Mental Health Services Act (MHSA):
Three-Year Program & Expenditure Plan 2017 – 2020
Kings County

KINGS COUNTY
behavioral health
kcbh.org

WELLNESS • RECOVERY • RESILIENCE

Prepared by:

Resource Development Associates

January 2018

Resource Development Associates' MHSA 3-Year Program and Expenditure Community Program Planning Process services funded by Kings County Behavioral Health

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Acknowledgments

This plan is the result of a collaborative effort that included the participation of multiple stakeholders. Without all of the public input we have received through the Community Program Planning (CPP) process, we would not have been able to develop such a comprehensive MHSA Three-Year Program and Expenditure Plan for 2017 – 2020. Kings County Behavioral Health (KCBH) wishes to thank the many consumers, family members, community members, agencies, and other Kings County staff who participated and helped guide the development of this plan. Although this is not a comprehensive list of all the representative organizations and agencies who participated in the CPP process, we would like to specifically thank:

- Adventist Health
- Champions Recovery Alternative Programs
- County Board of Supervisors
- Kings County Behavioral Health Advisory Board
- Kings County Public Guardian and Veterans Service Office
- Kings County Commission on Aging
- Kings County Department of Health
- Kings County Department of Probation
- Kings County Human Services Agency
- Kings County Office of Education
- Kings County Sheriff's Office
- Kings View Behavioral Health Systems
- Santa Rosa Tribal Social Services
- Women with Visions Unlimited

We are also thankful for the vision and commitment of the KCBH Leadership Team. Throughout this process, KCBH demonstrated a deep commitment to the values of the MHSA and to the communities it serves. We would like to especially thank Katie Arnst, Ahmad Bahrami, Yadira Amial-Cota, Stephanie Bealer, Diana Diaz-Madera, Cristobal Hernandez, Mary Jewell, Nathan Lacle, Ana Lopez, UnChong Parry, Michelle Phillips, Juan Ramirez, Zoila Sanchez-Gonzalez, Juan Torres, Lupe Wong, and former KCBH Director Mary Anne Ford-Sherman.

We also appreciate the efforts of the Resource Development Associates team of Roberta Chambers, Kira Gunther, Caitlin Palmer, Jessica Lobedan, and Christopher Ndubuizu for their work facilitating the CPP process and developing this plan.

Our hope is that this MHSA Three-Year Program and Expenditure Plan provides a transparent look into how Kings County will meet the mental health needs of its residents. Thank you again to all who are interested in this important work.

Be Well,

Lisa Lewis, PhD

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MHSA County Compliance Certification

County: Kings

☒ **Three-Year Program and Expenditure Plan**

☐ **Annual Update**

County Behavioral Health Director	Program Lead
Name: Lisa Lewis, PhD Telephone Number: 559-582-2382 Email: Lisa.Lewis@co.kings.ca.us	Name: Katie Arnst, MA Telephone Number: 559-852-2317 Email: Katie.Arnst@co.kings.ca.us
County Behavioral Health Mailing Address: Kings County Behavioral Health 450 Kings County Drive, Suite 104 Hanford, CA 93230	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This 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 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 January 23, 2018.

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.

Lisa D. Lewis, PhD — Lisa D Lewis, PhD

County Behavioral Health Director (PRINT) | Signature | Date

MHSA County Fiscal Accountability Certification

County: Kings

☒ **Three-Year Program and Expenditure Plan**

☐ **Annual Update**

☐ **Annual Revenue and Expenditure Report**

County Behavioral Health Director	Program Lead
Name: Lisa D. Lewis, PhD Telephone Number: 559-582-2382 Email: Lisa.Lewis@co.kings.ca.us	Name: Katie Arnst, MA Telephone Number: 559-852-2317 Email: Katie.Arnst@co.kings.ca.us
County Behavioral Health Mailing Address: Kings County Behavioral Health 450 Kings County Drive, Suite 104 Hanford, CA 93230	

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.

Lisa D. Lewis, PhD — Lisa D Lewis PhD

Mental Health Director/Designee (PRINT) | Signature | Date

I hereby certify that for the fiscal year ended June 30, 2017, 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, 2016. I further certify that for the fiscal year ended June 30 2017, 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.

Rob Knudson		1-31-18
County Auditor Controller/City Financial Officer (PRINT)	Signature	Date

Introduction

Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in 2004 to expand and transform the public mental health system. MHSA represented a statewide movement to provide a better coordinated and more comprehensive system of care for those with serious mental illness. In addition, MHSA defined an approach to the planning and the delivery of mental health services that are embedded in the MHSA values (see Figure 1).

Figure 1: MHSA Principles

MHSA is funded through a one percent tax on individual annual income exceeding one million dollars. California counties receive an MHSA allocation from the state, which typically makes up about 50% of a county's behavioral health budget. Counties distribute funds at the local level through a Community Program Planning (CPP) process that culminates in a three-year plan.

In 2006, Kings County Behavioral Health (KCBH) was formed, in large part due to the passage of the MHSA. KCBH's designed its mission "to promote, support, and invest in the wellness and recovery of individuals living in the communities of Kings County by creating opportunities to contribute, learn, work, and find hope in each day" to be in alignment with MHSA principals.

In March of 2017, KCBH began a CPP process to develop the Mental Health Services Act (MHSA) *Three-Year Program and Expenditure Plan for 2017-2020*. KCBH contracted with Resource Development Associates (RDA) to facilitate the CPP activities that culminated in the plan. This plan is designed to describe Kings County's CPP process, provide an assessment of the needs identified from an inclusive stakeholder process, and describe the proposed programs and expenditures developed through the CPP process to support a robust mental health system based in MHSA principles. This plan includes the following sections:

- **Overview of the CPP process** that took place in Kings County from March 2017 through January 2018. KCBH leadership recognized that the successful creation and implementation of MHSA funded services that fulfill the agency's mission is dependent on two key concepts: 1) consumer, family member, and community involvement at all

stages of the planning process and 2) commitment to increasing the community's capacity to participate meaningfully in MHSA funded service planning and program development. Kings County's CPP process was built upon the meaningful involvement and participation of mental health consumers, family members, county staff, providers, and many other stakeholders.

- **Assessment of mental health needs** that identified both strengths and opportunities to improve the mental health service system in Kings County. The needs assessment used multiple data sources (key informant interviews, data from 14-17 MHSA programs and services, community meetings, and feedback from a Steering Committee) to identify the service needs to be addressed by Kings County's MHSA programs for 2017 – 2020.
- **Description of Kings County's MHSA programs** by system of care, which includes a detailed explanation of each program, its target population, the mental health needs it addresses, and the intended outcomes of the program. This section of the plan also provides information on the expected number of unduplicated clients to be served and amount of the program funding.

Highlights from this plan include the following:

Programs from previous MHSA programs are being enhanced, such as strengthening Full Service Partnership (FSP)/Wraparound services for children and FSPs for adults and older adults to provide intensive services to individuals with the most serious mental health needs.

New programs and services including:

- **Assertive Community Treatment** to provide intensive services to adults with the most severe mental health needs to decrease hospitalization, incarceration, and homelessness.
- **Early Intervention Clinical Services** to provide transition age youth with services when they first begin to show signs and symptoms of a serious mental illness.
- **KARELink** to provide a comprehensive approach to linking adults with substance use and or mental health conditions with immediate care, integrative screenings and assessment, and comprehensive treatment, with a focus on linking formerly incarcerated people to services.
- **Cultural Ambassabor Program** to use community-based, peer mental health workers to deliver mental health information to the Latino community and connect community members to services.
- **Avenal One-Stop** to streamline access and enrollment into mental health programs and incorporate services that address physical health, mental health, employment, and basic needs to promote engagement in a rural, historically underserved community. The facility will be developed within the CFTN feasibility study initiatives.

This plan reflects the deep commitment of Kings County Behavioral Health leadership to design MHSA programs that are wellness and recovery focused, client and family driven, culturally competent, integrated, and collaborative.

