan planning, development, and evaluation activities were discussed with the Behavioral Health Board members; during QIC meetings; at Cultural Competence Committee meetings; to AB109 service recipients; during Katie A meetings; during inter-agency planning committees; and at staff meetings, to obtain input and strategies for improving our service delivery system.

All stakeholder groups and boards are in full support of this MHSA Three-Year Plan and the strategy to maintain and enhance services.

2. Identify the stakeholders involved in the Community Program Planning (CPP) Process (e.g., agency affiliation, populations represented, ages, race/ethnicity, client/family member affiliation, primary languages spoken, etc.).

A number of different stakeholders were involved in the CPP process. Input was obtained at the Behavioral Health Board meetings and with stakeholder focus groups. In addition, MHSA staff, consumers, family members, Behavioral Health Director, administrative and fiscal staff, quality improvement staff, representatives from allied providers and agencies, and others involved in the

delivery of MHSA services provided input into the planning process. The CPP also included input from law enforcement, as well as from child and adult team meetings in mental health and substance abuse services, and the multiple agencies involved with delivering quality services to our community. Consumers who utilize the Esperanza Wellness Center were involved in the CPP through group meetings. Over 100 surveys were distributed to gather input from consumers, family members, stakeholders, staff, providers, partner agencies, and the general public, with 86 completed and returned. This process helped to enhance input from multiple perspectives in our county.

The participants who completed the survey reflect the race/ethnicity of our community: 33.1% were Caucasian, 48.6% Hispanic, 1.4% Black/African American 1.4% Native American, and 2.8% Asian. There were 12.7% who did not report their race/ethnicity. Twenty-one percent (21.2%) of the participants were male and 78.8% female. School personnel represented 36.3% of the respondents; 41.4% were family members; and 22.6% were adults. The adults included consumers; individuals from the Behavioral Health Board; provider agency staff and health care providers. Veterans and persons who are LGBTQ also participated in focus groups and completed the survey.

LOCAL REVIEW PROCESS

1. *Describe methods used to circulate, for the purpose of public comment, the annual update. Provide information on the public hearing held by the local mental health board after the close of the 30 day review.*

This proposed MHSA FY 2014/15-2017/18 Three-Year Plan was posted for a 30-day public review and comment period from August 19, 2014 through September 18, 2014. An electronic copy was available online at www.san-benito.ca.us. Hard copies of the document were available at the Behavioral Health clinic and in the lobbies of all frequently accessed public areas, including the Court House, Hazel Hawkins Hospital, County Administration, and the local library. In addition, hard copies of the proposed Annual Update were distributed to all members of the Behavioral Health Advisory Board; consumers (on request); staff (on request); Esperanza Center (our Adult/TAY Wellness Center); and with partner agencies.

A public hearing was conducted on Thursday, September 18, 2014, from 12:00 pm to 1:00 pm, at the County Behavioral Health Department, Main Conference Room, 1131 San Felipe Road, Hollister, CA 95023. The public hearing was held in conjunction with the Behavioral Health Advisory Board meeting. Twelve (12) individuals participated in the public hearing, comprised of five (5) Behavioral Health staff members; four (4) representatives from partner agencies, including Education; one (1) representative from law enforcement; and two (2) community members. Four (4) participants identified as consumers/family members. The race/ethnicity of the participants was approximately 42% Hispanic, 42% Caucasian, and 16% Other races/ethnicities. All of the participants were adults or older adults; over 65% were female.

The 30-day comment period and the public hearing were announced on our website and via a newspaper ad, as well as posted prominently on each copy of the proposed Plan.

2. *Include summary of substantive recommendations received during the stakeholder review and public hearing, and responses to those comments. Include a description of any substantive changes made to the annual update that was circulated. Indicate if no substantive comments were received.*

No comments or suggestions were made during the 30-day posting period. Participants at the public hearing expressed support of the Plan, but had no changes or suggestions. As a result, no substantive changes were made to the posted MHSA FY 2014/15-2017/18 Three-Year Plan. The Behavioral Health Board reviewed and approved the proposed Plan during the public hearing.

The final MHSA FY 2014/15-2017/18 Three-Year Plan will be submitted to the County Board of Supervisors for approval. After BOS approval, the MHSA FY 2014/15-2017/18 Three-Year Plan will be submitted to the California Mental Health Services Oversight and Accountability Commission (MHSOAC) for review.

Exhibit B

**MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS**

- 1. Provide a program description (must include number of clients served, age, race/ethnicity). Include achievements and notable performance outcomes.**

The SBCBH MHSA Community Supports and Services (CSS) program provides services to all ages [children (ages 0-17); transition age youth (ages 16-25); adults (ages 18-59); older adults (ages 60+)]; all genders; and all races/ethnicities. This CSS Program embraces a “whatever it takes” service approach in helping individuals achieve their goals. Services for all populations help reduce ethnic disparities, offer peer support, and promote values-driven, evidence-based practices to address each individual’s unique needs, and support health and wellness. These services emphasize wellness, recovery and resiliency and offer integrated services for clients of all ages and their families. Services are delivered in a timely manner and are sensitive to the cultural needs of each individual.

The CSS Program includes comprehensive assessment services; wellness and recovery action planning; case management services; individual and group mental health services; crisis services; linkages to needed services; and housing support. Our Drop-In Wellness Center (Esperanza Center) provides adults and older adults with necessary services and supports in a welcoming environment, including classes, social activities, and group therapy. In addition, several days per week, Esperanza Center provides Transition Age Youth (TAY) with a safe, comfortable place to receive services and participate in peer-driven, age-appropriate activities. Outreach and engagement activities are provided to the migrant worker population, the homeless, and other at-risk individuals.

Figure 1 shows the total unduplicated number of clients served by the CSS program in FY 13/14. As shown, there were 1,367 persons served with 26.3% children (0-15 years), 17.3% Transition Age Youth (16-25 years), 49.5% adults (26-59 years), and 6.9% older adults (60+ years).

**Figure 1
CSS Clients (FY 13/14)
By Age**

0 - 15 years	360	26.3%
16 - 25 years	236	17.3%
26 - 59 years	676	49.5%
60+ years	95	6.9%
Total	1,367	100.0%

Figure 2 shows that females represent 53.8% of the CSS client population.

**Figure 2
CSS Clients (FY 13/14)
By Gender**

Male	631	46.2%
Female	736	53.8%
Total	1,367	100.0%

Figure 3 shows that the majority of person served are Hispanic (57.1%). Caucasians represent 35.9% of the persons served.

**Figure 3
CSS Clients (FY 13/14)
By Race/Ethnicity**

Caucasian	491	35.9%
Hispanic	781	57.1%
African American	13	1.0%
Asian/Pacific Islander	19	1.4%
American Indian	11	0.8%
Other	52	3.8%
Total	1,367	100.0%

Figure 4 shows that the average CSS client received \$3,059 of services.

**Figure 4
CSS Clients (FY 13/14)
Dollars per Client**

Total Dollars	\$ 4,181,332
Total Clients	1,367
Avg. Dollars/Client	\$ 3,059

2. Describe any challenges or barriers, and strategies to mitigate.

We find that the most difficult group to engage in services is the migrant worker population. The migrant worker population is reluctant to access behavioral health services due to stigma, cultural values, and perceptions of behavioral health utilization. Our outreach efforts help to engage this population to reduce stigma and help them utilize prevention and early intervention services. One strategy has been placing a bilingual clinician at the Health Foundation, a Federally Qualified Health Center (FQHC). This individual offers mental health services for 12-15 hours per week at the FQHC and has been well accepted by both staff and patients.

In addition, we have been successful in reaching out to the migrant workers by visiting the seasonal migrant labor camps that are open during the summer months. Bilingual, bicultural Spanish-speaking Behavioral Health staff visit the camps and provide behavioral health

education and access information. This year, we also conducted a focus group with 52 migrant farmworker families. During this informational focus group, the family members also completed our MHSA survey. These families reported that depression, anger management, and disrespect were the biggest issue for children and youth. They also reported that depression, employment, and education were the biggest issues for adults in the family.

We strive to create a welcoming environment to improve access to services. Our front office staff are bilingual and bicultural and are able to immediately communicate in either language when a person calls or walks into the clinic. As a result of this welcoming environment and bilingual staff, over 57% of our clients are Hispanic. However, stigma continues to prevent some individuals from requesting mental health services. We continually offer outreach services to help reduce these barriers and mitigate the fear of accessing services. Our FY 2011/12 – 2013/14 Innovation Program integrated behavioral health services at the Health Foundation to help improve access by receiving referrals from a physical health care provider. While we will no longer use INN funds to support this program, we will sustain the program through CSS funding.

We have been pleased with our ability to maintain our services through MHSA funding to meet the needs of our clients. Funding has made a difference in helping clients and their families to meet their goals and achieve positive outcomes.

3. List any significant changes in Three-Year Plan, if applicable.

There are no significant changes to the Three Year CSS Program.

**MHSA Program Component
PREVENTION AND EARLY INTERVENTION #1
Children and Youth Services**

- 1. Provide a program description (must include number of clients served, age, race/ethnicity, cost per person; try to separate data for Prevention and Early Intervention, if possible). Include achievements and notable performance outcomes.**

SBCBH contracts with the Youth Alliance (YA) to provide children and youth with Prevention and Early Intervention services in the schools and community. A YA Case Manager screens children and youth for mental health service needs, and refers potential clients to either SBCBH or the YA clinic for services. A component of this program implemented the promising practice program, *Joven Noble* – Rites of Passage, a Latino youth development and leadership enhancement program. This culturally-based program works with youth to develop life skills, cultural identity, character, and leadership skills. It is a program that has been effective at reducing gang involvement and providing mentoring and leadership to Latino youth who are considered at risk for mental illness, using drugs, and/or dropping out of school. Families are included in services one weekend a month, to help them learn how to support healthy outcomes for their children.

YA has successfully implemented all planned prevention and early intervention activities in the schools and community. Youth and families involved in the *Joven Noble* program have achieved positive outcomes and youth are developing positive leadership skills and reducing involvement in gangs. This program has also helped to reduce cultural and ethnic disparities in our mental health system. The YA Team is integrated within the school environment and is well received by staff and students.

Figure 5 shows the number of children and youth served by the Youth Alliance (YA) using PEI funding, by age group. YA served 95 children and youth, with 82.1% ages 0-15 and 17.9% ages 16-25.

**Figure 5
PEI YA Clients (FY 13/14)
By Age**

0 - 15 years	78	82.1%
16 - 25 years	17	17.9%
26 - 59 years	-	0.0%
60+ years	-	0.0%
Total	95	100.0%

Figure 6 shows that 86.3% of the children and youth served by YA were Hispanic.

Figure 6
PEI YA Clients (FY 13/14)
By Race/Ethnicity

Caucasian	12	12.6%
Hispanic	82	86.3%
African American	-	0.0%
Asian/Pacific Islander	-	0.0%
American Indian	-	0.0%
Other/Multi	1	1.1%
Total	95	100.0%

Figure 7 shows the average cost per YA child was \$1,644.

Figure 7
PEI YA Clients (FY 13/14)
Dollars per Client

Total Dollars	\$ 156,225
Total Clients	95
Avg. Dollars/Client	\$ 1,644

2. Describe any challenges or barriers, and strategies to mitigate.

YA has continued to provide a variety of culturally appropriate services to the children and youth in our community through the various programs supported through MHSA Prevention and Early Intervention funds. YA staff are well received in the schools, and the youth and families benefit from their services. There are no challenges or barriers for this program.

3. List any significant changes in Three-Year Plan, if applicable.

There are no changes anticipated to this PEI Project in this fiscal year.

**MHSA Program Component
PREVENTION AND EARLY INTERVENTION #2
Suicide Prevention Training**

- 1. Provide a program description (must include number of clients served, age, race/ethnicity, cost per person; try to separate data for Prevention and Early Intervention, if possible). Include achievements and notable performance outcomes.**

SBCBH contracts with a local community resource (Family Service Agency of the Central Coast) to provide suicide prevention trainings to first responders in our county, such as law enforcement. These trainings teach first responders to recognize the warning signs of suicidal behavior, develop techniques to improve response to situations involving suicide threat, and develop methods for safe intervention and linking individuals to community intervention and support resources.

In FY 13/14, there were 429 individuals who participated in Juvenile Prevention Training (see Figure 8). These trainings were held at local schools, the Hollister Police Department, Chamberlain’s Children Center, the San Benito County jail, the County Office of Education, a local nursing facility, a local homeless shelter, Veterans Hall, and various community agencies. This program has been successfully implemented and receives positive comments from the community. The average cost per person attending was \$18.36.

**Figure 8
PEI Suicide Prevention Clients (FY 13/14)
Dollars per Client**

Total Dollars	\$ 7,875
Total Individuals	429
Avg. Dollars/Person	\$ 18.36

- 2. Describe any challenges or barriers, and strategies to mitigate.**

We will continue to encourage Family Service Agency of the Central Coast to increase the number of trainings on Suicide Prevention to the schools, local communities, and partner agencies this fiscal year.

- 3. List any significant changes in Three-Year Plan, if applicable.**

There are no changes anticipated to this PEI Project in this fiscal year.

**MHSA Program Component
PREVENTION AND EARLY INTERVENTION #3
Older Adult Services**

- 1. Provide a program description (must include number of clients served, age, race/ethnicity, cost per person; try to separate data for Prevention and Early Intervention, if possible). Include achievements and notable performance outcomes.**

The Older Adult Prevention and Early Intervention Program utilizes a Case Manager to provide prevention and early intervention activities throughout the county to identify older adults who need mental health services. The program offers comprehensive assessment services to those older adults experiencing mental health problems that may interfere with their ability to remain living independently in the community. These individuals are then linked to resources in the community, including County Behavioral Health services. This program develops service alternatives for older adults who have been unserved and underserved in this community. Services are voluntary and client-directed, strength-based, employ wellness and recovery principles, address both immediate and long-term needs of individuals, and are delivered in a timely manner that is sensitive to the cultural needs of the population served.

The Case Manager collaborates with other agencies that provide services to this population, including Health and Human Services Agency, In-Home Supportive Services, Adult Protective Services, local physicians, Public Health, Senior Centers, nursing homes, Geropsychiatric Partial Hospitalization Program (Senior Connections), home health agencies, home delivery meals programs, and regional organizations which serve the elderly. Staff serving some of the agencies receive ongoing training to complete a brief screening tool to help them recognize signs and symptoms of mental illness in older adults.

The clinician served 95 older adults in FY 13/14 (see Figure 9).

**Figure 9
Older Adult PEI Clients (FY 13/14) By Age**

60+ years	95	100.0%
Total	95	100.0%

Of the 95 individuals served, 52.6% were Caucasian and 40% were Hispanic (see Figure 10).

Figure 10
Older Adult PEI Clients (FY 13/14)
By Race/Ethnicity

Caucasian	50	52.6%
Hispanic	38	40.0%
African American	1	1.1%
Asian/Pacific Islander	1	1.1%
American Indian	1	1.1%
Other	4	4.2%
Total	95	100.0%

Figure 11 shows that the average cost per older adult was \$1,500.

Figure 11
Older Adult PEI Clients (FY 13/14)
Average Dollars per Client

Total Dollars	\$ 142,480
Total Clients	95
Avg. Dollars/Client	\$ 1,500

The bilingual Spanish speaking Case Manager who serves older adults also provides case management services for older adults who are at risk of hospitalization or institutionalization, and who may be homeless or isolated. This individual offers prevention and early intervention services, and linkage, brokerage, and monitoring services to older adults in community settings that are the natural gathering places for older adults, such as *Jóvenes de Antaño*, our Senior Center. Older adults who are identified as needing additional services are referred to Behavioral Health for ongoing treatment.

The Case Manager who serves older adults also facilitates group services for caregivers who provide support and early intervention to family members who are caring for an elderly relative.