Community Program Planning Process

I. Description of Community Planning Process

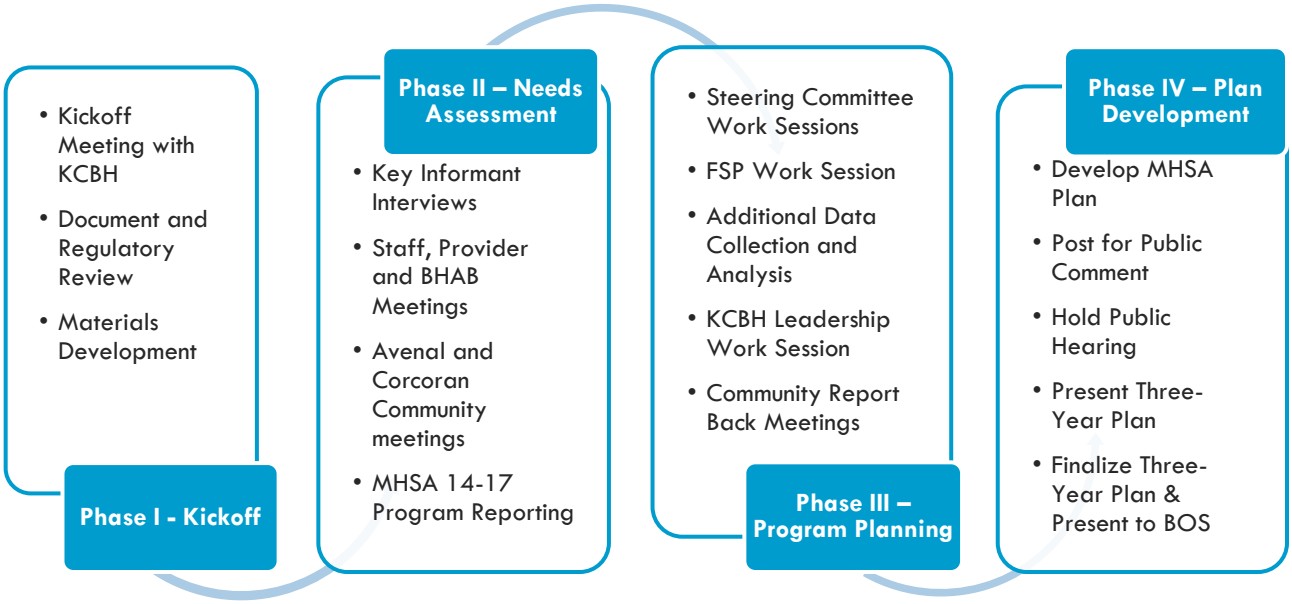
Planning Approach and Process

In March 2017, KCBH began its planning process for the MHSA Three-Year Program and Expenditure Plan for fiscal years 2017-2020. The planning process was divided into four phases: 1) Kickoff, 2) Needs Assessment, 3) Program Planning, and 4) Plan Development. Figure 2 lists the activities that were included in each phase.

The Kings County MHSA Planning Team (planning team) included Program Manager Katie Arnst, Program Manager Ahmad Bahrami, Clinical Program Manager Yadira Amial-Cota, Program Manager Stephanie Bealer, Program Manager Cristobal Hernandez, Clinical Unit Supervisor Nathan Lacle, and Fiscal Analyst UnChong Parry, Prevention Unit Supervisor Michelle Phillips, with oversight from KCBH Director Lisa D Lewis, PhD and KCBH Former Director Mary Anne Ford Sherman. RDA, a consulting firm with mental health planning expertise, provided planning support.

The planning team made presentations to the Kings County Behavioral Health Advisory Board (BHAB) and Board of Supervisors (BOS) at critical moments in the CPP process in order to review and comment on recommendations made. All meetings of the BHAB and BOS were open to the public.

Figure 2: Community Planning Process (CPP)



Community Planning Activities

The planning team carried out a set of community meetings and information-gathering activities to engage stakeholders in all stages of the planning and program development process in order to ensure that the plan reflected stakeholders' experiences and suggestions. The planning team also created a Steering Committee to guide the CPP process. Planning activities and their corresponding dates are presented in the table below, followed by a detailed description of each activity.

Table 1: Community Planning Activities and Dates

Activity	Date
Planning Process Refinement	
Kickoff Meeting	April 18, 2017
Needs Assessment	
Key Informant Interviews	April - May 2017
Community meetings	May 22, 2017 - May 23, 2017
Plan Development	
Steering Committee Meetings (3)	July 11, 2017; August 8, 2017; September 12, 2017
Full Service Partnership Work Session	August 24, 2017
KCBH Executive Committee Meeting	September 28, 2017
Community Report-back Meetings	November 6, 2017 - November 7, 2017
Public Review Process	
30-Day Review Period	December 23, 2017 - January 21, 2018
Public Hearing	January 22, 2018
BOS Plan Approval	January 23, 2018

Kickoff Meeting

The planning team held a full day kickoff meeting and work session. This meeting included former Kings County Behavioral Health Director, MHSA Coordinator, and other assigned county staff. The purpose of the kickoff meetings was to provide information about the proposed planning process and timeline and to gather feedback about how to ensure the process would include meaningful engagement of stakeholders. At the meeting, RDA used a PowerPoint presentation to inform participants of the proposed process. The planning team reviewed MHSA regulations, including new requirements. The planning team also identified key stakeholders for key informant interviews and a Steering Committee that would lead the planning process. In

accordance with MHSA, the planning team ensured there was stakeholder participation from the following groups:

- Adults and seniors with severe mental illness
- Families of children, adults, and seniors with severe mental illness
- Providers of mental health services
- Law enforcement agencies
- Education agencies
- Social services agencies
- Veterans and representatives from veterans organizations
- Providers of alcohol and drug services
- Health care organizations

The planning team reviewed the stakeholder list together and identified individuals from each group to participate in the needs assessment and planning process.

Key Informant Interviews

On behalf of the planning team, RDA staff conducted 12 key informant interviews (KIIs) with county staff, representatives from all stakeholder groups listed above, and members of the local Behavioral Health Advisory Board and Board of Supervisors. These interviews were designed to gather information about key mental health service strengths, needs, unserved and underserved populations and geographic areas, barriers to access, workforce shortages, and needs related to capital facilities and technology. KCBH staff on the planning team identified interview participants. All interviews were conducted by phone and lasted approximately one hour. A comprehensive list of all stakeholders interviewed is included in Appendix A.

Community meetings

Community meetings took place at the beginning and end of the CPP process. The first set of community meetings took place over a two-day period in May of 2017 in Hanford, Avenal, and Corcoran. The community meetings served the purpose to inform and update county and community stakeholders about the community planning process and gain more insight about program and service strengths and needs. One community meeting was held in Avenal, one in Corcoran, and three in Hanford. For the meetings in Hanford, RDA met with KCBH providers and staff, and presented at the Behavioral Health Advisory Board's public meeting. The goal of these meetings were to introduce the CPP process, present what had been accomplished since the previous plan was developed, and gather information for the needs assessment. For the community meetings in Avenal and Corcoran, RDA presented the aforementioned topics and provided the opportunity for community members to discuss the needs in their communities.

Flyers announcing the community meetings were printed in English and Spanish and were posted in KCBH offices, provider sites, and in the community. Interpreters were available at all community meetings. In addition to a copy of the presentation, participants were given a feedback form (included in Appendix B). The feedback form asked community meeting participants to evaluate the effectiveness of the CPP process.

Steering Committee Meetings

KCBH convened a group of stakeholders to form a Steering Committee who met in three day-long work sessions to develop the MHSA plan content. Members of the Steering Committee are included in Table 2.

Table 2: Steering Committee Members

Name	Agency
Yadira Amial-Cota	King County Behavioral Health
Katie Arnst	King County Behavioral Health
Ahmad Bahrami	King County Behavioral Health
Stephanie Bealer	King County Behavioral Health
Jaynece Bradley	Community representative
Ambar Castillo	Santa Rosa Tribal Social Services/Tachi Yokut
Brittni Chism	Sheriff's Department
Mary Anne Ford Sherman	King County Behavioral Health
Zaid German	Sheriff's Department
Debbie Grice	Kings County Public Health
Cris Hernandez	King County Behavioral Health
Vianey Hernandez	Owens Valley Career Development Center
Codi Hicke	Veterans Service Office & Public Guardian
Mary Jewell	King County Behavioral Health
Nathan Lacle	King County Behavioral Health
Julie LeFils	Kings Partnership for Prevention
Lisa Lewis, PhD	King County Behavioral Health
Dan Luttrell	Kings County Probation
Paula Massey	Women with Visions Unlimited/Sister Speak
Wendy Osikafo	Kings County Human Services
UnChong Parry	King County Behavioral Health
Michelle Phillips	King County Behavioral Health

Carlos Poblano	Behavioral Health Advisory Board
Pastor James Purser	Praise Chapel/Kings Spirituality Organization for Wellness
Rebecca Russell	Adventist Health
Rebecca Strong	Kings County Office of Education
Lupe Ponce Wong	King County Behavioral Health

Each Steering Committee meeting was designed to accomplish specific key objectives and to build off of the prior meeting. The first meeting focused on overall strengths, needs and visions for the county; the second meeting focused on services for children, transition age youth, adults, and older adults; the third meeting focused on all other MHSA services. Detailed descriptions of each meeting are described below (see Appendix C – D for meeting materials).

Steering Committee 1: The purpose of the first Steering Committee was to provide an overview of MHSA and the CPP process, review findings from the Needs Assessment, present data on who was served by MHSA programs from 2014 to 2017, and begin to identify focal areas for the 2017 to 2020 plan. After the introduction, Steering Committee members broke into smaller groups to identify key priorities to address by system of care. Steering Committee members decided whether to focus on children, youth, and families or adults/older adults. Each group identified key strengths and problems to solve on a worksheet and then presented to the larger group. After the initial small group activity and larger group discussion, members once again broke up into smaller groups and used a worksheet to develop vision statements for each system of care. The smaller groups presented, and the Steering Committee ended the meeting with draft statements of the vision for each system of care.

Steering Committee 2: The purpose of the second Steering Committee was to build off the vision statements created in the first meeting for children, youth and families and adults/older adults and to design services that address the needs for each group. The meeting began with the larger group reviewing, revising, and finalizing the vision statements. After, a group of young adults that have been involved in an Innovation project presented on the needs of youth and young adults. This was an interactive presentation to inform Steering Committee members about existing research activities and key focus areas for youth. After the presentation, committee members participated in a series of small group activities and large group discussions to design services for each system of care.

Steering Committee 3: The purpose of the third Steering Committee was to confirm direct services (designed in the second meeting) to be included in the plan, provide an overview of other services through MHSA, and design services for community-wide Prevention and Early Intervention; Workforce, Education, and Training; and Capital Facilities and Technology Needs.

The meeting began with a large group review of program descriptions for direct services designed in the previous meeting. The Steering Committee made modifications and confirmed the programs to be included in the plan. Throughout the rest of the day, the Steering Committee members participated in a series of small group activities and larger group discussions to design all other services for the plan.

Full Service Partnership Work Session

During the course of MHSA planning, KCBH staff convened a smaller-group meeting with KCBH leadership and RDA to discuss options for Full Service Partnership (FSP) clinical services. The group designed a vision for FSP, examined different types of provider models in place in various counties, and reviewed options for FSP in Kings County. From this work session, KCBH leadership refined direct services designed in the second Steering Committee. Decisions from the FSP work session were brought back to the third Steering Committee meeting for review and approval by the larger group.

KCBH Executive Committee Meeting

Following the Steering Committee and FSP work sessions, KCBH leadership held a half day work session. The purpose of this meeting was to review and validate the programs that had been developed in partnership with the Steering Committee; confirm that the plan was feasible and in alignment with KCBH and county goals; and review that programs and services were in the correct component.

Community Report-Back Meetings

The second set of community meetings took place over a two-day period in November in Hanford, Avenal, and Corcoran. One community meeting was held in Avenal, one in Corcoran, and one in Hanford. For the meetings in Hanford, RDA met with KCBH providers, staff, as well as the public. RDA presented a PowerPoint presentation that reviewed the CPP process and the plan components that were developed during the Steering Committee work sessions. During these meetings, stakeholders discussed their impressions of the proposed Plan and provided feedback on how well they felt the community planning process included their input. Flyers announcing the community meetings were printed in English and Spanish and were posted in KCBH offices, provider sites, and in the community. Interpreters were available at all meetings. In addition to a copy of the presentation, participants were given a feedback form (included in the Appendix F). The feedback form asked community meeting participants to evaluate the effectiveness of the CPP process and sought additional input on the needs assessment findings and the proposed programs and services.

Public Review and Hearing Process

The public review process is described in Section III.

II. Stakeholder Participation

Outreach for Community Program Planning Activities

Outreach efforts were shaped by MHSA requirements for stakeholder participation, the input of the planning team, steering committee, and feedback from the local Behavioral Health Advisory Board members to ensure that the planning process reached a broad spectrum of stakeholders and that the process was driven by community input.

As described in Section I, outreach for community meetings include flyers posted in English and Spanish throughout KCBH buildings, community based organizations, and the community. Additionally, any community members that signed up for updates, received calls and emails about community feedback meetings. Emails were sent in English and Spanish and callers reaching out to the community were bilingual.

Key informant interviewees and Steering Committee members were selected by KCBH staff to represent a diverse cross-section of stakeholders based on MHSA guidelines. RDA on behalf of KCBH contacted Key informants via email and phone to participate in KIIs. KCBH staff invited stakeholders to the Steering Committee meetings via email and phone. As mentioned in Section I, Steering Committee members were selected to represent a diversity of affiliations, including KCBH; Behavioral Health Advisory Board; consumers with mental illness; providers of mental health services; law enforcement, education, and social service agencies; veterans and representatives from veterans organization, providers of alcohol and drug services; and health care organizations.

Efforts to Include Consumers and Unserved and Underserved Populations

Special efforts were made to ensure that consumers were represented in all phases of the planning process including outreach by community-based agencies and service providers most connected to consumer groups, community meetings in rural areas, and postings and outreach efforts in English and Spanish. Additionally, KCBH ensured that people with lived experience and representatives from cultural and geographically specific communities were included in the Steering Committee.

Summary of Stakeholder Participation Demographics

As shown in Table 3, across the CPP process, KCBH engaged over one hundred community members. This represents a duplicated count, as some individuals participated in multiple planning events. At each planning activity, RDA asked participants to complete an anonymous demographic form in either Spanish or English (included in Appendix). Steering Committee members completed a demographic form for the first meeting only since attendance was not expected to change across meetings. The demographic form asked participants to report their age, gender, race/ethnicity, and whether they identified as a consumer, family member, or service provider (participants could choose more than one status). Responses from the demographic forms are described below. Because demographic forms were optional for participants, some participants may not have submitted forms or may have declined to respond to certain questions.

Table 3. Total Number of Participants, by Activity

Activity	Total Participants
Kickoff meeting	21
Key Informant Interviews	12
Steering Committee	37
Community meetings	45
Total	**115**

Participants by Gender

About three quarters (70%) of CPP participants identified as female, and one third (30%) of CPP participants identified as male (see Figure 3).

Participant Age Ranges

Participants were given the choice of selecting from four different age ranges corresponding to the MHSA categories of Children, Transition Age Youth (TAY), Adults, and Older Adults. Figure 4 shows the proportion of CPP participants by the four age ranges. Adults (25-59 years of age) comprised the largest percentage of CPP participants (89%).

Figure 3.Participants by Gender (n=97)

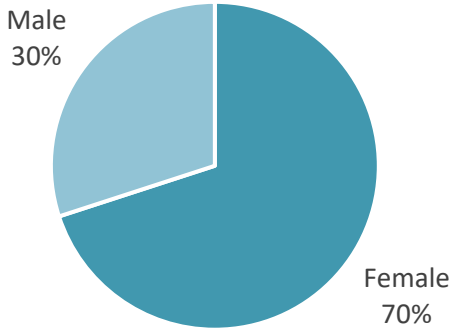
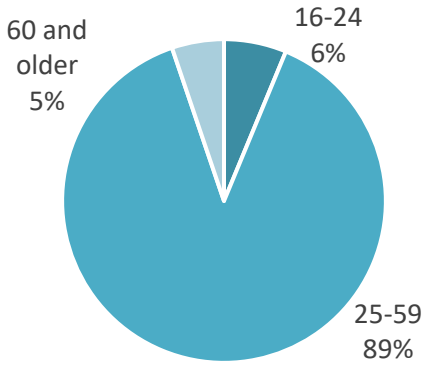


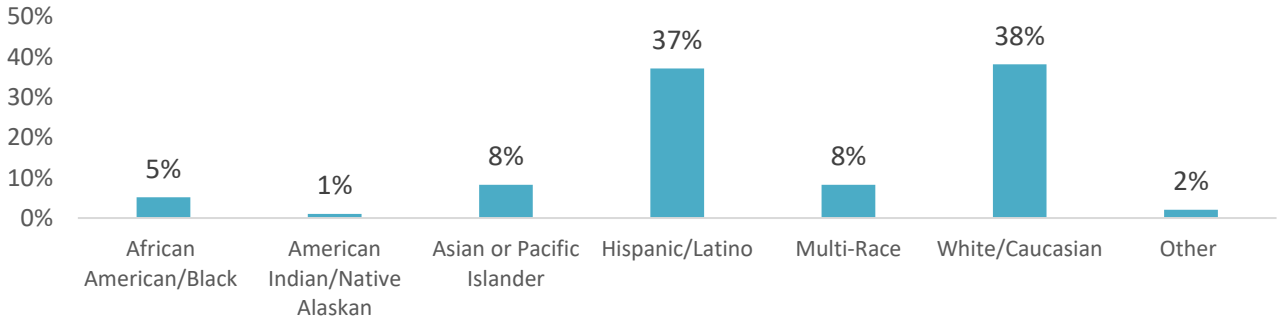
Figure 4. Participants by Age (n=96)



Participant Race/Ethnicity

Figure 5 shows the race/ethnicity composition of CPP participants. The majority of participants identified as White/Caucasian (38%) or Hispanic/Latino (37%). Given Kings County has a large Hispanic community, a concerted outreach effort was made to engage members from this community in all CPP activities. Representing smaller proportions were participants who identified as African American/Black (5%), American Indian (1%), Asian or Pacific Islander (8%), and Multi-Race (8%). Two percent of participants marked Other.