2. Describe any challenges or barriers, and strategies to mitigate.

Older adults experience barriers to accessing mental health services because of stigma. However, we work to help them understand that many people need supportive services to help them cope and manage stressful situations (e.g., death of a spouse, decreased mobility, isolation, etc.).

3. List any significant changes in Three-Year Plan, if applicable.

There are no changes anticipated to this PEI Project in this fiscal year.

**MHSA Program Component
PREVENTION AND EARLY INTERVENTION #4
Women's Services**

- 1. Provide a program description (must include number of clients served, age, race/ethnicity, cost per person; try to separate data for Prevention and Early Intervention, if possible). Include achievements and notable performance outcomes.**

The Women’s Prevention and Early Intervention program offers mental health early intervention groups at a local community domestic violence shelter to help victims of domestic violence, reduce stigma, and improve access to the Latino community. Approximately 57% of San Benito’s population is comprised of persons of Latino origin. Many of the Latino families in the county are immigrants or first generation Mexican-Americans.

A women’s group was developed to provide prevention and early intervention services for women. Interpreter services are available to accommodate monolingual Spanish speakers who are victims of domestic violence. The group also functions as a support group to promote self-determination; develop and enhance the women’s self-advocacy skills, strengths, and resiliency; discuss options; and help develop a support system to create a safe environment for women and their children. The group is held in the community to promote easy access and to assist with the development of healthy relationships.

Figure 12 shows that there were 58 persons served in the PEI Women’s Services program. The majority were Adult women, ages 26-59 years (77.6%).

**Figure 12
Women’s PEI Clients (FY 13/14)
By Age**

0 - 15 years	1	1.7%
16 - 25 years	10	17.2%
26 - 59 years	45	77.6%
60+ years	2	3.4%
Total	58	100.0%

Figure 13 shows that the majority of women were Hispanic (48.3%)

**Figure 13
Women’s PEI Clients (FY 13/14)
By Race/Ethnicity**

Caucasian	20	34.5%
Hispanic	28	48.3%
African American	0	0.0%
Asian/Pacific Islander	0	0.0%
American Indian	4	6.9%
Other	6	10.3%
Total	58	100.0%

Figure 14 shows that the average cost per client was \$96.41.

**Figure 14
Women’s PEI Clients (FY 13/14)
Dollars per Client**

Total Dollars	\$ 5,592
Total Clients	58
Avg. Dollars/Client	\$ 96.41

2. Describe any challenges or barriers, and strategies to mitigate.

At times, difficulty has been encountered in breaking the cycle of dependence in which victims of domestic violence are enmeshed with their significant other who is the perpetrator of the domestic violence. We will work with our contract provider to continue to conduct outreach to promote these available services.

3. List any significant changes in Three-Year Plan, if applicable.

No changes are anticipated to this PEI Project in this fiscal year.

We will work with our Contractor to identify opportunities for expanding the number of women referred to these services and to help link them to additional community resources.

MHSA Program Component
PREVENTION AND EARLY INTERVENTION #5
Mental Health First Aid Training

- 1. Provide a program description (must include number of clients served, age, race/ethnicity, cost per person; try to separate data for Prevention and Early Intervention, if possible). Include achievements and notable performance outcomes.**

We began offering Mental Health First Aid Training in FY 2013/14. Community members participated in 12 hours of training to become certified in providing Mental Health First Aid. They learned a 5-step action plan encompassing the skills, resources, and knowledge to help an individual in crisis and to link the individual with appropriate professional, peer, social, and self-help care.

The Mental Health First Aid USA course has been used to train a variety of audiences and key professionals, including: primary care professionals, employers and business leaders, faith leaders, school personnel and educators, state police and corrections officers, nursing home staff, volunteers, young people, families and the general public.

We offered two (2) Mental Health First Aid courses during the year. Approximately thirty (30) people attended each group. Attendees included SBCBH Employees, Contract Employees, Consumers/Family Members, Education Representatives, Physical Health Care Providers, Community Representatives, Local Community Based Organization Staff, Behavioral Health Board Members, San Benito Food Bank staff, Faith Based Representatives, and California Forensic Medical Group Staff.

While the training requires a large commitment of time for professionals, this program is an evidence-based program that develops important skills for community members who may be the first to respond to individuals with mental health symptoms. These skills include learning a five-step action plan for individuals to provide help to someone who may be in crisis.

- Assess for risk of suicide or harm
- Listen non-judgmentally
- Give reassurance and information
- Encourage appropriate professional help
- Encourage self-help and other support strategies

Following the course, participants developed important skills that help them respond appropriately to individuals having symptoms of a mental illness.

- 2. Describe any challenges or barriers, and strategies to mitigate.**

The 12-hour time commitment was the biggest barrier. However, the training participants found the training extremely valuable and were pleased to receive the skills and training. The Mental

Health First Aid Training program has recently been streamlined to complete the training in 8 hours. This change will help eliminate the time barrier.

3. *List any significant changes in Three-Year Plan, if applicable.*

There are no changes anticipated to this PEI Project in this fiscal year.

MHSA Program Component INNOVATION

- Completely New Program**
- Revised Previously Approved Program**

Program Number/Name:

Select **one** of the following purposes that most closely corresponds to the Innovation’s learning goal.

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

1. Describe why your selected primary purpose for Innovation is most relevant to your learning goal and why this primary purpose is a priority for your county.

Health Care Integration has been a high priority for us over the past several years. Our first Innovation project co-located a bilingual, bicultural clinician at one of our local Federally Qualified Health Centers (FQHC), the San Benito Health Foundation, for the past three years to begin integrating behavioral health and primary care services for persons needing mental health services. This co-location developed innovative strategies for engaging the low-income Hispanic population and creating a safe, trusting relationship, to help improve access to mental health services. The Hispanic population in San Benito County, who receive primary care services at the Health Foundation, are primarily migrant farm workers from Mexico. These individuals have a strong stigma against mental health symptoms, and typically do not acknowledge depression, anxiety, or other behavioral symptoms. As a result, they present to the primary care physician with physical health ailments: headaches, stomach aches, etc. Our Innovation Project trained Health Foundation staff to recognize these symptoms and link these individual to the bilingual, bicultural behavioral health clinician for services. This project was successful at increasing referrals and providing feedback to primary care and other Health Foundation staff on making appropriate and timely mental health referrals.

While this project has been an important step in building a collaborative relationship with the Health Foundation, and improving access for hard-to-reach populations to Behavioral Health Services in our community, it primarily served individuals at the FQHC who needed brief mental health therapy. As we expand our healthcare integration activities, we have identified a need to improve health care for our clients with a Serious Mental Illness (SMI) who also have a chronic health condition (or are at risk of developing a chronic health condition).

Currently, we do not have a systematic method for coordinating health and behavioral health care for our clients. For example, we do not routinely screen clients for chronic health conditions; notify the psychiatrist when labs are due; have a notification system when routine blood work should be ordered for different health conditions and/or prescribed medications; or have a notification system when nurses should conduct routine health screenings on clients (e.g., Quarterly Assessments for Tardive Dyskinesia).

Our new Innovation Project, the Health Care Integration (HCI) Project, adapts an existing evidence-based practice, the IMPACT model, to meet the needs of our small, rural county, and evaluate whether this modification obtains desired outcomes. The traditional IMPACT model utilizes a Health Care Nurse Practitioner/Nurse Care Manager in consultation with a psychiatrist, along with mental health staff, to deliver coordinated and integrated person-centered care in collaboration with the primary care physicians in the community. The traditional IMPACT model was designed to be delivered in a fully-staffed medical clinic, with a broad range of services and staff. In this small, rural community, where we have difficulty hiring psychiatrists and nurses, we need to adapt the IMPACT model to accommodate the skills and expertise of our workforce. In addition, we need to adapt the IMPACT model to address the complex needs of persons with a SMI and chronic health conditions. We will utilize the IMPACT model's core principles and modify it to develop a systematic protocol for improving the health of our clients with both an SMI and chronic health condition(s).

The HCI Project will create a systematic method for identifying persons with an SMI who also have chronic health condition, and develop a protocol for systematically monitoring their health conditions and coordinating care between the client's health care provider and Behavioral Health staff. The HCI Team will also treat, monitor, and support persons with an SMI who also have chronic health conditions. We have found that our clients with SMI need additional support and coordination with both BH and primary care to promote health and wellness.

This approach delivers more intensive services to meet the complex needs of our clients. Many clients with a Serious Mental Illness need assistance in keeping medical appointments, taking medications as prescribed, and making healthy meal choices. Add a chronic health condition to these individual's lives, exacerbates the need to support clients in keeping multiple appointments, managing multiple medications, and adapting meals to help control health conditions (i.e., Type 2 diabetes).

The HCI Team will evaluate the effectiveness of this collaborative process to determine if it improves health outcomes for our clients. The HCI Project will develop the following activities to promote health and wellness for our clients:

1. Develop and utilize a Health Screening Questionnaire for nurses to assess for chronic health conditions. This tool will include:
 - a. Brief health history, including physical health conditions and/or medications which may indicate a chronic health condition
 - b. Mental health history, including identifying prescribed psychiatric medications (which may increase the risk of developing a chronic health condition)
 - c. Substance use history (which may indicate increased risk for Hepatitis C, HIV, etc.)
 - d. Tobacco use and measurement of carbon monoxide (CO)
 - e. Previous lab work to review cholesterol, diabetes, COPD, etc.
 - f. Blood pressure
 - g. Height and weight to calculate Body Mass Index (BMI);

2. Review the Health Screening Questionnaire to identify clients who could benefit from enhanced health care coordination, care (case) management, and support and enroll the individual into the HCI Program;
3. Develop a list of psychiatric medications that could trigger or put a person at increased risk of a chronic health condition;
4. Develop a tracking protocol to notify the nurse to periodically measure BMI, blood pressure, and coordinate with the psychiatrist to order lab work on HCI clients;
5. Strengthen collaboration between behavioral health, primary care, and local pharmacists to strengthen integration and coordination of care for HCI clients;
6. Train staff and clients on developing skills in managing chronic health conditions and promote healthy life styles;
7. Deliver collaborative and supportive services to HCI clients with chronic health conditions; and
8. Create and deliver wellness activities to promote health and wellness.

The protocol for screening clients, identifying those with /or at risk for developing chronic health conditions, will be developed. This protocol will coordinate care by strengthening our medical and lab practices in the BH clinic, as well as promote collaboration between Behavioral Health nurses, psychiatrists, and case managers and the physical health care providers in the community.

The principles of Wraparound will be used by the Collaborative to promote health and wellness. These principles will guide the delivery of culturally-appropriate services that are client-directed and person-centered. The development of a Wellness and Recovery Action Plan (WRAP) or an Individual Health Care Plan (IHCP) will provide the roadmap for health and wellness. We will also support clients to learn how to manage their health conditions by exercise, nutrition, cooking skills, and wellness activities.

Our nurse will initiate the process by screening potential clients for signs of chronic health conditions and/or behaviors that increase the risk of developing a chronic health condition. In addition, we will utilize mental health instruments, service utilization data, and health monitoring tools to help staff understand the client's medical conditions, mental health needs, and risk and resiliency factors. The HCI evaluation process will collect information at admission, periodically throughout treatment, and at the time of discharge. Individual Wellness Reports will be developed to show the client's health indicators at admission, and every six months. Staff and clients will be able to monitor their client's medical conditions, communicate with the client's psychiatrist and physician, link clients to medical appointments, and support clients manage their daily activities (diet and exercise) to improve health outcomes.

Clients, family, and staff will benefit from an enhanced, collaborative, person-centered health care system that focuses on coordinating health care to manage the chronic health conditions and mental health needs of clients.

- 2. Describe the INN Program, the issue and learning goal it addresses, and the expected learning outcomes. State specifically how the Innovation meets the definition of Innovation to create positive change; introduces a new mental health practice; integrates practices/approaches that are developed within communities through a process that is inclusive and representative of unserved and underserved individuals; makes a specific change to an existing mental health practice; or introduces to the mental health system a community defined approach that has been successful in a non-mental health context.**

This HCI INN Project will adopt and modify the evidence-based practice IMPACT model by developing a collaborative team that specifically focuses on persons with an SMI who also have a chronic health condition, or are at risk for developing a chronic health condition. The HCI Team will systematically screen individuals when they begin receiving mental health services; screen individuals currently enrolled in behavioral health services who are identified and referred by behavioral health staff; and/or screen clients when they are prescribed a medication that increases the client's risk of adverse side effects, complications with pre-existing health conditions, and the development of other physical health-related concerns.

Once the client is identified, screened, and enrolled in the HCI project, the client will also be enrolled in the Full Service Partnership (FSP) program. Once enrolled as an HCI client, the client's health indicators will be collected and monitored. These health indicators will include periodic measurement of height, weight, Body Mass Index (BMI), cholesterol, CO, A1c, and other key indicators. HCI staff will also work closely with clients to learn how to manage their health conditions and support them to develop healthy lifestyles. In addition, the HCI Team will collaborate with the client's primary care provider, as appropriate, to coordinate care and promote healthy outcomes.

The learning goal of this project is also to assess the effectiveness of this collaborative HCI team approach, which has access to only limited resources, and the improvement of client outcomes. We will utilize a mental health registered nurse (RN), case manager, psychiatrist(s), and primary care provider(s) to create a collaborative team that promotes health and wellness. An active evaluation process will assess the collaboration between team members, development of knowledge of chronic health conditions and wellness skills for staff and clients, and the health outcomes of the client.

The Interagency Collaboration Activities Scale (IACAS) survey will be administered at the beginning of the project, and annually, to measure the collaboration between HCI team members and health care providers in the county. This instrument measures perceptions of communication, collaboration, resource sharing, and improvement in client health outcomes over time. By measuring the perception of these collaborative activities over time, we will be able to evaluate the success of our collaboration over time.

We will also be able to evaluate individual health outcomes for HCI clients to assess the effectiveness of coordinating health care services, ongoing follow-up, treatment, and healthy outcomes. These activities will provide the needed information to track individual outcomes over time to assess the effectiveness of the program.

On a system level, we will evaluate the effectiveness of the SBC HCI model, to support and promote health and wellness, and determine what works and how our learning can be applied to other small counties.

3. Include a description of how the project supports and is consistent with the applicable General Standards as set forth in CCR, Title 9, Section 3320.

The HCI Team model of coordination of services for persons with an SMI and a chronic health condition, with enhanced collaboration from psychiatry and primary care is consistent with the General Standards outlined in CCR, Title 9. We will develop, measure, and test the HCI Collaborative approach to promote the management of chronic health conditions that will be effective in a small rural county. We are adopting and modifying a proven model to promote health and wellness. The HCI will develop a protocol for screening and identifying clients with an SMI who also have chronic health conditions (or are at risk), strengthen our partnerships with community health care providers, and develop strategies for training staff and clients to understand how to change behaviors to manage and improve chronic health conditions.

Our services will be culturally competent and available in English and Spanish. As we work closely with our health care partners in the community, we will offer supportive services to clients with chronic health conditions. If the client, or family, is monolingual Spanish speakers, we will have bilingual, bicultural nurses, case managers, and psychiatrist available to offer services in their primary language.

We have a strong history of delivering mental health services that focus on wellness, recovery, and resilience. Our Esperanza Wellness Center was developed with MHSA CSS funding, and utilizes clients to deliver services, and support clients and families to be active participants in their services. The Esperanza Center supports recovery and wellness and has clients working actively with individuals, teaching skills and mentoring others. The HCI Team will help promote collaboration and integrated health care services with primary care providers and coordinate services with community partners, as appropriate, to improve health outcomes. We utilize a Risk-Resiliency Scale that measures key risk factors and resiliency factors for clients. We utilize this tool at admission and every six (6) months. Progress on developing resiliency factors is shared with clients and staff through an Individual Progress Report. This information helps to guide services and strengthen resiliency skills over time.

We initiated the development of the HCI Team to implement and test an enhanced collaboration across multiple agencies in our community to systematically identify chronic health conditions and coordinate care to meet the needs of our unserved and underserved persons with an SMI and a chronic health condition. The enhanced collaboration with our primary care providers will offer a full range of services and develop a systematic protocol for enhancing collaboration, coordination, and integration of services to promote healthy outcomes. The evaluation activities will assess the effectiveness of this collaboration using standard measures.

4. If applicable, describe the population to be served, number of clients to be served annually, and demographic information including age, gender, race, ethnicity, and language spoken.

We anticipate that we will serve 50 clients on this project. Approximately 5% will be children; 10% will be TAY; 80% will be adults; and 5% will be older adults. It is expected that approximately 50% of the individuals will be Hispanic, 40% Caucasian, and 10% other culturally diverse groups. Approximately 50% will be females. The majority of the TAY will speak English, while 15% of the adults and older adults will be monolingual Spanish speakers.

5. Describe the total timeframe of the program. In your description include key actions and milestones related to assessing your Innovation and communicating results and lessons learned. Provide a brief explanation of why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the Innovation.

We will develop, implement, and evaluate the effectiveness of the modified HCI Team collaboration across a three-year time period. This time period will allow ample time to hire and train staff, develop a health care screening tool, and develop protocols to identify chronic health conditions and/or specific psychiatric medications that may increase the risk of developing chronic health conditions. We will also train staff and develop training materials for clients to use to help them understand their chronic health condition and develop methods for managing these conditions through diet, exercise, and healthy life style changes.

We anticipate that we can start to implement components of this project within the first three months of funding approval. However, full implementation and collaboration of services with primary care and pharmacy will occur by the end of the first year. This time frame will allow two additional years to fully implement and study the effectiveness of this approach and share our experiences with other counties.

Evaluation activities will be developed in the first three months, and collected and analyzed on an ongoing basis. Evaluation outcomes and lessons learned will be shared with the HCI Team; at the Behavioral Health Quality Improvement Committee (QIC) meetings; at Management Team meetings; and at the Behavioral Health Advisory Board meetings. In addition, we will share our experiences of HCI collaboration within a rural county that has a high proportion of persons who are Hispanic. These lessons learned will be shared with other small counties, so they may be able to implement similar strategies to improve the health of their clients.

After the three-year time period, the success of the project will be determined through the evaluation activities and stakeholder input. If deemed successful, the project will be transitioned to another category of MHSA funding, such as CSS funding.

- 6. Describe how you plan to measure the results, impacts, and lessons learned from your Innovation, with a focus on what is new or changed. Include in your description the expected outcomes of the Innovation program, how you will measure these outcomes, and how you will determine which elements of the Innovation Program contributed to successful outcomes. Include in your description how the perspectives of stakeholders will be included in assessing and communicating results.**

We will collect data on both client level outcomes and measure the effectiveness of the HCI project and sources of collaboration. Client-level outcomes will include improvement on key Health Indicators including BMI, carbon monoxide levels (CO levels that are impacted by smoking), blood pressure, A1c (indicator of diabetes), cholesterol, and substance use. We will also review the number of persons screened, number of persons with an identified chronic health condition, Risk Resiliency Factors, and number of persons receiving case management and participating in the wellness activities. We will measure key events for clients, including crisis services, psychiatric inpatient services, linkage to primary care, and medication management. Program effectiveness will also measure the collaboration activities between agencies, prior to the development of the HCI Team and ongoing collaboration activities as the HCI Team is implemented.

Collaboration between agencies will be measured using the IACAS to survey partner agency staff at the beginning of the project and annually. By measuring perception of collaborative activities over time, we will be able to evaluate the success of our project. Through this project, we will improve how our collaborative agencies share information, data, evaluation, training, case reviews, and formal written agreements.

Our evaluation activities will be developed and implemented with guidance from our QIC, oversight by the SBC Behavioral Health Board, and management team. Outcomes and lessons learned will be shared with the HCI Team and systematically throughout the system, including regional and/or statewide meetings that involve other small, rural counties.

- 7. If applicable, provide a list of resources to be leveraged.**

In addition to MHSA funding, we will utilize Medi-Cal revenue, whenever possible, to support the activities of the HCI Team.

- 8. Please provide projected expenditures by each fiscal year during the program time frame, including both the current and future funding years. Please also describe briefly the logic for this budget: how your proposed expenditures will allow you to test your model and meet your learning and communication goals.**

Project: **Health Care Integration (HCI) Team**

Estimated Project Costs (Total per Year):

- **Year 1:** \$312,639
- **Year 2:** \$303,382
- **Year 3:** \$303,382

This Innovation Project utilizes a proven model to develop a comprehensive, innovative, mentoring program to address the need for health care integration and coordination in our county. The HCI Team will systematically screen individuals to identify current health conditions or risk of developing a chronic health condition. Once enrolled as an HCI client, the client's health indicators will be collected and monitored. Lab work, height, weight, Body Mass Index (BMI) calculated, and blood work periodically measured. HCI staff will also work closely with clients to learn how to manage their health conditions and support them to develop healthy lifestyles. The HCI Team will also collaborate with the client's primary care provider and pharmacist, as appropriate, to coordinate care and promote healthy outcomes.

Extensive evaluation activities will provide an assessment of project effectiveness and client-level outcomes achieved as a result of the HCI activities; outcomes and lessons learned will be shared through established staff and stakeholder meetings. Expenditures will support this model; ensure that we are able to fully implement the project; and allow us to conduct supervision, evaluation, reporting, and dissemination activities.

After the three-year timeframe, the success of the project will be determined through the evaluation activities and stakeholder input. If deemed successful, the project will be transitioned it to another category of MHSA funding, such as CSS.

A detailed budget for the Innovation Project (Years 1 – 3) is included below.

**Innovation Project
Budget Detail – Year 1**

Type of Expenditure		County MHSA	Other Funding Sources	Total
1.	Personnel	191,900		191,900
2.	Operating Expenditures	12,500		12,500
3.	Non-recurring Expenditures	2,000		2,000
4.	Contract Services (Subcontracts/Professional Services)	30,000		30,000
5.	Evaluation	35,460		35,460
6.	Other Expenditures (Admin)	40,779		40,779
	Total Proposed Expenditures	312,639		312,639
B. REVENUES				
1.	New Revenues			
	a. Medi-Cal (FFP only)			
	b. State General Funds			
	c. Other Revenues			
	Total Revenues			
C. TOTAL FUNDING REQUESTED		312,639		312,639
D. TOTAL IN-KIND CONTRIBUTIONS				

**Innovation Project
Budget Detail – Year 2**

Type of Expenditure		County MHSA	Other Funding Sources	Total
1.	Personnel	191,900		191,900
2.	Operating Expenditures	7,500		7,500
3.	Non-recurring Expenditures	0		0
4.	Contract Services (Subcontracts/Professional Services)	30,000		30,000
5.	Evaluation	34,410		34,410
6.	Other Expenditures	39572		39572
	Total Proposed Expenditures	303,382		303,382
B. REVENUES				
1.	New Revenues			
	a. Medi-Cal (FFP only)			
	b. State General Funds			
	c. Other Revenues			
	Total Revenues			
C. TOTAL FUNDING REQUESTED				
		303,382		303,382
D. TOTAL IN-KIND CONTRIBUTIONS				

**Innovation Project
Budget Detail – Year 3**

Type of Expenditure		County MHSA	Other Funding Sources	Total
1.	Personnel	191,900		191,900
2.	Operating Expenditures	7,500		7,500
3.	Non-recurring Expenditures	0		0
4.	Contract Services (Subcontracts/Professional Services)	30,000		30,000
5.	Evaluation	34,410		34,410
6.	Other Expenditures	39572		39572
	Total Proposed Expenditures	303,382		303,382
B. REVENUES				
1.	New Revenues			
	a. Medi-Cal (FFP only)			
	b. State General Funds			
	c. Other Revenues			
	Total Revenues			
C. TOTAL FUNDING REQUESTED				
		303,382		303,382
D. TOTAL IN-KIND CONTRIBUTIONS				

Budget Narrative

A. EXPENDITURES

1. Personnel – This line items includes salaries and benefits for a Registered Nurse (1.0 FTE) and a Case Manager (1.0 FTE). Expenditures in this category are based on current County Personnel Salary tables.
2. Operating Expenditures – This category includes facility costs, such as rent, and other operating expenses including communications, office supplies, utilities, IT, and janitorial costs. Expenses also include ongoing CO monitor supplies, client supports, lab work, mileage for staff to transport clients, medications, food, housing, etc. In addition, dissemination of lessons learned to other counties and interested stakeholders are included. Expenditures are based on historical costs.
3. Non-Recurring Expenditures – This line item includes costs associated with purchasing the CO Monitor and Pediatric Blood Pressure Cuff; initial set up; and training. Year 1 only.
4. Contract Services – This category covers the project’s portion of our contract Psychiatrist (0.20 FTE).
5. Evaluation – This line items covers project evaluation, which will provide an assessment of project effectiveness and client-level outcomes achieved as a result.
6. Other Expenditures – This category includes administration costs associated with the project.

B. REVENUE – Revenues have not been projected at this time.

C. TOTAL FUNDING – Total funding for this project is \$312,639 (Year 1), \$303,382 (Year 2); and \$303,382 (Year 3).

D. TOTAL IN-KIND CONTRIBUTIONS – No in-kind contributions are expected for this project.

MHSA Program Component WORKFORCE EDUCATION AND TRAINING

1. Provide a program description. Include achievements.

The SBCBH Workforce Education and Training (WET) program provides training components, internship tracks, and consumer education to staff, volunteers, clients, and family members.

SBCBH has developed a multi-year contract with Relias Learning which offers online courses, ethics and regulations compliance training, and an array of clinical skills building courses that also fulfill continuing education (CEU) requirements for licensed behavioral health professionals. All SBCBH employees, including clinical, clerical, and administrative staff are currently enrolled in and utilize the Relias Learning component.

Additional training opportunities are provided through WET funding for staff and volunteers both onsite and off-site, at local and regional trainings.

After the Consumer Pathways Program with Gavilan College was eliminated (through the FY 2013/14 Annual Update), SBCBH has focused efforts on providing our own consumer training program, and has successfully completed multiple 6-week training programs. Several consumer employees/peer mentors have been hired by SBCBH following these consumer training programs.

WET funding has also allowed SBCBH to support up to two (2) interns each year to work at the county mental health program. Through the WET funds, SBCBH provides mileage reimbursement stipends for the interns to help them travel to the county. Currently, one (1) undergraduate from San Jose State University is participating in this placement.

2. Describe any challenges or barriers, and strategies to mitigate. Identify shortages in personnel, if any.

Intern Recruitment: San Benito County is not in an ideal location to recruit interns. Interns must commute about 45 minutes from their university campuses to Hollister, so they often choose internship sites closer to their campuses. We have chosen to offer mileage reimbursement round trip from the interns' homes to the SBCBH office. Last year, our CSUMB MSW intern was highly satisfied with the internship placement and she shared her positive experiences with her cohorts. We interviewed many eager interns who shared the positive accolades given to SBCBH. However, the mileage reimbursement and the \$9 per hour stipend still has not resulted in a high level of interest. The CSUMB MSW internship coordinator concluded that the location of SBCBH has created a challenge for recruiting interns.

3. List any significant changes in Three-Year Plan, if applicable.

There are no changes anticipated to the WET component in this fiscal year.

**MHSA Program Component
CAPITAL FACILITIES/TECHNOLOGY**

- 1. *Provide a program description (must include number of clients served, age, race/ethnicity). Include achievements.***

San Benito County Behavioral Health has determined that these components will not be implemented at this time. Capital Facilities/Technological Needs Plans may be developed in the future, as feasible and appropriate.

- 2. *Describe any challenges or barriers, and strategies to mitigate.***

Not applicable.

- 3. *Describe if the county is meeting/met benchmarks and goals, or provide the reasons for delays to implementation.***

Not applicable.

- 4. *List any significant changes in Three-Year Plan, if applicable.***

Not applicable.

**MHSA Program Component
HOUSING**

- 1. Provide a brief program description (include notable performance measures, such as progress towards implementation of plan).***

SBCBH has entered into the application phase of a Housing Plan Project with the Community Housing Improvement Systems and Planning Association, Inc. (CHISPA) for a four-unit, 5 bed Buena Vista Apartments project. The Housing application is currently being developed and, once submitted, will be expedited by CalHFA. Application approval is anticipated in 2015. Full project completion is anticipated in 2017.

- 2. Describe any challenges or barriers and strategies to mitigate.***

Not applicable at this time.

- 3. Describe if the county is meeting benchmarks and goals, or provide the reasons for delays to implementation.***

The Buena Vista Apartments Housing Project application is currently being developed and, once submitted, will be expedited by CalHFA. Application approval is anticipated in 2015. Full project completion is anticipated in 2017.

- 4. List any significant changes in Three-Year Plan, if applicable.***

Not applicable at this time.

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary**

County: SAN BENITO

Date: 8/19/2014

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	3,086,521	899,992	625,100	394,638	788,500	
2. Estimated New FY2014/15 Funding	1,957,061	489,265	128,754			
3. Transfer in FY2014/15 ^{a/}	(110,000)					110,000
4. Access Local Prudent Reserve in FY2014/15						0
5. Estimated Available Funding for FY2014/15	4,933,582	1,389,257	753,854	394,638	788,500	
B. Estimated FY2014/15 MHSA Expenditures	2,035,343	508,835	312,639	131,546	0	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,898,239	880,422	441,215	263,092	788,500	
2. Estimated New FY2015/16 Funding	2,054,914	513,728	135,192			
3. Transfer in FY2015/16 ^{a/}	0					
4. Access Local Prudent Reserve in FY2015/16						0
5. Estimated Available Funding for FY2015/16	4,953,153	1,394,150	576,407	263,092	788,500	
D. Estimated FY2015/16 Expenditures	2,137,111	534,278	303,382	131,546	0	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,816,042	859,872	273,025	131,546	788,500	
2. Estimated New FY2016/17 Funding	2,157,660	539,415	141,951			
3. Transfer in FY2016/17 ^{a/}	0					
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	4,973,702	1,399,287	414,976	131,546	788,500	
F. Estimated FY2016/17 Expenditures	2,243,966	560,992	303,382	131,546	0	
G. Estimated FY2016/17 Unspent Fund Balance	2,729,735	838,295	111,595	0	788,500	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	929,050
2. Contributions to the Local Prudent Reserve in FY 2014/15	110,000
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	1,039,050
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	1,039,050
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	1,039,050

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

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS System Transformation (FSP)	1,038,025	1,038,025				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. CSS System Transformation (non-FSP)	692,017	692,017				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	305,301	305,301				
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Program Estimated Expenditures	2,035,343	2,035,343	0	0	0	0
FSP Programs as Percent of Total	51.0%					

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS System Transformation (FSP)	1,089,926	1,089,926				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. CSS System Transformation (non-FSP)	726,618	726,618				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	320,567	320,567				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	2,137,111	2,137,111	0	0	0	0
FSP Programs as Percent of Total	51.0%					

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS System Transformation (FSP)	1,144,423	1,144,423				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. CSS System Transformation (non-FSP)	762,949	762,949				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	336,595	336,595				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	2,243,966	2,243,966	0	0	0	0
FSP Programs as Percent of Total	51.0%					