Figure 5. Percent of CPP Participants by Race/Ethnicity (n=97)

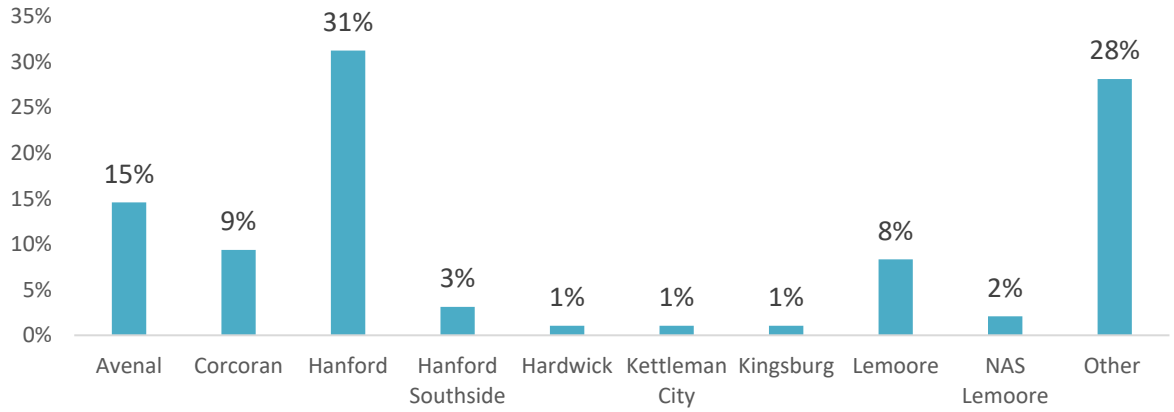


Participant Place of Residence

Kings County is primarily a rural county. Nonetheless, the county is still comprised of a diverse range of populations, each with their own unique needs. As such, efforts were made to include

participants representing the county's diverse geography. The table below provides a count of CPP participants according to their place of residence. The majority of CPP participants resided in Hanford (n=30). Other popular places of residence were (in decreasing order): Other communities (n=27), Avenal (n=14), and Corcoran (n=9).

Figure 6: Count of CPP Participants by Place of Residence (n=96)



In the overall planning process, 90 participants indicated their organizational affiliation. The following table depicts the number and percentage of each type of stakeholder group represented in the planning process. Most participants came from King County Staff, community-based organizations, or other stakeholder affiliations.

Table 4: Number and Percent of Total Participants by Stakeholder Affiliation

Stakeholder Affiliation	Total Count	% of Total
Kings County Staff	52	58%
Community-based organization	9	10%
Medical or health care agency *(primary and mental health care)*	4	4%
Education provider and youth services	3	3%
Other affiliation	10	11%
State government agency	1	1%
Social services agency	3	3%

Law enforcement agency	1	1%
Provider of mental health services	6	7%
Provider of alcohol and drug services	1	1%
Total	**90**	**100%**

III. Public Review Process and Hearing

The 30-day public comment period opened December 23, 2017 and closed on January 21, 2018. The county announced and disseminated the draft plan to the Board of Supervisors, Behavioral Health Advisory Board, county staff, service providers, consumers and family members, and those whose email addresses are associated with the stakeholder email list compiled throughout this planning process. A public notice was also submitted and published through The Hanford Sentinel (see Appendix G for the filling stamp). The draft plan was posted to the county's website and could be downloaded electronically and paper copies were also made available at KCBH offices in Hanford, as well as other locations throughout Kings County. Any interested party could request a copy of the draft plan by submitting a written or verbal request to the MHSA coordinator.

A public hearing was held on January 22, 2018 by the Behavioral Health Advisory Board, during which stakeholders were engaged to provide feedback about the Kings County MHSA *Three-Year Program and Expenditure Plan 2017-2020* (see Appendix G for the 30-Day Public Comment form). Twenty one stakeholders attended the public hearing, representing county staff, the behavioral health advisory board, consumers, and family members.

RDA presented the plan to public hearing participants by reviewing the CPP process and the MHSA funded programs by component (see Appendix G for RDA's public hearing presentation). The meeting was then opened for public comment.

No substantive comments were received during the public hearing. There were also no public comments submitted in writing or over email to the MHSA coordinator during the public comment period that ended January 21, 2018. Stakeholders general expressed support of the new plan and reported that they were excited for the changes that it described.

Community Needs Assessment

Background

KCBH serves a geographical region covering 1,392 square miles that includes a population of almost 150,000 residents (as of 2016).[1] Over one-third (55,547[2]) of the county's population resides in Hanford, the county seat and the location of KCBH's main branch. Outside of Hanford, the main population centers are Lemoore (pop. 25,785)[3], Corcoran (pop. 22,691), and Avenal (pop. 15,505).[4] Kings County is home to three state prisons (Avenal State Prison, California Substance Abuse Treatment Facility, and Corcoran State Prison). Incarcerated persons make up approximately 8% (12,443 individuals) of the total population of Kings County.

Kings County has a large population of military associated individuals. Kings County is home to approximately 25,000 residents of the Naval Air Station Lemoore, including military members, civilians, dependents, and reservists.[5] Over 11,000 Veterans lived in Kings County between 2008 and 2012.[6] Individuals and family members of individuals who serve or have served in the military face unique mental health challenges and concerns, including Post Traumatic Stress Disorder and depression.[7] This is further complicated by distance as the nearest Veteran's Affairs Medical Center for the VA Central California Health Care System is in Fresno County. Within the military community, there are also unique challenges to accessing mental health services. Across military studies, one of the most frequently reported barriers to seeking help for mental health challenges is concerns about stigma.[8] Concerns about stigma within the military community may create barriers to these populations accessing mental health services at the Naval Air Station and may result in veterans and active members seeking care from KCBH.

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[1] State of California, Department of Finance, California County Population Estimates and Components of Change by Year, July 1, 2010-2016. Sacramento, California, December 2016
[2] United States Census Bureau, Quick Facts. Retrieved from https://www.census.gov/quickfacts/fact/table/hanfordcitycalifornia/PST045216
[3] United States Census Bureau, Quick Facts. Retrieved from https://www.census.gov/quickfacts/fact/table/lemoorecitycalifornia,corcorancitycalifornia,avenalcitycalifornia/PST045216
[4] United States Census Bureau, Quick Facts. Retrieved from https://www.census.gov/quickfacts/fact/table/avenalcitycalifornia/PST045216
[5] http://apps.militaryonesource.mil/MOS/f?p=MI:CONTENT:0::::P4_INST_ID,P4_CONTENT_TITLE,P4_CONTENT_EKMT_ID,P4_CONTENT_DIRECTORY:465,Fast%20Facts,30.90.30.30.60.0.0.0.0,1
[6] United States Census Bureau, Quick Facts. Retrieved from https://www.census.gov/quickfacts/fact/table/avenalcitycalifornia/PST045216
[7] https://www.nami.org/Find-Support/Veterans-and-Active-Duty

[8] https://doi.org/10.1093/epirev/mxu012

The county economy is primarily agricultural, though other major employers include the U.S. Navy Air Station with between 5,000 and 9,999 employees and the California Department of Corrections and Rehabilitation with between 2,000 and 9,999 employees.[9]

Like most counties in California, Kings was severely affected by the economic recession that began in 2008. As of September 2017, the County's unemployment rate is 9.4%[10], compared to the state's average unemployment rate of 4.8%[11]. Twenty-two percent of county residents live in poverty[12].