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Children & Youth Services	259,506	259,506				
2. Suicide Prevention Training	18,000	10,177				
3. Older Adult Services	127,209	127,209				
4. Women's Services	20,353	20,353				
5. Mental Health First Aid Training	15,265	15,265				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	76,325	76,325				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	516,659	508,835	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Children & Youth Services	272,481	272,481				
2. Suicide Prevention Training	18,000	10,686				
3. Older Adult Services	133,569	133,569				
4. Women's Services	21,371	21,371				
5. Mental Health First Aid Training	16,028	16,028				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	80,142	80,142				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	541,592	534,278	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Children & Youth Services	286,106	286,106				
2. Suicide Prevention Training	18,000	11,220				
3. Older Adult Services	140,248	140,248				
4. Women's Services	22,440	22,440				
5. Mental Health First Aid Training	16,830	16,830				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	84,149	84,149				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	567,772	560,992	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Health Care Integration Team	271,860	271,860				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	40,779	40,779				
Total INN Program Estimated Expenditures	312,639	312,639	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Health Care Integration Team	263,810	263,810				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	39,572	39,572				
Total INN Program Estimated Expenditures	303,382	303,382	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Health Care Integration Team	263,810	263,810				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	39,572	39,572				
Total INN Program Estimated Expenditures	303,382	303,382	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET Coordination	6,577	6,577				
2. Fundamental Learning Program	92,082	92,082				
3. Internship Program	32,887	32,887				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	131,546	131,546	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET Coordination	6,577	6,577				
2. Fundamental Learning Program	92,082	92,082				
3. Internship Program	32,887	32,887				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	131,546	131,546	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET Coordination	6,577	6,577				
2. Fundamental Learning Program	92,082	92,082				
3. Internship Program	32,887	32,887				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	131,546	131,546	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet**

County: SAN BENITO

Date: 8/19/2014

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

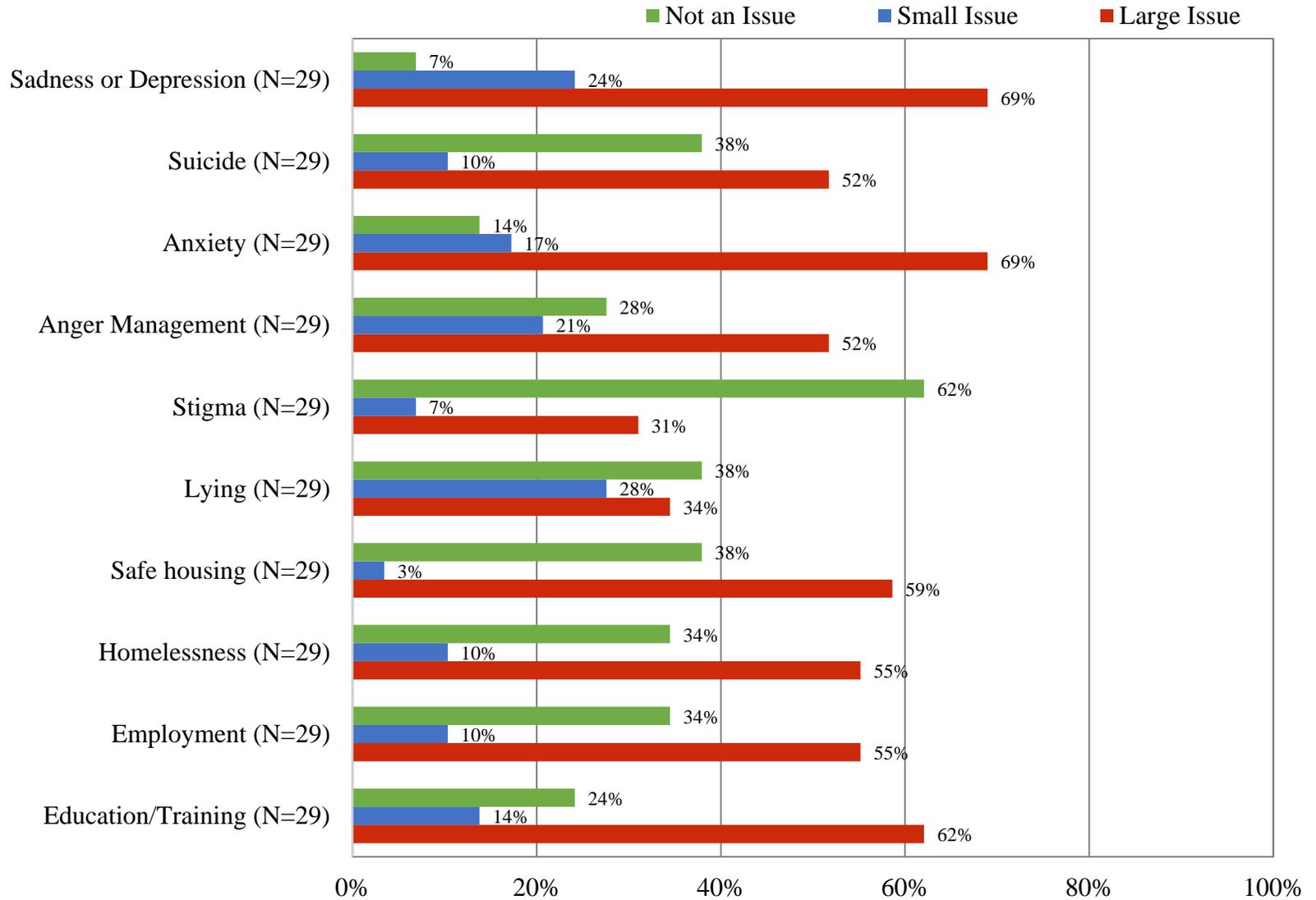
**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet**

County: SAN BENITO

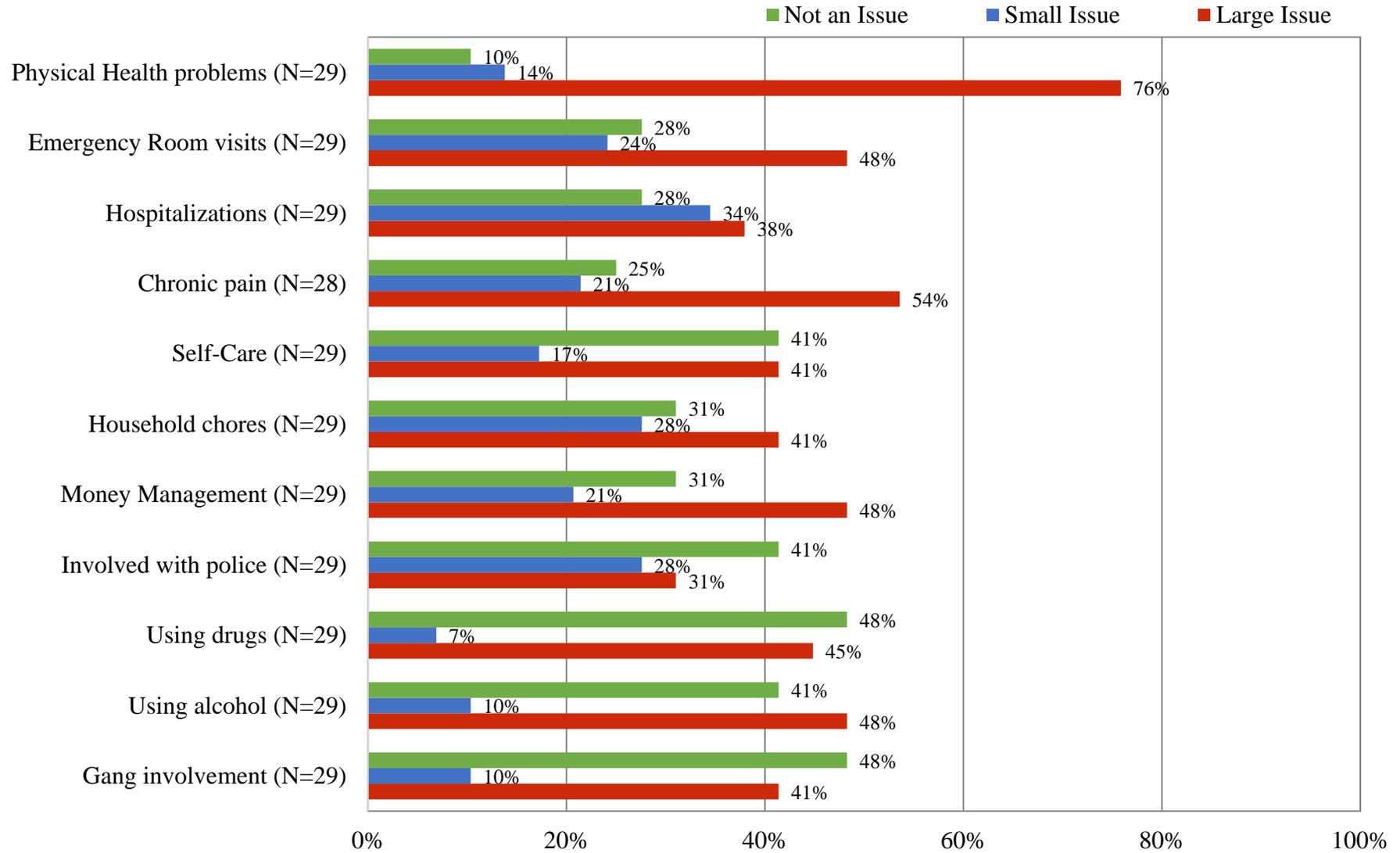
Date: 8/19/2014

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

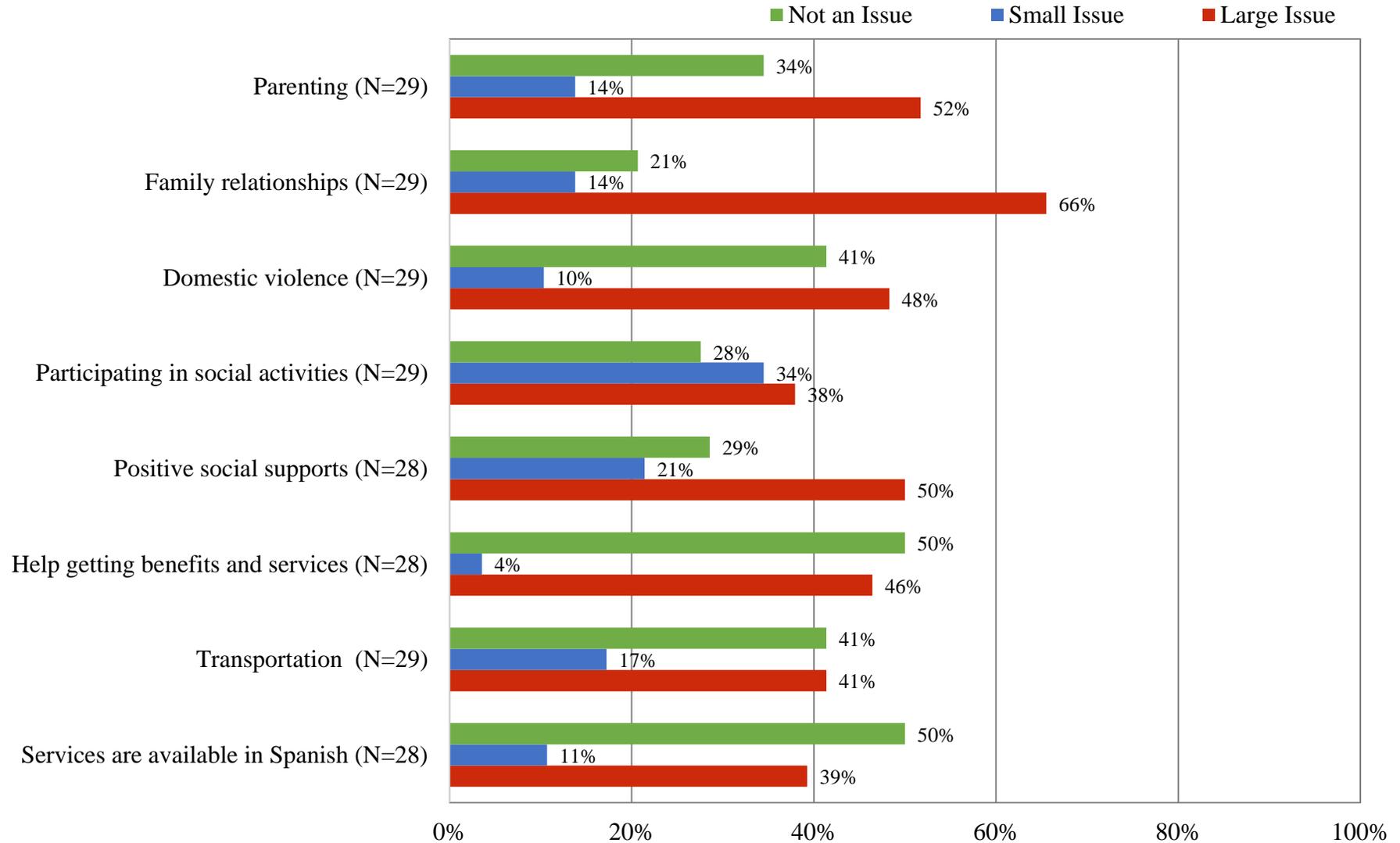
**San Benito County Behavioral Health
MHS Adult Survey Results
Adult Issues
2014**



**San Benito County Behavioral Health
MHSa Adult Survey Results
Adult Issues
2014**

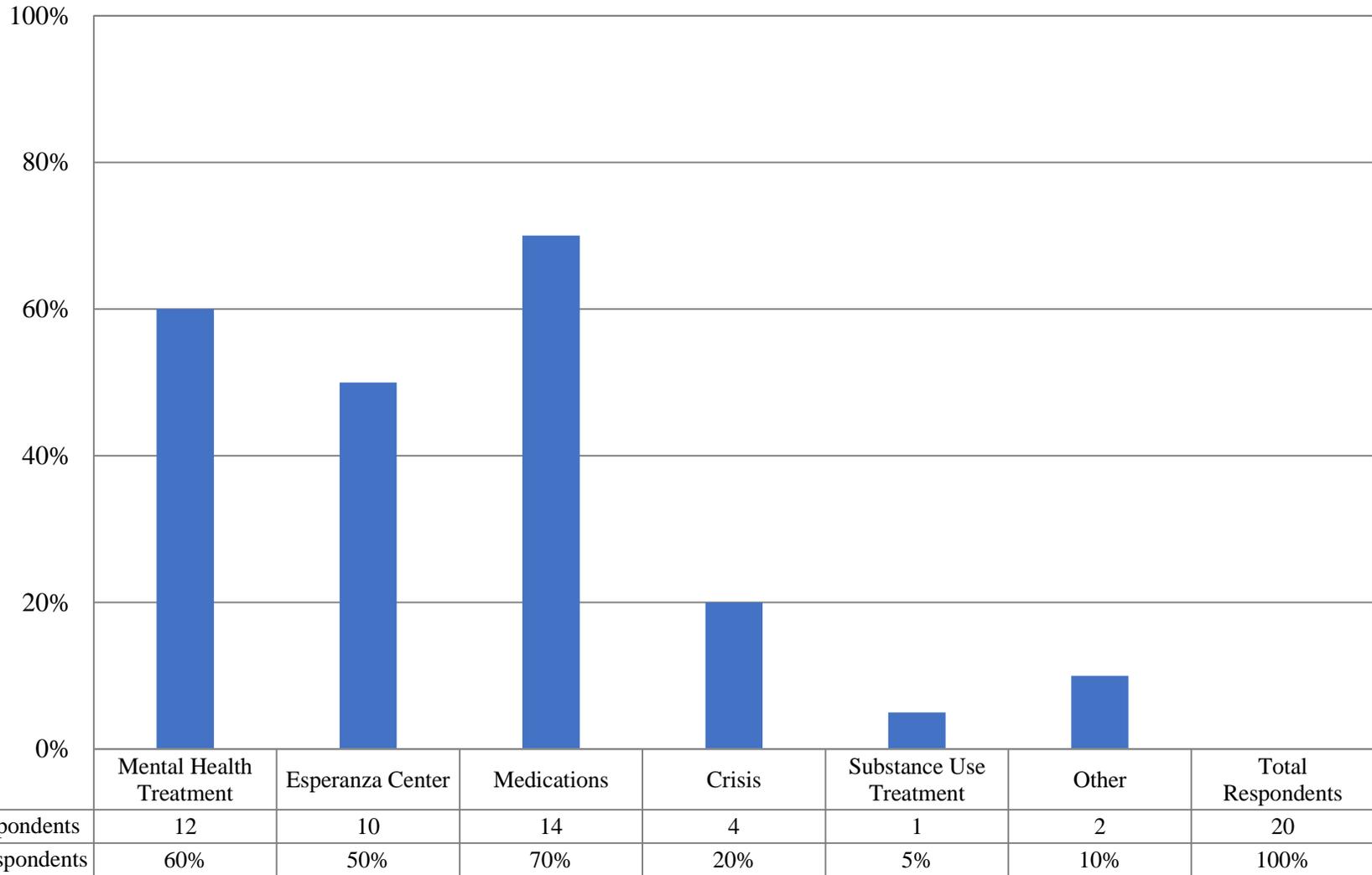


**San Benito County Behavioral Health
MHS Adult Survey Results
Adult Issues
2014**

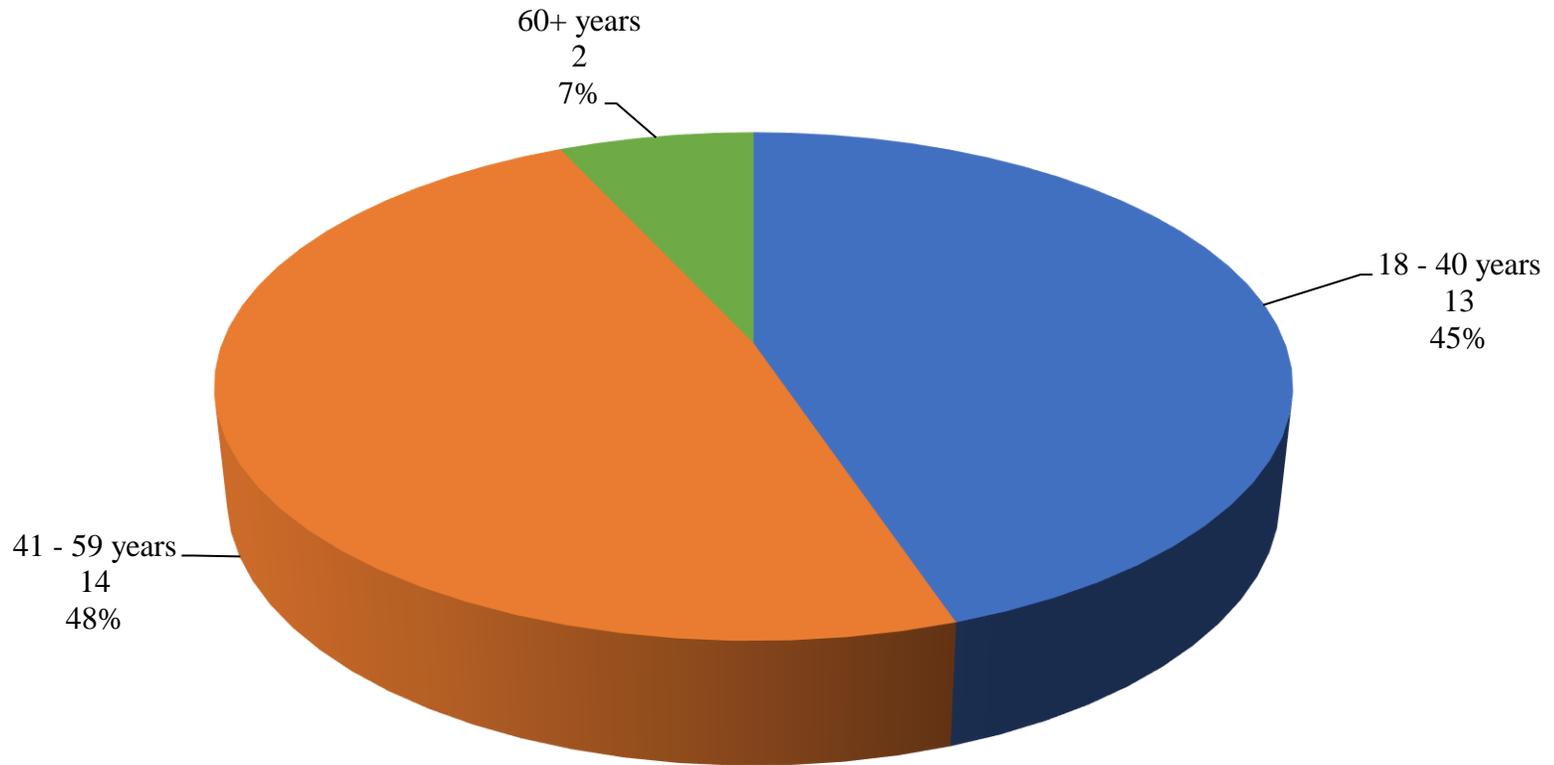


**San Benito County Behavioral Health
MHSa Adult Survey Results
2014**

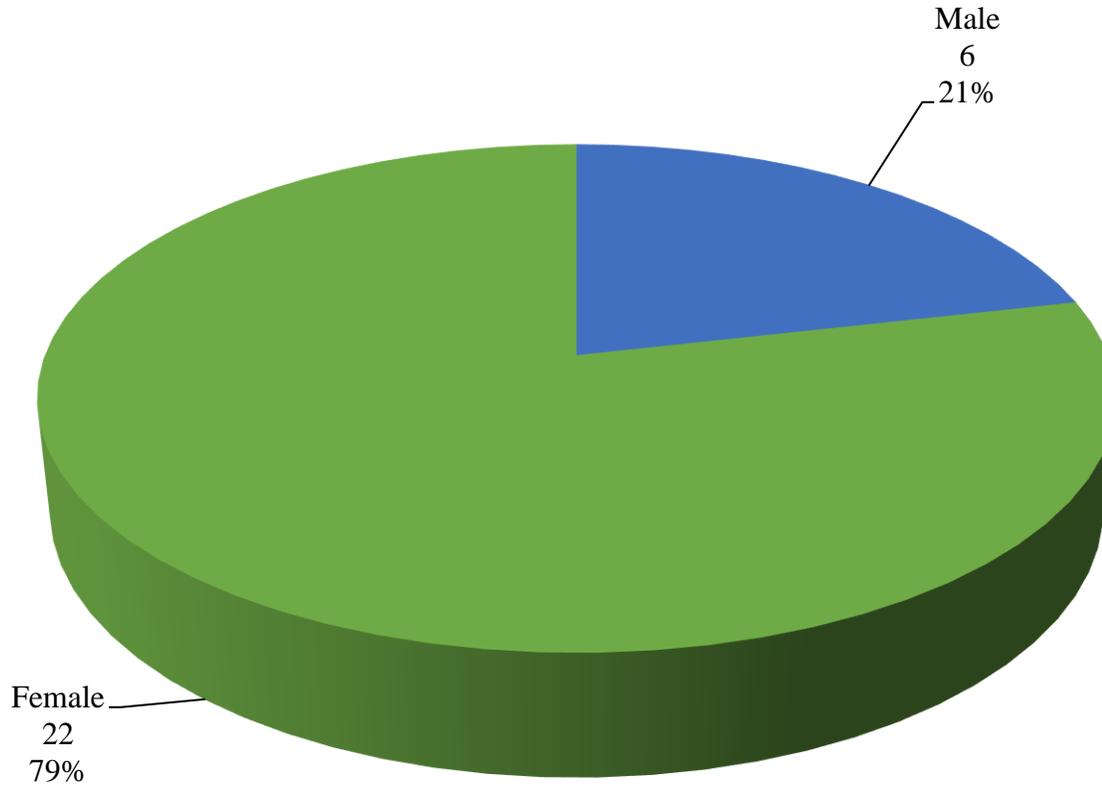
What Behavioral Health services have you used in the past year?
(Respondents may choose multiple responses)



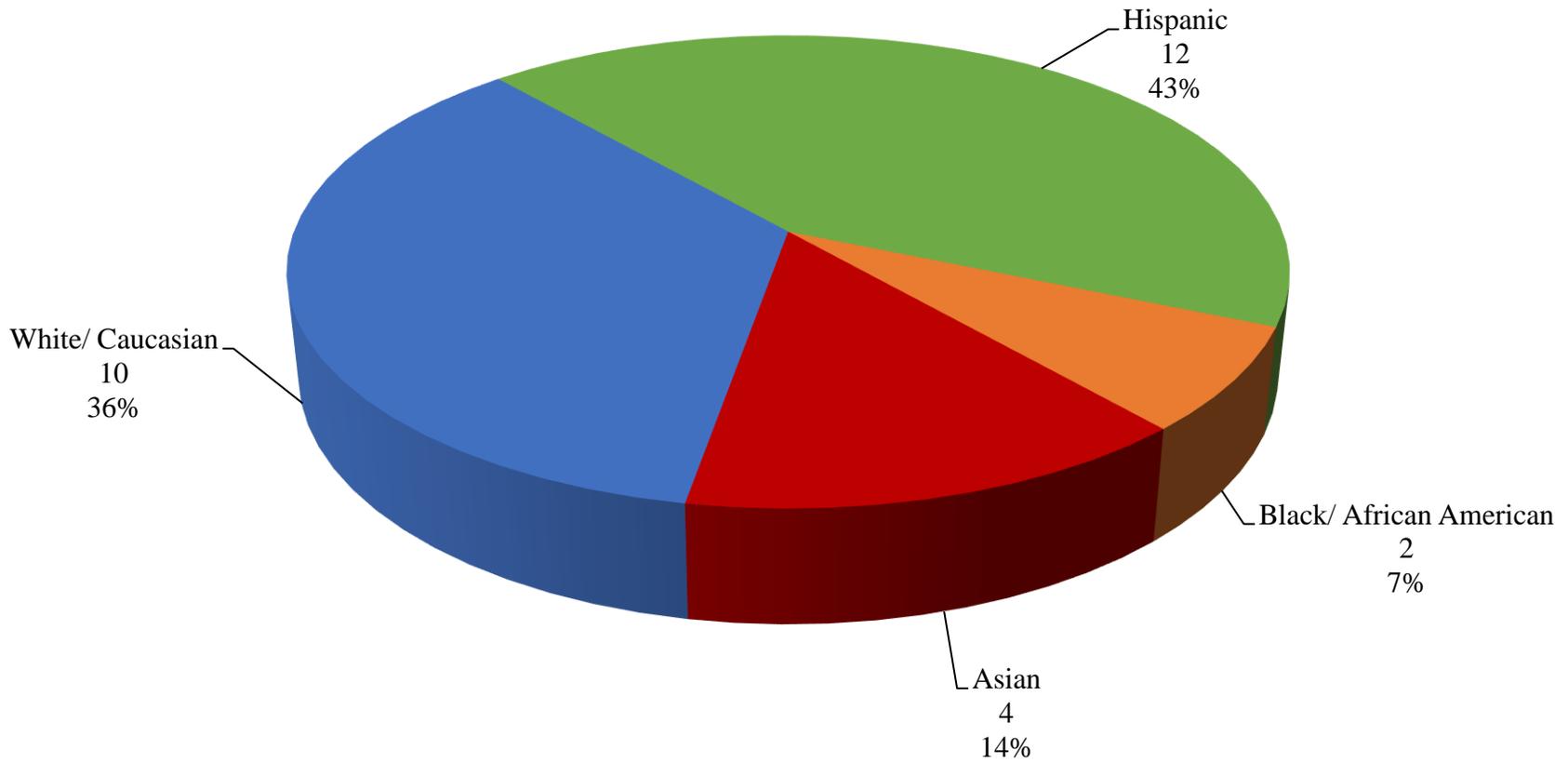
**San Benito County Behavioral Health
MHSA Adult Survey Results
2014
Age (N=29)**



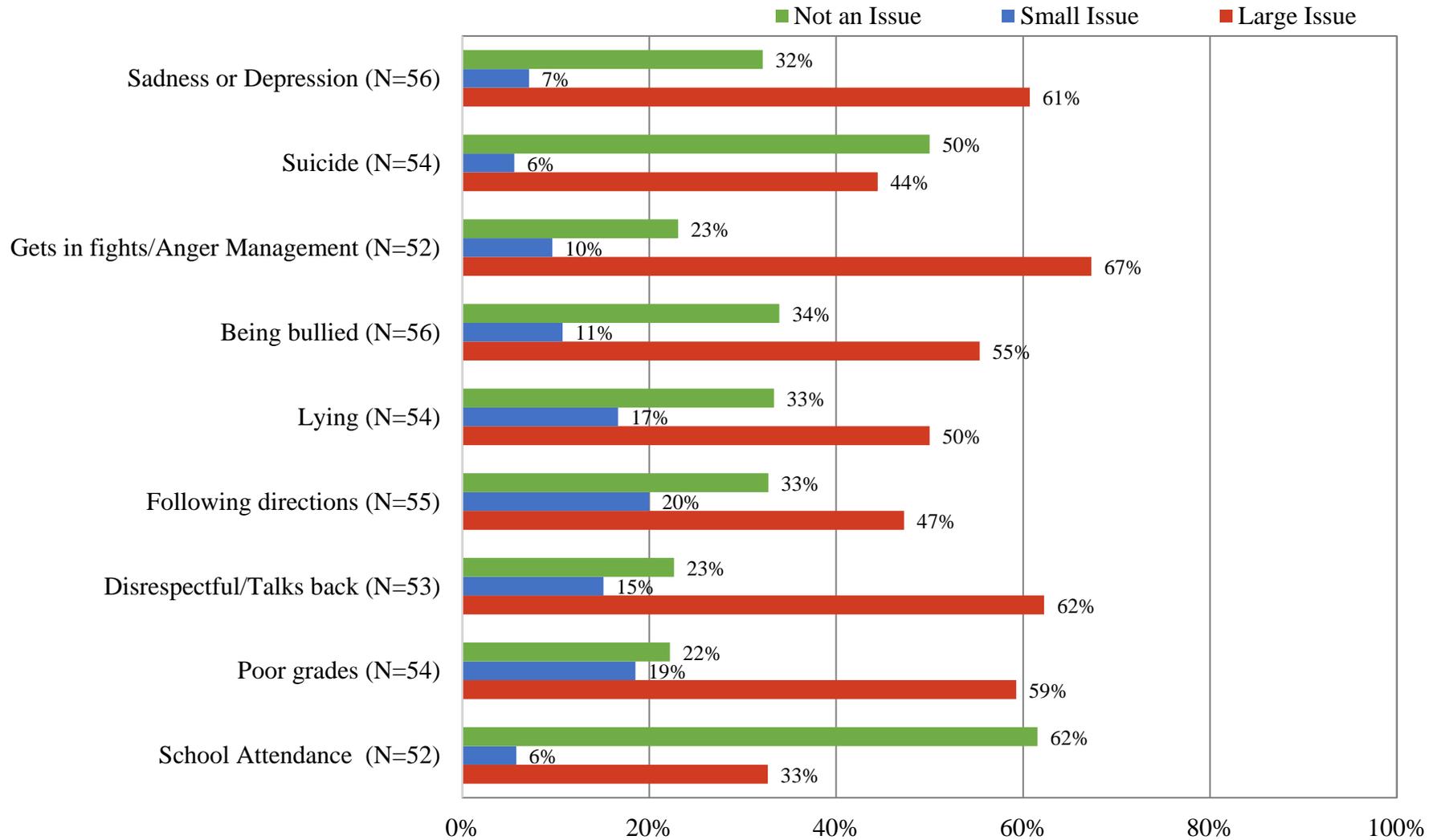
**San Benito County Behavioral Health
MHSA Adult Survey Results
2014
*Gender (N=28)***