Kings County is geographically dispersed, taking 40 minutes to drive from Avenal to Hanford and 27 minutes from Hanford to Corcoran. Without a personal vehicle, transportation between cities is very difficult and may take hours. For this reason, it may be challenging for individuals who live outside the county seat to access services. Furthermore, even with personal transportation, it may be difficult for people without flexibility in their schedules, such as full-time students and seasonal workers, to take the additional travel time to get to services during the day.

The ethnic makeup of Kings County is predominantly White and Latino, with 54% of residents identifying as Latino and 33% identifying as White in 2016. Kings County has one of the highest proportions of Latino residents in California. The Tribal/Native American presence is significant and comprises 3% of the population. The Santa Rosa Rancheria is located 4.5 miles outside of Lemoore and belongs to the federally recognized Tachi Yokut tribe.[13] Over 40%[14] of county residents have a primary language other than English with 33% of residents as native Spanish speakers.[15]Twenty-one percent of county residents are linguistically isolated. Individuals and households that are linguistically isolated may have difficulty accessing services that are available to fluent English speakers. The language barrier may prevent individuals from accessing transportation, medical, and social services, as well as limit educational and employment opportunities. There are an estimated 9,000 undocumented residents in the County.

King's County has a unique and challenging combination of high rates of poverty and high rates of adult serious mental illness. The rate of adult serious mental illness is second highest in the

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[9] State of California, Employment Development Department, Major Employers in Kings County. Retrieved from http://www.labormarketinfo.edd.ca.gov/majorer/countymajorer.asp?CountyCode=000031

[10] Bureau of Labor Statistics

[11] Ibd.

[12] United States Census Bureau, Quick Facts. Retrieved from https://www.census.gov/quickfacts/fact/table/kingscountycalifornia/PST045216

[13] https://www.tachi-yokut-nsn.gov/

[14] Data USA, Profile. Retrieved from https://datausa.io/profile/geo/kings-county-ca/

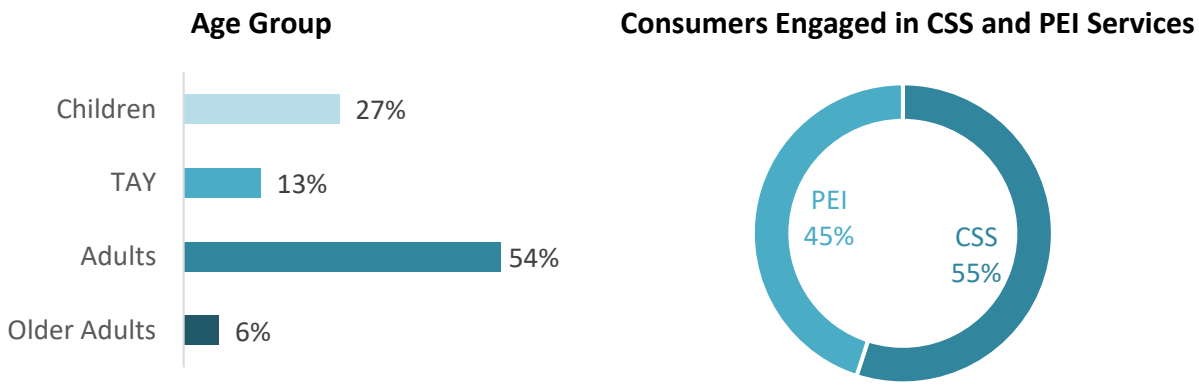
[15] Data USA, Profile. Retrieved from https://datausa.io/profile/geo/kings-county-ca/

state, at 7%[16]. The poverty rate is also one of the highest in the state, at 22% of the county residents living in poverty. In addition, despite having one of the highest rates of serious mental illness, Kings County, like many other rural regions in California, has a low rate of psychiatrists and other licensed mental health professionals. For every 100,000 residents, Kings County has approximately six psychiatrists.[17] This creates ongoing structural challenges to providing mental health services to all residents and indicates a high need for behavioral health services in Kings County.

Overview of Behavioral Health Services in Kings County

MHSA-funded programs provided direct services to 11,452[18] people in FY 2014-15 through FY 2016-17. Over half of consumers were adults (54%) and the second largest group of consumers were children and youth under 25 (27%). The majority of consumers engaged in CSS programs and services (55%).

Figure 7. Consumers Served

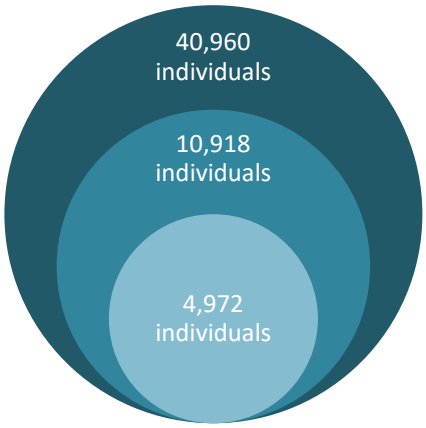


KCBH and community-based providers served consumers and the general public with both direct and other services at different levels of intensity. The total number of people Kings County served through all MHSA services, both indirect and direct, is 40,960 (see Figure 8).

[16] http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf
[17] http://www.chcf.org/publications/2013/07/data-viz-mental-health
[18] The number of people served, 11,452, includes duplicates to reflect consumers who may have participated in more than one service.

- **All MHSA-funded services** includes services that occur on a one-time basis and activities that are not direct services, such as public education campaigns.
- **Direct services** are different from indirect services in that they can occur on an ongoing basis and involve services to consumers or community members who provide mental health interventions either one-on-one or in a group setting, such as temporary mental health intervention programs.
- **Ongoing direct services** are a subset of direct services that are generally more intensive when consumers are enrolled in a service. In ongoing direct services, consumers engage in one-on-one or with a group of other consumers. Direct services and include clinical services, therapy or counseling, or training.

Figure 8. Consumers Served by Direct and Indirect Services



All MHSA-funded services
All direct and/or indirect services, and activities such as public information campaigns

All direct services
Only direct services that range from intensive ongoing services to one-time or "low-touch" services

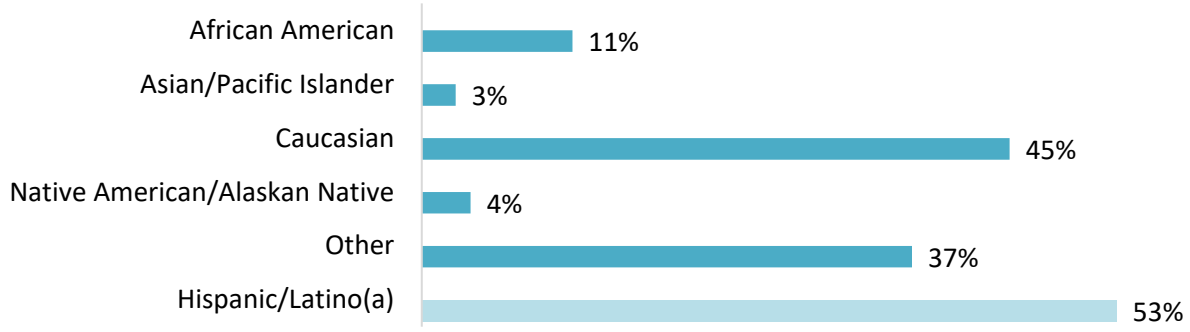
Ongoing direct services
Only direct services that are either more intensive or that support ongoing engagement

Consumer Demographics

According to electronic health record data, 45% of consumers served in Kings County identified as White/Caucasian and are the largest group of consumers by race (see Figure 9). The second largest proportion of consumers reported their race as "other." Over half of all consumers (53%) who reported their ethnicity identified as Hispanic/Latino(a).[19]

[19] Ethnicity and race are reported separately, and Hispanic/Latino(a) consumers may also identify as any race.

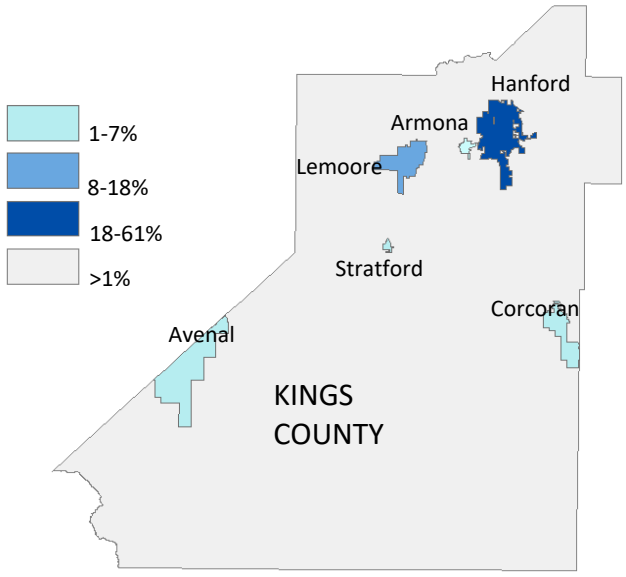
Figure 9. Consumer Race and Ethnicity



Consumer Areas of Residence

Across the county, approximately 37% of residents live in Hanford and about 17% live in Lemoore. The distribution of MHSA consumers served was even more concentrated in these two areas. About three quarters of MHSA consumers lived in Hanford (61%) or Lemoore (17%). About 17% of MHSA consumers in Kings County lived in rural areas and smaller communities outside of Hanford and Lemoore. Six percent of consumers lived outside of Kings County.

Figure 10. Percentage of MHSA Consumers by Community of Residence

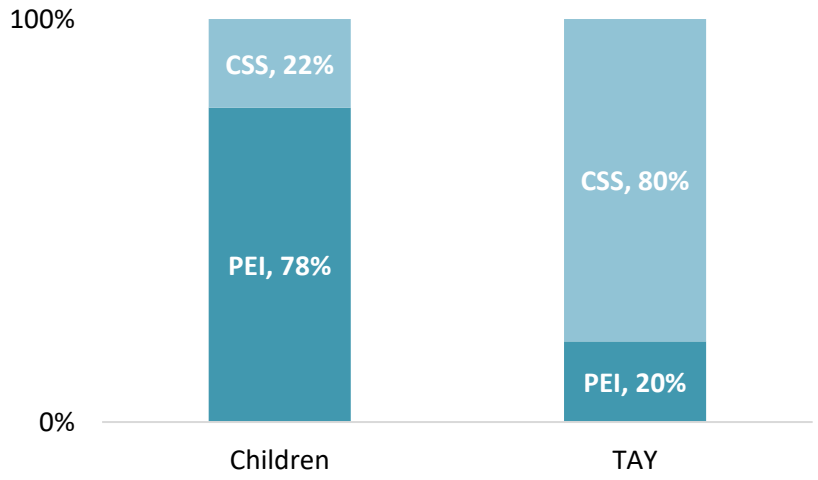


Kings County	
Hanford	61%
Lemoore	17%
Corcoran	7%
Armona	3%
Stratford	1%
Other communities, combined	4%
Outside of Kings County	
Visalia	3%
Fresno	2%
Merced	1%

Children, Youth, and Families System of Care

During fiscal years 2014-15 through 2016-17, MHSA-funded direct services served 3,182 children (0-15) and transition age youth (TAY) (16-25) in Kings County (see Figure 11). Three-quarters of children were served in PEI programs (78%), and 22% were served in CSS programs. This ratio is reversed for TAY; about 80% of TAY were served in CSS programs and 20% were served in PEI.

Figure 11. Children and TAY Served by MHSA Component

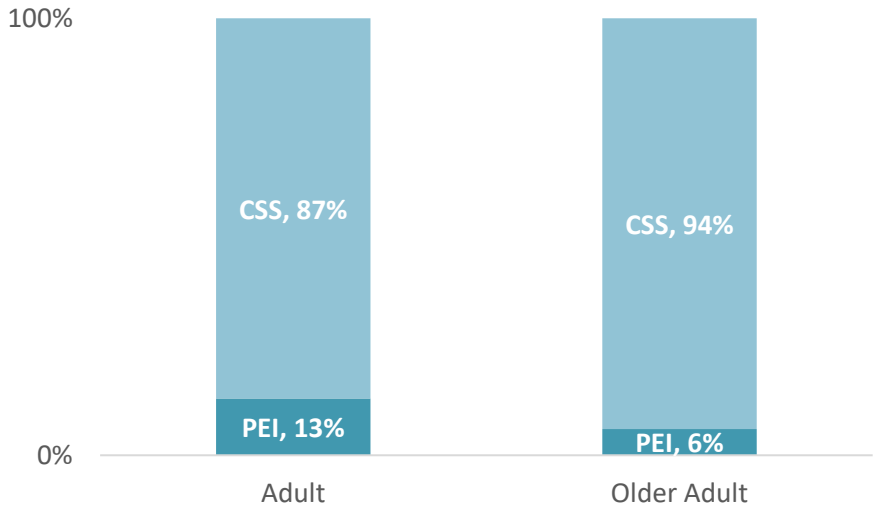


This distribution of children and TAY in PEI services is expected because efforts to *detect* early signs of mental illness in children and youth—either before they develop mental health problems or in the early stages of mental illness—and to *intervene early* are most effective in preventing the development of serious mental illness or decreasing the impact of mental illness on a person's quality of life. MHSA regulations encourage this practice by requiring counties to dedicate at least 51% of their PEI funding to serving children and TAY. TAY receive more CSS services than PEI because symptoms of serious mental illnesses such as schizophrenia and psychotic disorders begin to occur in early adulthood.

Adult and Older Adult System of Care

KCBH MHSA-funded direct services engaged 8,505 adults and older adults, about three times the number of children and TAY served (see Figure 12). Both adults and older adults primarily engaged in CSS services: 87% of adults and 94% of older adults utilized CSS services. Utilization of CSS services is expected to be higher for adults given that any mental illness requiring intensive direct CSS services fully manifest by age 26.

Figure 12. Adults and Older Adults Served by MHSA Component



Needs Assessment Process

The Community Needs Assessment process engaged participants across the County with the goal of learning about strengths, barriers and gaps in the behavioral health system. As part of the 2017-2020 MHSA Plan, Kings County convened a series of meetings and interviews to gather input from key mental health stakeholders. The previous section of this report outlined the data collection activities that took place from April through November 2017. The data collection methods and general participant demography for each of these data collection activities was also described above.

Over the course of the last three years, Kings County staff have undergone a number of efforts to address the key issues that arose in the last needs assessment. Recognizing that many of these efforts are newly implemented or are still in the implementation phase, the impact of the county's efforts have not reached the communities they intend to serve. With this in mind, the county chose to target this needs assessment to build off of, rather than replicate the findings presented in the last three-year plan.

Findings

From the community planning process, five domains emerged as areas of both progress and ongoing need: 1) Outreach and engagement, 2) Access and referrals, 3) Mental health services, 4) Crisis system services, and 5) Partnership development. Outreach and engagement findings

and suggestions examine how residents of Kings County learn about KCBH services. Findings and suggestions related to access and referrals discuss how people get connected to services, including the referral process into services. Findings 3 and 4 discuss mental health services in Kings County, both new services that have been created in the past three years and the range of services offered by the county. Lastly, partnership development addresses successful collaborations made in the last three years and partnerships to develop in the coming years. Comments from surveys, focus group participants, and community meeting participants regarding these impacts will be referenced throughout the needs assessment section.

Finding 1: While outreach efforts in the community have improved in the last three years, rural and native communities continue to struggle to gain access to and engage with mental health services due to geographic isolation and challenges faced by traditionally underserved communities.

Since 2014, Kings County has successfully expanded widespread outreach efforts throughout the community in an effort to increase outreach and engagement outside of the clinical setting. Examples of successful outreach efforts include:

- Promoting awareness of the 2-1-1 system
- Outreaching to all school districts on KCBH referrals
- Strengthening relationships with tribal communities
- Creating partnerships and collaboration with multiple agencies that strengthen the KCBH referral process
- Technological advancements that allow for increased remote outreach and engagement

These efforts have increased awareness of local services, increased understanding of the school based referral process, and strengthened community relations. As one KCBH staff member shared, “We focused on raising the level of mental health literacy and awareness.” Staff are looking into ways to broaden outreach such as “using technology in rural areas and finding ways to step out of traditional models.” Additionally, KCBH staff shared that in the past three years they have developed relationships with tribal social services that have allowed them to conduct more outreach with tribal communities.

For adults and children alike, geographic distance from services can complicate the process of accessing services. As one provider stated, when people determine that they want services they would like the ability to show up in person and be assessed the same day. While providers are working toward having more flexibility, there are still limits and wait times for assessment. For example, same day access for referrals in Hanford currently ends at 2pm. As one community member stated in Corcoran, there is a clinician who comes out to provide services, but is only

available for those that are already enrolled. If someone is interested in being assessed for services, they must go into Hanford.