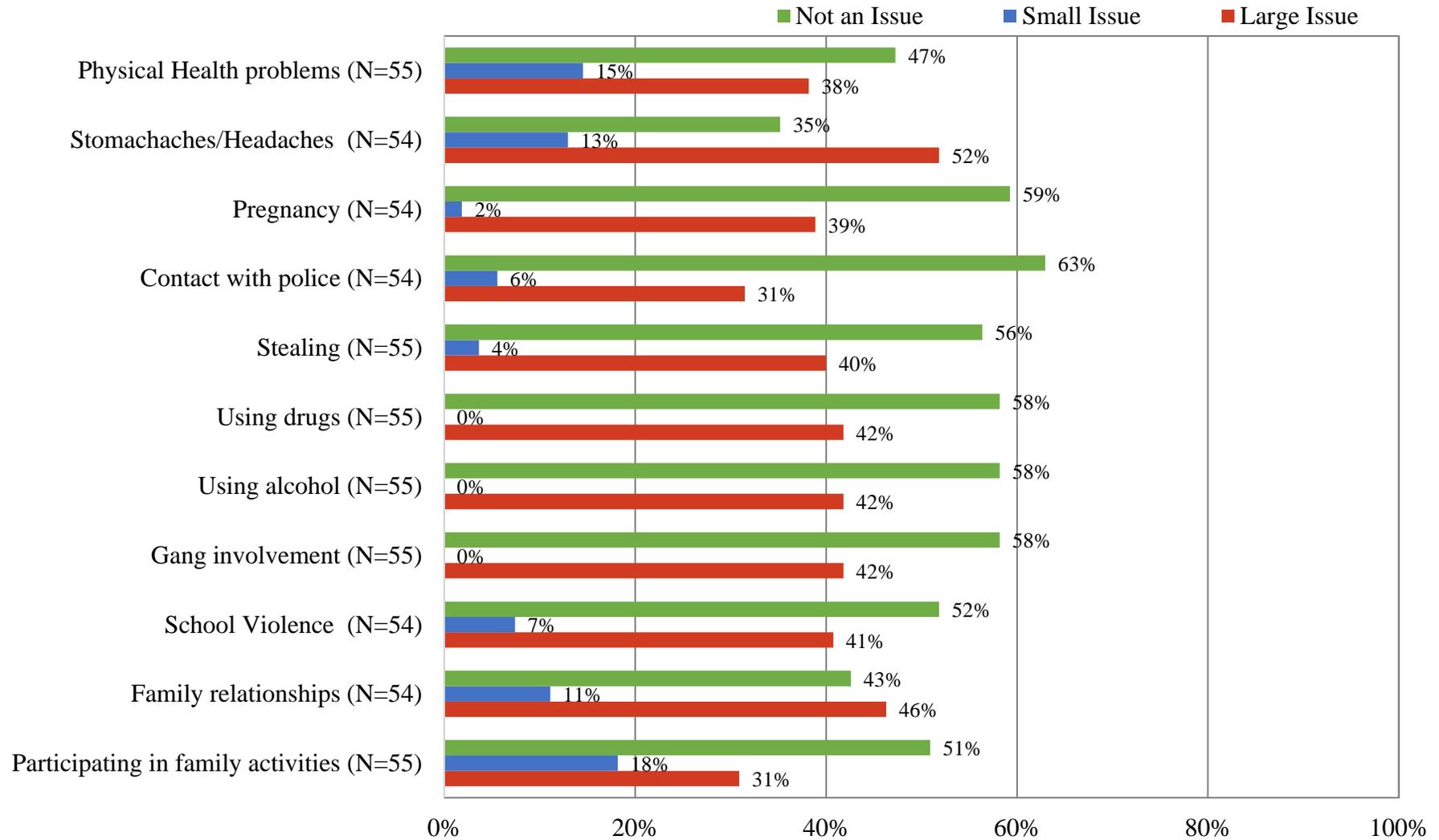
**San Benito County Behavioral Health
MHSA Adult Survey Results
2014
*Race/Ethnicity (N=28)***



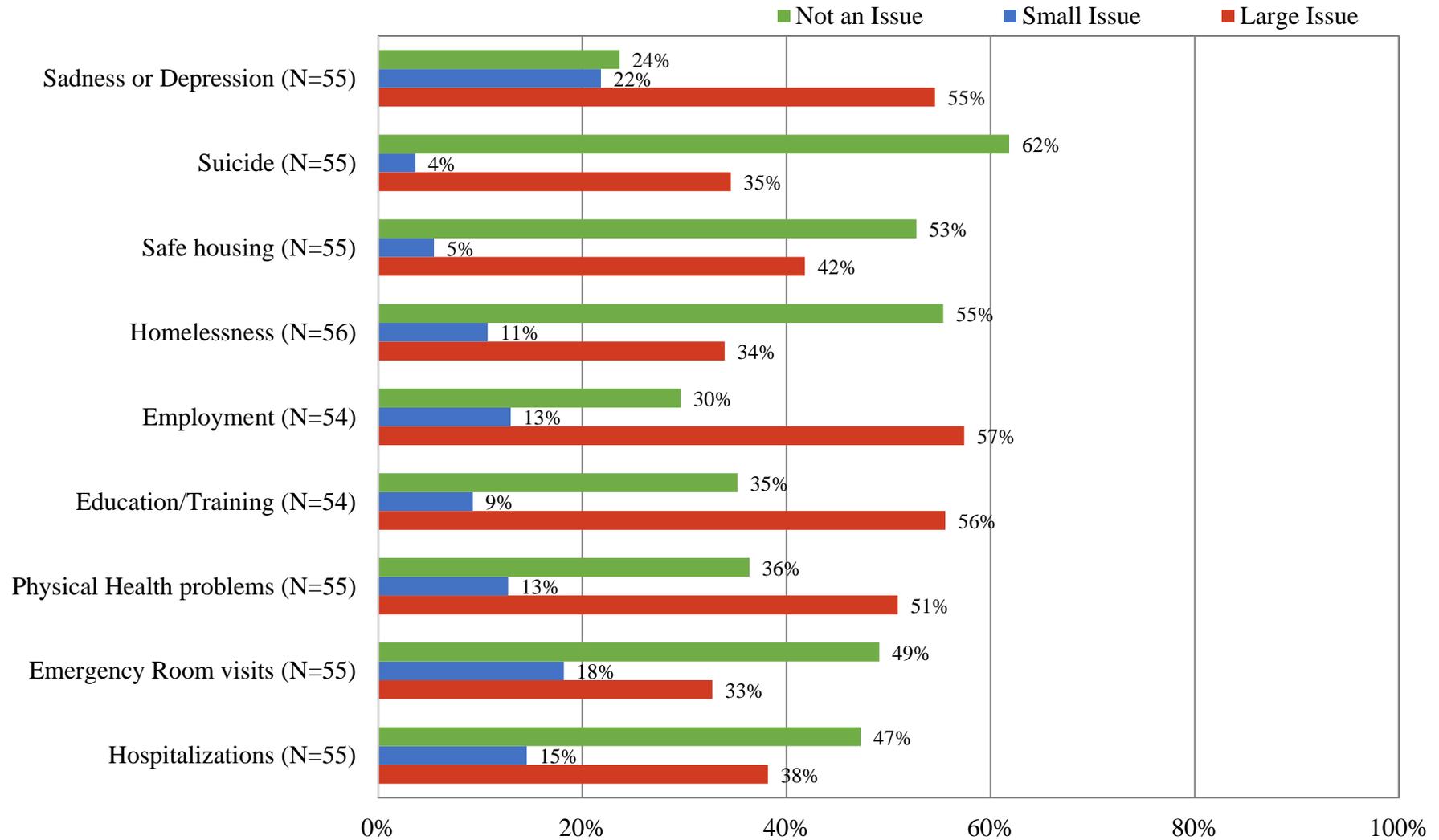
San Benito County Behavioral Health
MHSA Migrant Farm Worker Family Survey Results
Child and Youth Issues
 2014



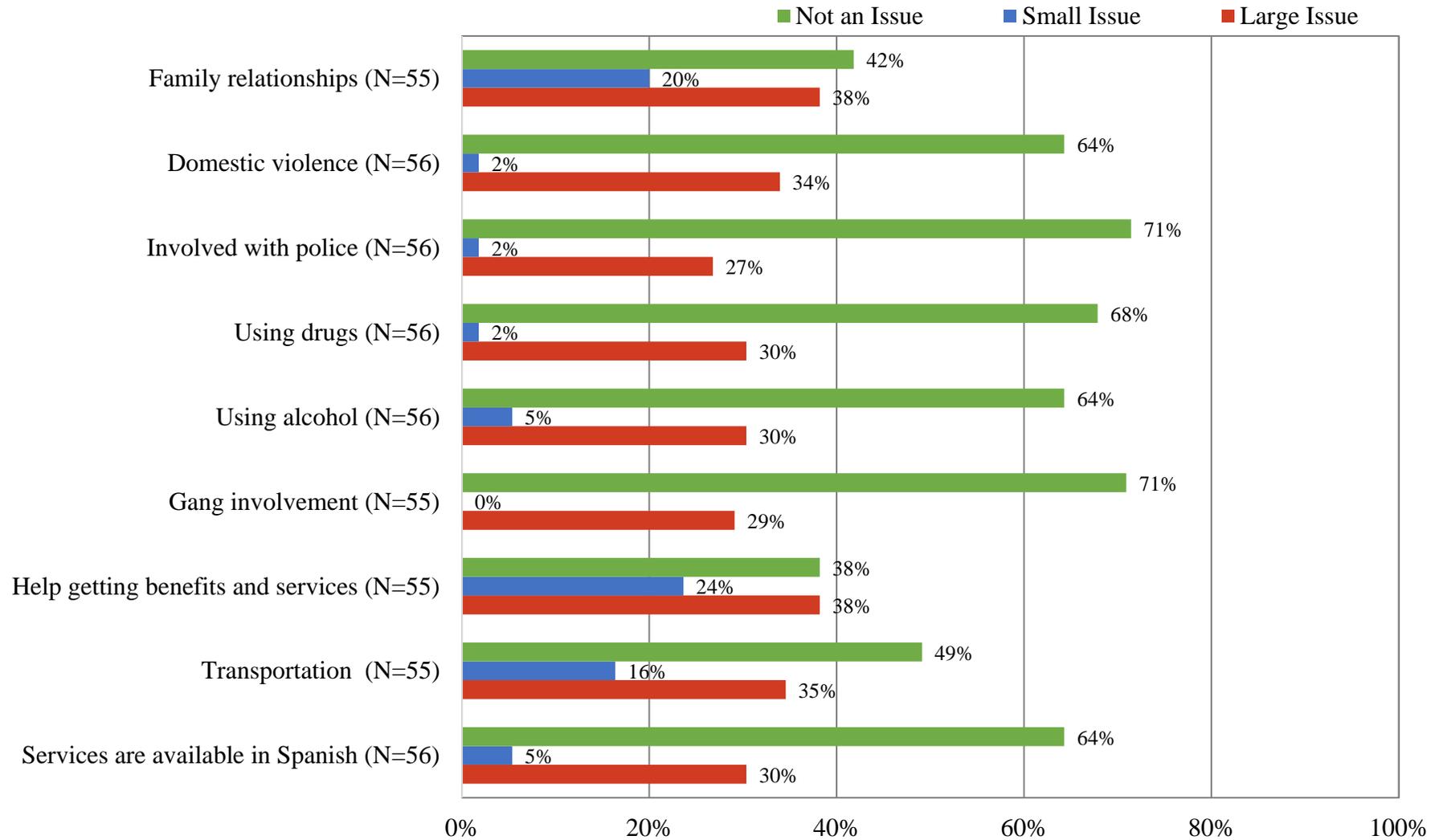
San Benito County Behavioral Health
MHSA Migrant Farm Worker Family Survey Results
Child and Youth Issues
 2014



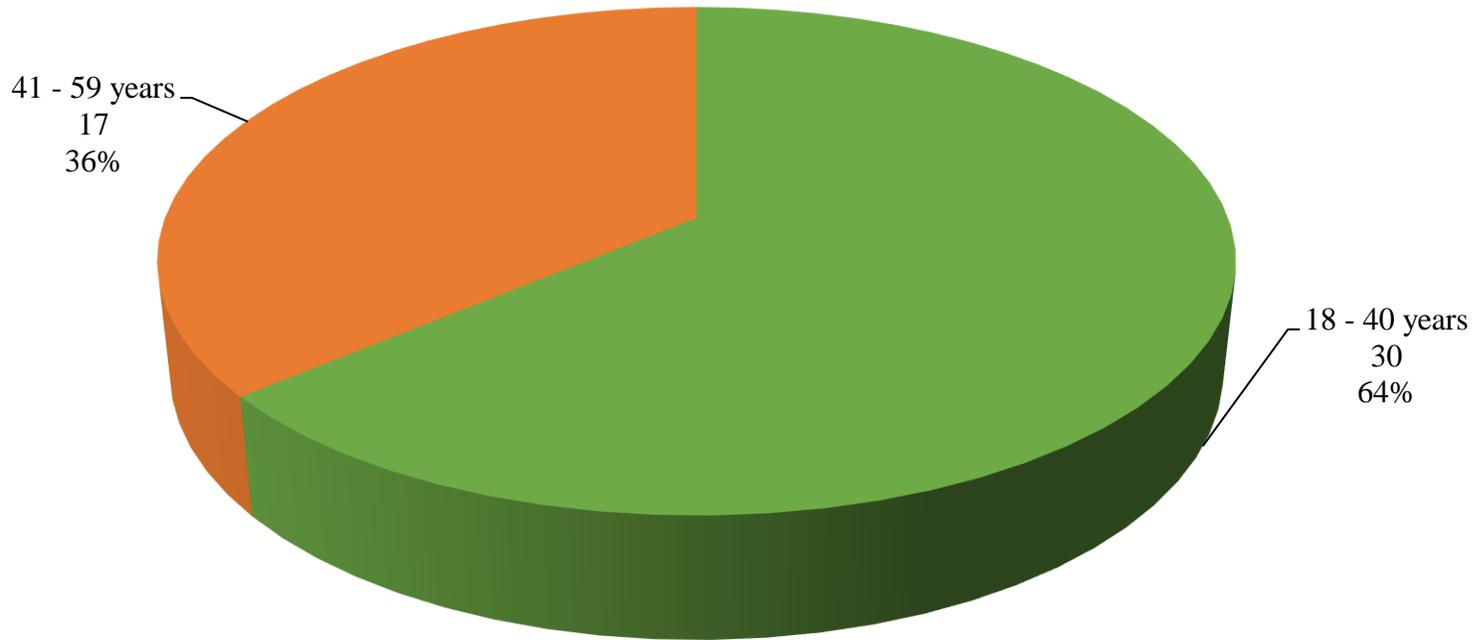
San Benito County Behavioral Health
MHSA Migrant Farm Worker Family Survey Results
Parent and Family Issues
 2014



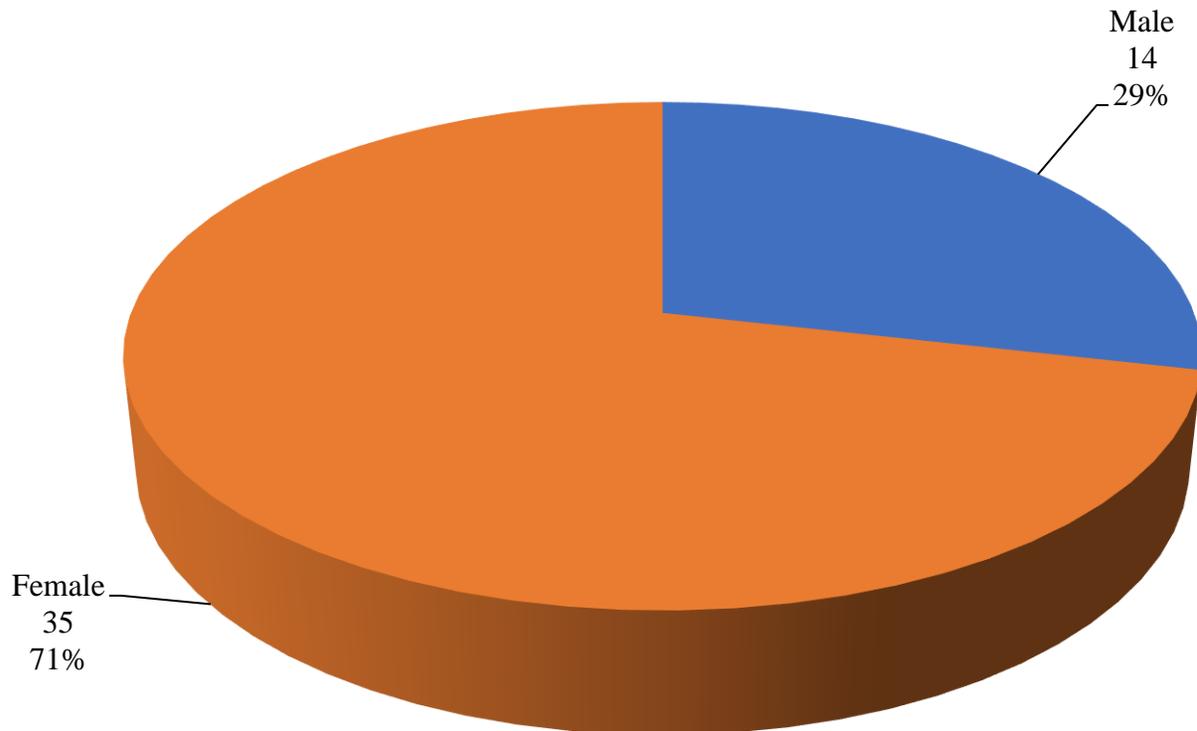
San Benito County Behavioral Health
MHSA Migrant Farm Worker Family Survey Results
Parent and Family Issues
 2014