In the past three years, KCBH has conducted extensive outreach to school districts throughout the county to educate staff on referring children to mental health services. As one teacher in Avenal reported, "We have all the referral information from our vice principal at the school." However, while the outreach to schools has increased awareness of the referral process among staff, this posed a challenge to translating referrals into services. For example, a staff person for behavioral health provides some services to non Medi-Cal eligible students in the middle and high school in Avenal, but must refer out for students that can receive services billable to Medi-Cal. Even when parents are linked through the referral process to a service provider, the parents have trouble connecting to services because the assessments and psychiatric services are only offered in Hanford.

To help connect referred consumers to services, KCBH has made a concerted effort to simplify the referral process and has worked to increase access to mental health services in rural areas. KCBH placed staff in outlying areas, participated in the Avenal needs assessment to learn more about the issues the community is facing, and displayed their commitment to working creatively with the community. However, because most services are clustered in Hanford, transportation to the county seat is not always feasible and may prevent people from accessing what they need. Furthermore, there is a large population of migrant farm workers in rural Kings County. These residents may not have the same protections as other workers, further limiting access to service.

Through the community meetings and key informant interviews, stakeholders have identified that there remains a need to focus targeted outreach efforts for vulnerable populations in culturally relevant ways. Despite widespread outreach efforts, vulnerable populations continue to face challenges in learning about KCBH services. The following groups were identified by stakeholders as potentially at-risk: rural communities, migrant workers, Native Americans, African Americans, homeless individuals, LGBTQ individuals, and veterans. Stakeholders discussed particular concern around rural and tribal communities experiencing difficulty learning about services.

Due to the geographic spread of the county, individuals in the outlying rural areas also face challenges learning about the primarily Hanford-based services. Many individuals in these rural communities are migrant farm workers and traditional outreach strategies may not resonate with these groups. Similarly, tribal populations on Santa Rosa Rancheria face challenges in learning about services outside the reservation. As one stakeholder associated with the Rancheria shared, having someone from KCBH conduct outreach on the reservation would be helpful to increase knowledge of available services.

Tribal populations continue to face challenges in accessing services, largely in part to the historical trauma faced by this group. As a member of the Santa Rosa Rancheria community shared, "all the programs and services that KCBH has to offer would be beneficial for the community, but if it's not on the reservation they are not going to participate because of historical trauma and mistrust around government." If residents of the Santa Rosa Rancheria do leave the reservation to get services at KCBH, there are reports of incidences where the individuals are then referred elsewhere, resulting in individuals being moved from service to service.

Finding 2: Stakeholders would like to see a more robust continuum of services that includes all levels of care.

Across the CPP, stakeholders shared concern that there are gaps in the mental health systems, particularly around access to the appropriate level of care and serving consumers and their families with the highest intensity of needs. Stakeholders shared that they would like to see a more robust continuum of services across the mental health service continuum.

> *"Rural access to care is really limited but these individuals have the same issues and compounded issues. They have the least amount of services." –Community Member*

Staff and providers shared the ways in which children and adults can have trouble getting into the correct level of care to meet their needs. For children and youth, there are a number of programs to provide preventive services, but there are no intensive services for those children and youth who have the most severe needs. This may mean that children do not receive services until they experience a mental health crisis and can also mean there are limited step-down options for children and youth as they begin to need a lower level of care. However, the new FSP/Wraparound program beginning February 2018 will provide those intensive services.

While clinical services currently exist in Kings County, many stakeholders shared that the lack of intensive clinical services for adults in the county make providing care to those with the most serious mental health needs a challenge.

Finding 3: KCBH established two new programs to serve individuals with the highest needs in an effort to reduce future crises; it may be beneficial to develop internal policies and procedures around how these new programs will be integrated with existing services.

In the past three years KCBH has explored a number of options for supporting crisis services and determined that the most important focus for this plan is to provide services for people with the highest needs. By creating two new programs, Assertive Community Treatment and KARElink, KCBH hopes to connect people with high needs into appropriate services, thereby reducing their need for crisis services. Assertive Community Treatment (ACT) serves adults 18 and older with serious mental illness and the highest level of need due to their risk or experience of frequent and repetitive hospitalizations and/or incarcerations, homelessness, or co-occurring disorders. ACT is a multidisciplinary team treatment approach including psychiatric, therapy, intensive case management and connection to the community that reliably decreases hospitalization while improving psychosocial outcomes and quality of life. The purpose of ACT is to engage individuals in evidence-based services that decrease hospitalizations, incarcerations, and homelessness, and increase recovery, quality of life, and other psychosocial outcomes. The evidence-based ACT Model serves FSP consumers at the highest level of need. The ACT model, which has been used both nationally and internationally, consistently shows positive outcomes for individuals with psychiatric disabilities.

KARELink is a program designed to target those in Kings County who typically access services at the highest level of care (e.g., emergency rooms, mental health care in jail) and are considered high cost and high utilizers of various public services. The target population for enrollment in the program must have one or more of the following: a substance use disorder, mental health issues, or a chronic health condition (e.g., diabetes or high blood pressure). KARELink will provide immediate screening and referral of all enrollees and then link enrollees to appropriate services and individualized levels of care, ranging from intense to moderate. KARELink will provide a cohesive system of referrals and follow-up to ensure that all individuals enrolled are accessing appropriate services without any barriers to care. Once individuals are referred to the appropriate service provider, extensive assessment and diagnosis will be provided in order to determine the appropriate treatment methods and teams.

With the addition of these two new programs to the existing continuum of services, it will be necessary to communicate clearly defined roles and responsibilities for the different programs. KARELink is an intensive referral and linkage program and ACT is an intensive mental health treatment program. These programs are designed to create a safety net for individuals to limit repeated crises contacts with police and the ED and to ensure they have the supports needed to engage in appropriate care.

Finding 4: Collaboration between KCBH and community partners is a strength and KCBH could continue to focus on communication and collaboration between substance use and behavioral health services.

In the last three years, KCBH has made great strides in partnership development and collaboration. From 2014 – 2017, KCBH:

- Convened faith-based leadership group
- Assisted in the development of a Whole Person Care collaborative
- Strengthened partnership with justice agencies
- Leveraged relationships with social services/child welfare and juvenile justice for Continuum of Care reform
- Increased collaboration with Adventist Health

While KCBH has seen success in relationship building and collaboration, stakeholders expressed that there continue to be areas that need more targeted relationship cultivation to better serve the community.

Stakeholders discussed the need for more dual-diagnosis services in the county and for collaboration and communication between mental health and substance use services. Stakeholders discussed that the lack of partnership between service areas may inhibit people from accessing needed behavioral health services. For example, the lack of collaboration between substance use services and mental health services results in people being treated in one area when they may need treatment in both areas. Mental health and substance use often operate in silos despite the common prevalence of co-occurring disorders. There may be clients who are need of both mental health and substance use services, but because there is a lack of communication between these systems individuals may not be connected to needed services. One stakeholder associated with substance use shared that they may have clients with "a family history of depression or schizophrenia, but we don't know and they don't know how to get the help that they need."

Growth Areas

The following have been identified as potential growth areas for KCBH to focus on in the coming years. These suggestions were created based on feedback from the community planning process. Many of these suggestions pertain to multiple findings.

Work to increase collaboration between physical health, mental health, and substance use services.

Stakeholders felt that stigma within the county may prevent people from engaging in behavioral health services, resulting in individuals not failing to connect with needed services. Mistrust of the government was discussed as a barrier in accessing mental health services, particularly among diverse communities.

Stakeholders expressed that integrating physical and behavioral health services and bolstering cross-agency collaboration could not only work to reduce stigma in accessing services but also to better serve the often myriad needs of clients. One community member suggested building relationships within the community, such as between KCBH, the housing authority, and other social services so that agencies that have the existing trust of community members could connect clients to services. Additionally, providing co-located services may provide increased opportunities for individuals to feel safe discreetly seeking mental health services, such as at a health center that provided more than just mental health services.

Strengthen partnership with school districts to ensure continuity of referrals and service accessibility across schools and for students.

A staff member shared that student referrals to services could be increased by training non-education school staff on the referral process. By training coaches and other school staff on recognizing warning signs and making referrals a wider safety net could be spread to connect students to services.