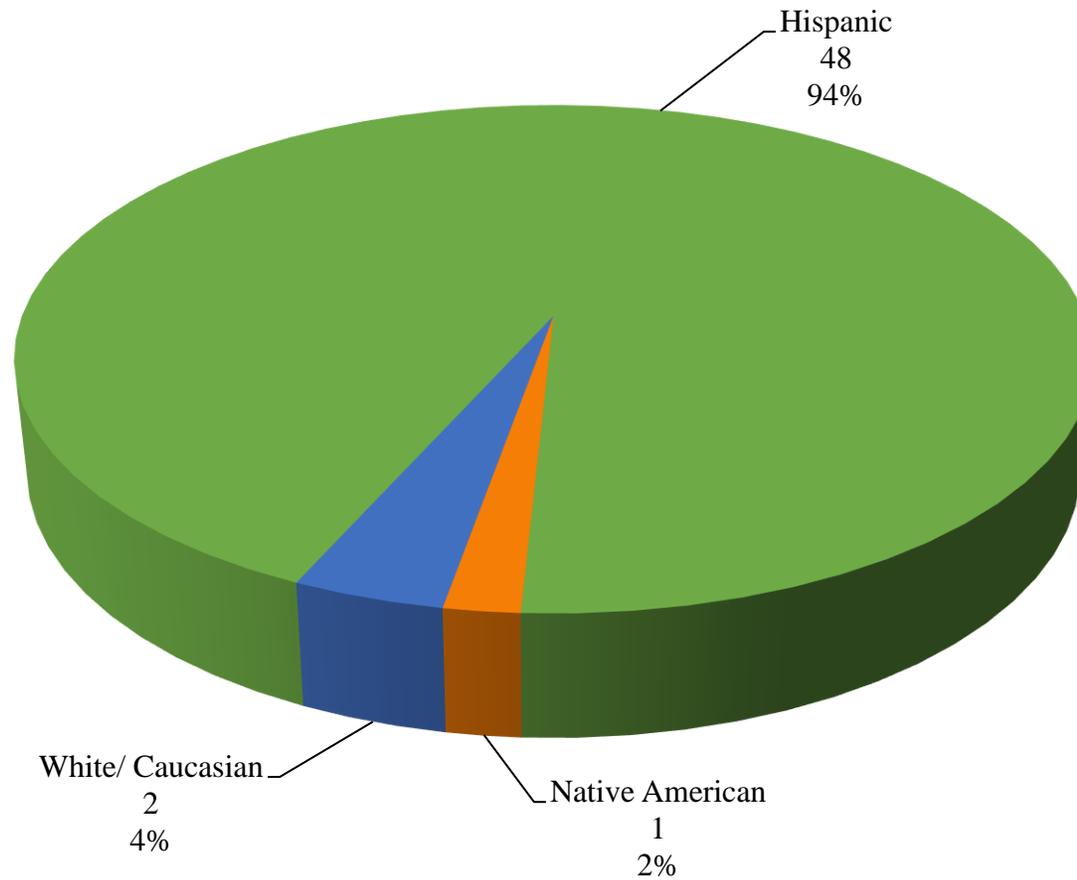
San Benito County Behavioral Health
MHSA Migrant Farm Worker Family Survey Results
2014
Age (N=47)



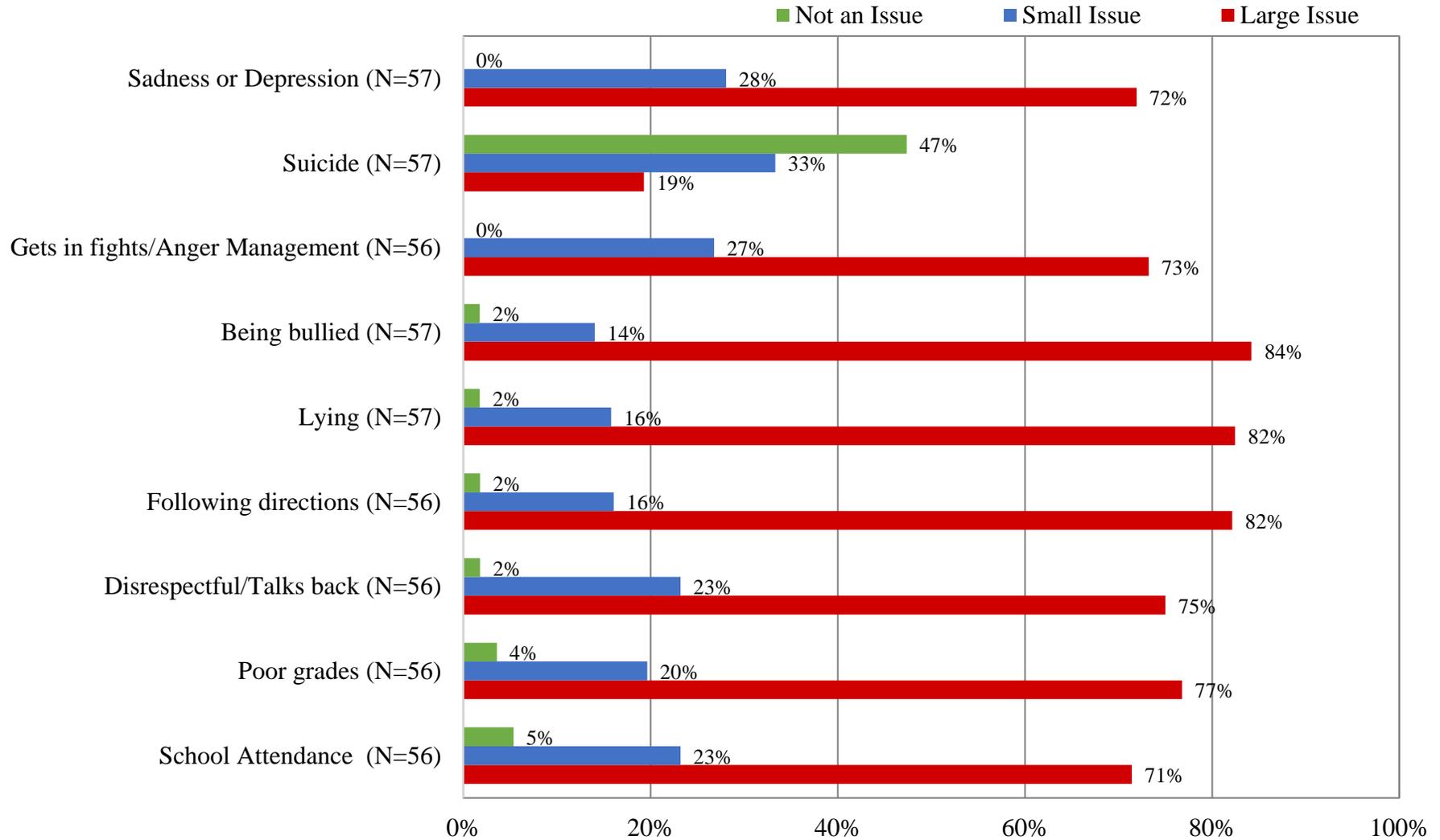
San Benito County Behavioral Health
MHSA Migrant Farm Worker Family Survey Results
2014
Gender (N=49)



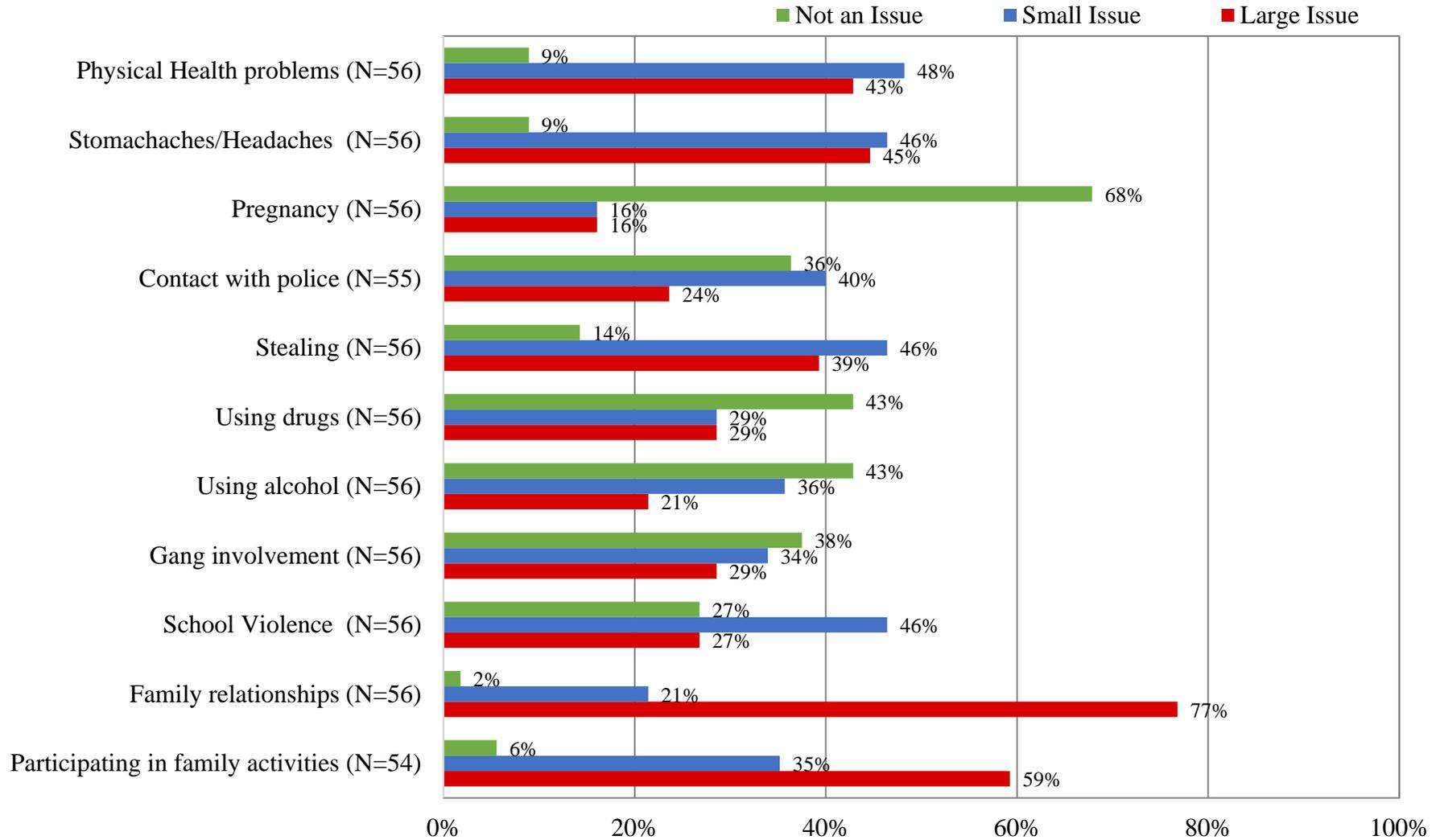
San Benito County Behavioral Health
MHSA Migrant Farm Worker Family Survey Results
2014
Race/Ethnicity (N=51)



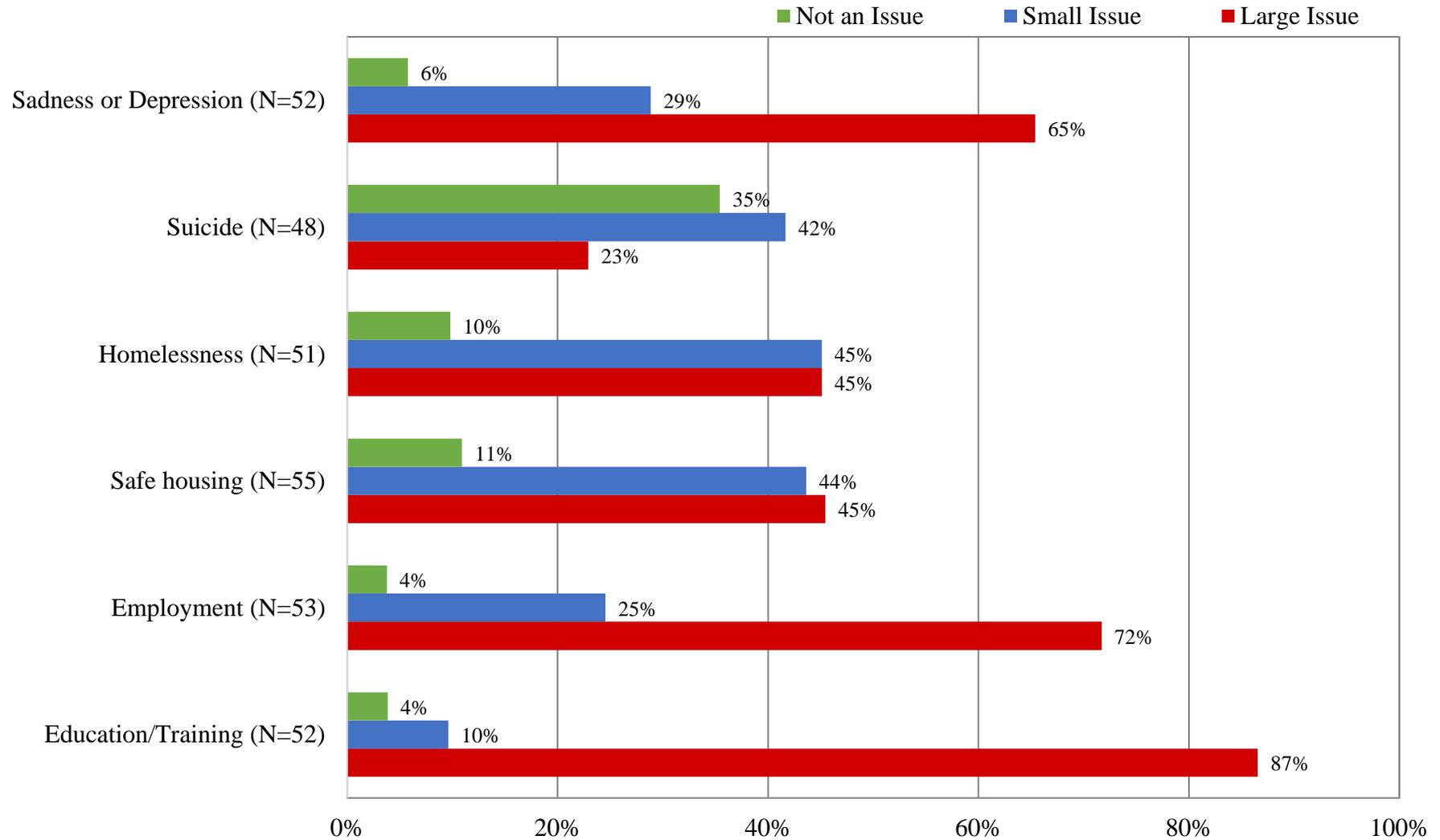
**San Benito County Behavioral Health
MHSa School Personnel Survey Results
Child and Youth Issues
2014**



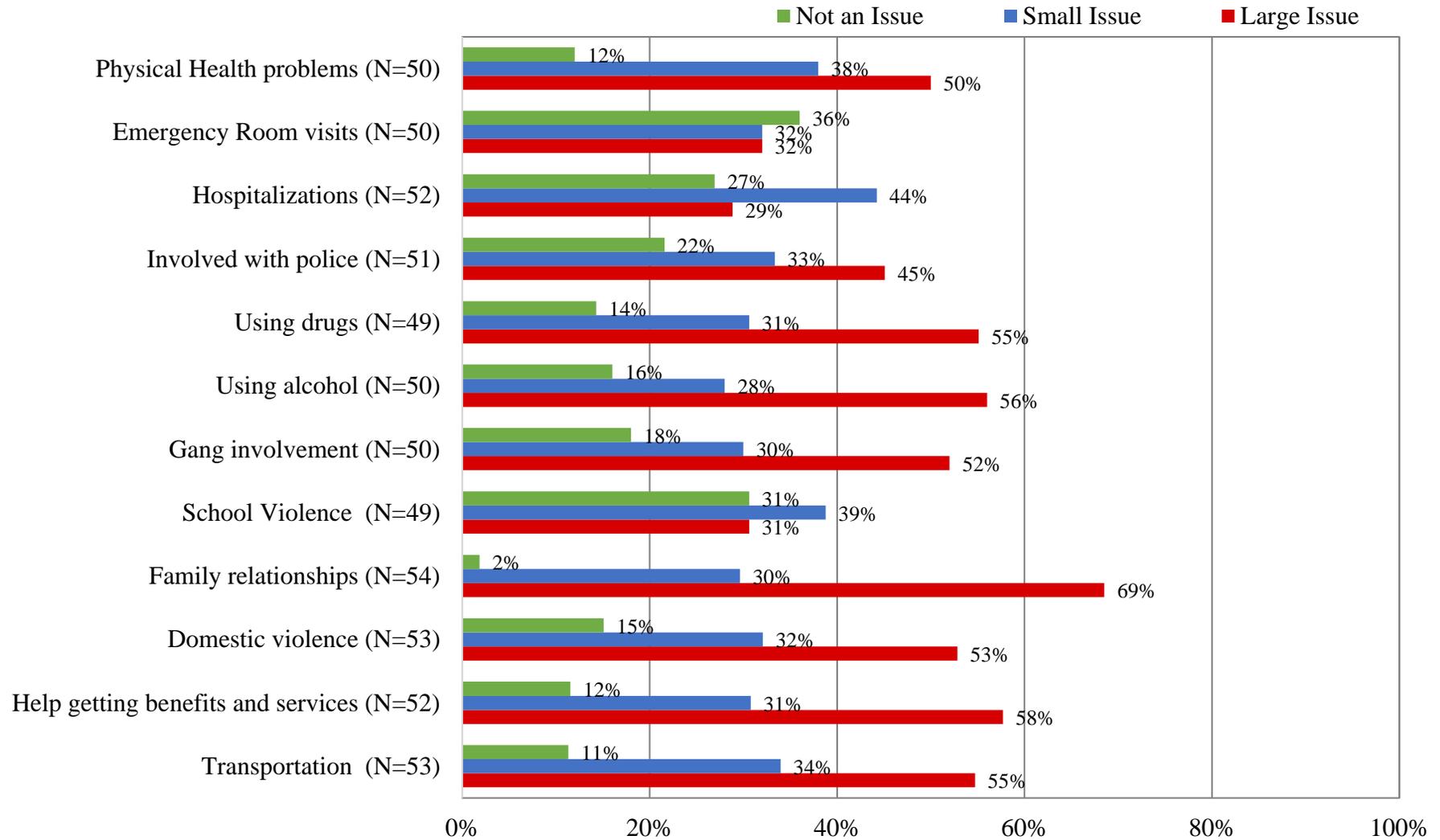
**San Benito County Behavioral Health
MHSA School Personnel Survey Results
Child and Youth Issues
2014**



**San Benito County Behavioral Health
MHSa School Personnel Survey Results
Parent and Family Issues
2014**

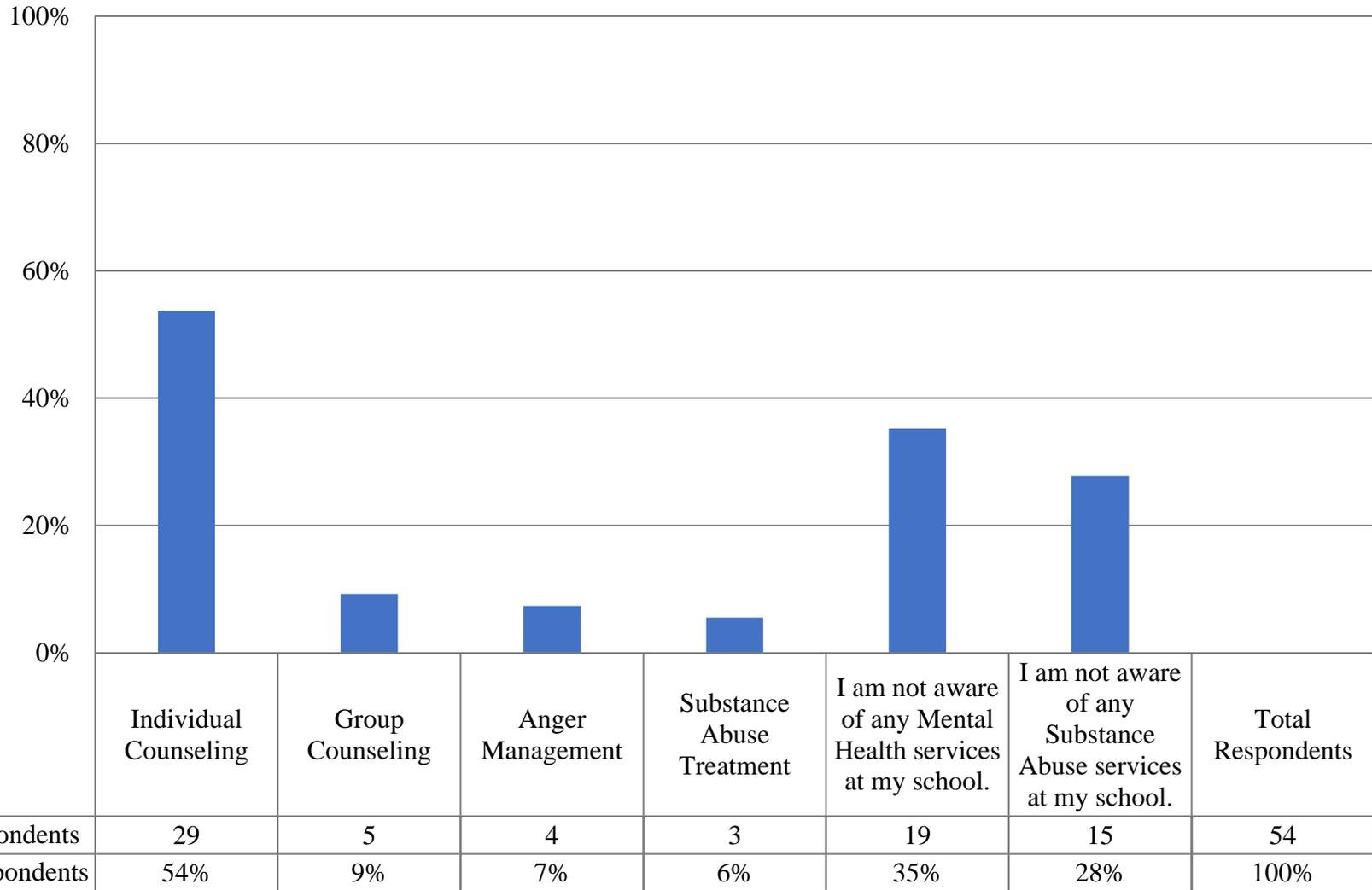


**San Benito County Behavioral Health
MHSa School Personnel Survey Results
Parent and Family Issues
2014**



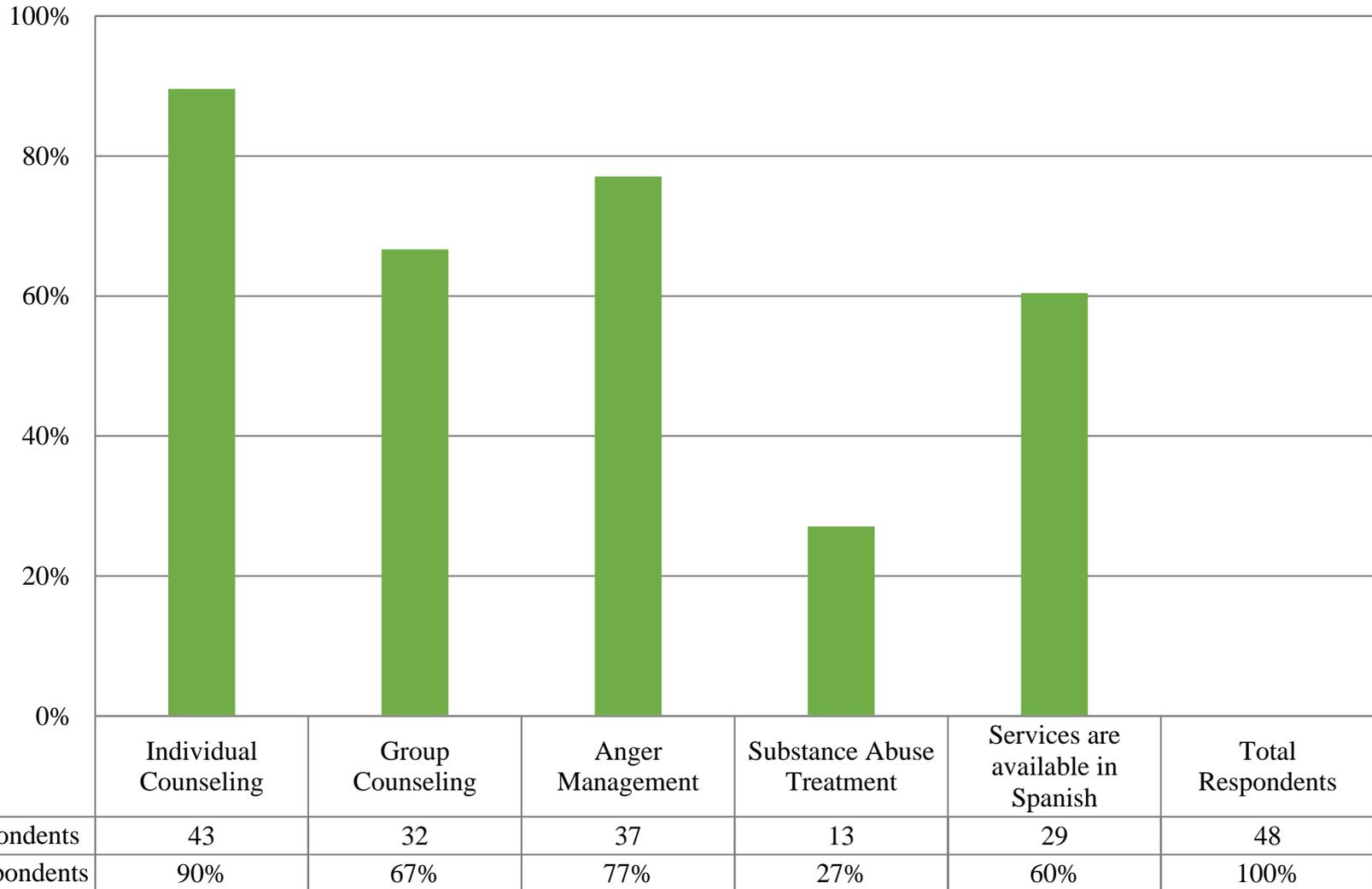
**San Benito County Behavioral Health
MHSA School Personnel Survey Results
2014**

What Behavioral Health services are currently available at your school?
(Respondents may choose multiple responses)

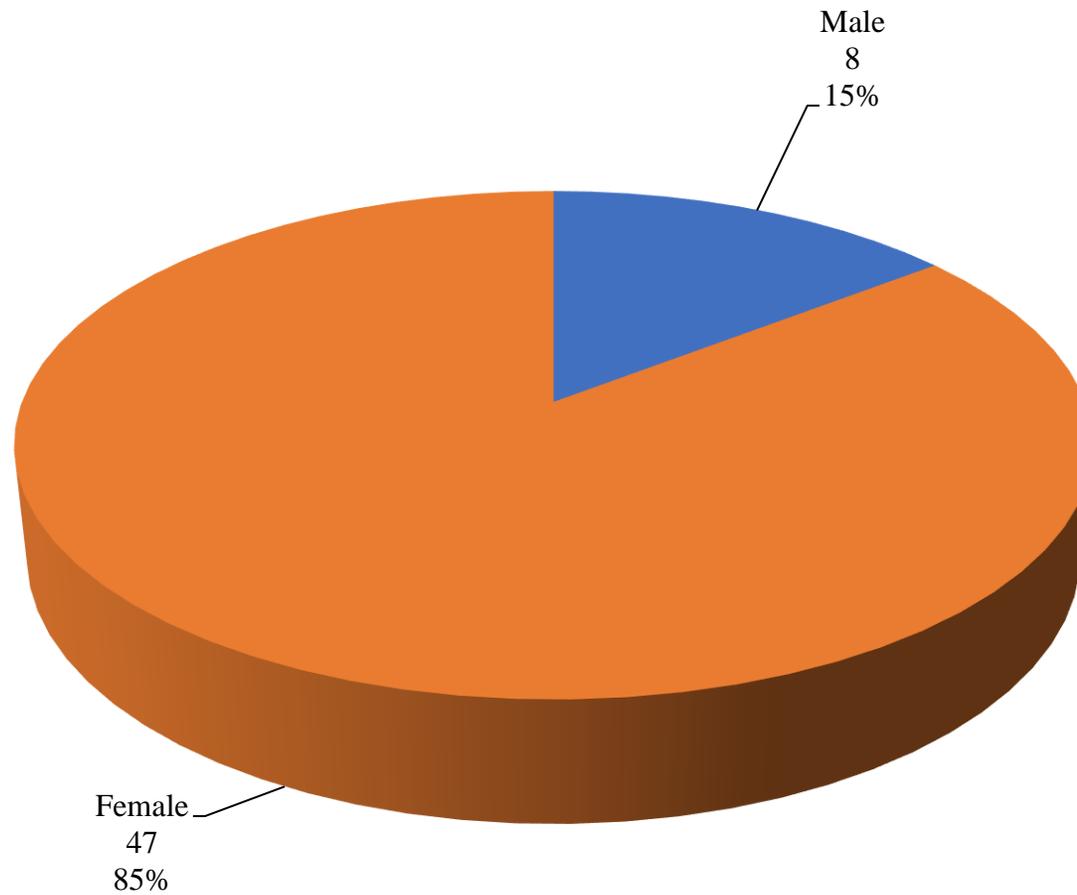


**San Benito County Behavioral Health
MHSA School Personnel Survey Results
2014**

Are there other Behavioral Health services needed at your school?
(Respondents may choose multiple responses)



**San Benito County Behavioral Health
MHSA School Personnel Survey Results
2014
Gender (N=55)**



**San Benito County Behavioral Health
MHSA School Personnel Survey Results
2014
*Race/Ethnicity (N=45)***