Stakeholders expressed wanting service accessibility across schools so that students across Kings can receive services at the school. Students who need to leave school to be assessed for services and to receive ongoing treatment miss school, which places them further behind their classmates. As is common in many rural counties, transportation in Kings County is a barrier to accessing services. In Kings County a student in Avenal would not be able to take a short break from classes for a treatment appointment – it would take at a minimum 40 minutes to get to services in Hanford, plus the length of the time at the appointment, and another 40 minutes, or more, to get back to school. By providing services at the school, students do not need to miss their classes and can get help without having to spend extensive length of time getting to services across the county.

Increase partners' awareness of referral process, ensure follow-up and tracking of referrals, and share referral outcomes with referring parties.

While stakeholders acknowledged that considerable progress has been made with the school based referral process, particularly in creating a universal referral form, many community members identified there remains a need to increase the community's awareness and understanding of the referral process. As multiple stakeholders shared, the behavioral health system can be difficult to understand and navigate.

One stakeholder in Avenal shared that they knew their child needed services, but didn't know how to access services because they were not aware of the process. Multiple stakeholders shared that they do not know where to access behavioral health services. By increasing clarity in how to access services and the referral process into services, community members may find it easier to become service connected. Additionally, stakeholders associated with schools shared how they had made referrals to services and never heard anything more regarding what happened with the referral. It would be beneficial to develop communication guidelines to keep referring parties abreast of progress.

Consider ways to expand geographic reach of crisis services.

As is common in many geographically dispersed counties, reaching outlying parts of the county can be a challenge. This can be especially concerning with time-sensitive crisis services. Across the CPP, community members shared that in the rural parts of the county an individual in crisis may have difficulty receiving timely care. Stakeholders suggested that providing a mobile crisis service or placing services in rural areas may work to meet the needs of these more isolated community members.

Establish communication and referral pathways between those in crisis and ongoing mental health programs.

Stakeholders shared that within behavioral health services there is a lack of knowledge about where to send people in crisis. One stakeholder shared that while doctors may know someone is having a problem and in need of services, they may not know where to send someone. KCBH should consider developing processes and procedures for how new services will work together with existing services, the referral process into and between services, and stakeholder education around new crisis services. With new systems and programs, it is necessary to ensure understanding and collaboration. Developing policy and procedure around the new services will aid in serving the community most effectively.

Develop mechanisms which prioritize the appropriate fit between individuals need and level of care.

For children and adults alike, stakeholders expressed concern that individuals may not always be in the appropriate and necessary level of care. This may mean that individuals are engaged in too intensive of services (such as someone who needs case management only receiving FSP) or that someone is not engaged in intensive enough care (such as someone receiving case management needing FSP). KCBH should consider developing procedure to ensure that individuals are assessed and placed into the appropriate level of care as well as to allow movement between levels of care.

As KCBH continues to expand their services and increase the number of service providers, it will become more and more important to have a consistent way for people to be assessed for level of care needed and linked to the correct level of care. In addition to determining where people go and how they get there, it will be important to create procedure for movement between services, and across providers, along their recovery journey.

Re-design the full-service partnership program for adults with plans to implement FSP according to the model.

As discussed above, in Kings County the rate of adult serious mental illness is second highest in the state indicating there is a high level of need in Kings County to provide intensive services to those in need. Across the CPP, stakeholders expressed a desire to improve services for consumers and their families with the highest intensity of needs. Kings County has already begun the process of obtaining a service provider who intends to implement FSP for children in accordance with the model, but the county is still in process of planning services for adults with the most serious mental health needs.

"We should take it to them instead of having them drive. People can't take time off of work. The need there is to have services at appropriate times and places. If we are providing a service, we need to have it at a time that is convenient." -Provider

The adult FSP program should seek to engage people with serious mental illness into intensive services in the community to provide a "whatever it takes" approach to treatment. Goals of FSP include promoting recovery and increased quality of life; decreasing negative outcomes such as hospitalization, incarceration, and homelessness; and increasing positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and

psychosocial supports. To meet these goals, KCBH will launch an Assertive Community Treatment team as part of the adult FSP redesign in 2018 (see page 46 for a description of the ACT program).

Match the demand in rural areas with capacity.

Across the planning process, stakeholder shared that physical access in rural areas is a limit to accessing services. Most services are clustered in Hanford and transportation to this part of the county is not always feasible and may prevent people from accessing services they need. Stakeholders discussed that despite demand for services in rural areas, providers are not always able to come to the outlying areas of the county, and providers do not provide sufficient services in outlying areas to meet the community need.

In addition to sending providers out into the community, stakeholders discussed the idea of having school or community based mental health centers staffed with full-time clinicians available in outlying areas. The centers would be open to students and families as well as members of the community. As discussed above, stakeholders feel it is important to provide discreet mental health services co-located with physical health services. Developing multi-use health centers in outlying areas may be a way to provide rural mental health services in a way that community members feel safe and comfortable accessing.

Consider flexible service provision that meets the needs of the community.

Stakeholders discussed the need for providing services in ways that meet the needs of the community. As one community member shared, it is not always possible for people who work during the day to take time off and access services. Stakeholders expressed that having services open additional hours outside of traditional business hours and meeting individuals in the community would more effectively meet the community's needs. Stakeholders also proposed ideas such as mobile intake and mental health buses to take individuals into Hanford for screening would help to combat transportation related challenges and meet the needs of the entire community.

Conduct outreach in accessible locations using culturally relevant outreach materials.

Stakeholders identified rural communities, migrant workers, Native Americans, African Americans, homeless individuals, LGBTQ individuals, and veterans as vulnerable populations. Community members felt that targeted outreach should be informed by the unique, and often compounded, traumas that each community has and continues to face. Targeted outreach works

to meet community members where they are to connect them to needed services. Without this type of proactive outreach, vulnerable populations may fail to be connected to services.

Stakeholders consistently discussed the importance of meeting individuals and families in the community, throughout the county. Participants shared that they valued providers' utilizing outreach mechanisms that resonate with the target population and understanding rural communities and the unique issues that these groups face. Community members noted that even if programs and services exist, without culturally responsive outreach, diverse populations may not learn about nor engage in services.

Stakeholders discussed conducting outreach through billboards, church bulletins, movie previews, television and radio commercials, as well as at cultural events, such as community barbeques. By conducting outreach in culturally relevant ways it may make it easier for these groups to access outreach mechanisms and connect to services.

Create systems to measure outreach efforts and allow for transparency within the community.

"One thing that is missing is robust and ongoing ways to hear from the clients about how things are going. We ask these questions of the providers and not of the clients. They have no real, ongoing way of asking that question. We need to ask the people getting the services."
–KCBH Staff

Stakeholders expressed their desire for increased transparency around KCBH's outreach efforts. Both widespread and targeted outreach efforts should be measured to illustrate the work that KCBH is doing to reach community members. Data collected could include location of outreach, individuals reached, and linkages to service made. Measuring these efforts would be valuable information for both the community to know and for KCBH to be able to see if outreach is effective at reaching target populations. Kings County staff echoed the concern that outreach efforts are often hard to measure, making it challenging to assess whether programs are reaching their intended goals. Staff reported interest in creating systems to improve tracking of outreach efforts.

Additionally, stakeholders expressed wanting this information to be publically available. Services should be measured for effectiveness and the results should be shared with the community to promote transparency within the mental health system.

MHSA Three-Year Program Plan

Introduction

This section provides an overview of the community's vision for MHSA and descriptions of each of the proposed programs for Kings County's MHSA Three-Year Program and Expenditure Plan 2017 – 2020.

The purpose of this Three-Year Program and Expenditure Plan is to document the community's vision for how to achieve the transformation and expansion of mental health services intended by the MHSA. In order to create a more collaborative and integrated mental health system of care, as written in the MHSA values, the Steering Committee developed a shared vision for the

> **Kings County Behavioral Health stakeholders envision a behavioral health system that is rooted in evidence-based practices and provides timely, culturally and linguistically competent, person-centered, and trauma-informed services throughout the entire county.**

County:

MHSA Programs and Services by System of Care

Children and Transitional Age Youth

Kings County Behavioral Health stakeholders envision a Children, Youth, and Family system that provides a full spectrum of services — from prevention and early intervention through clinical and crisis supports — and responds to the unique needs of children, youth, and their families by:

- Identifying and engaging children and youth with mental health challenges in appropriate and timely mental health services.
- Providing services that are available when and where children and youth already are, during hours when children and youth can attend.
- Providing adequate support to prevent children, youth, and their families from becoming involved in the juvenile justice and child welfare systems, making efforts to keep children and youth at home and avoiding unnecessary out of home placements.
- Providing crisis services when children, youth, and families need them, wherever they are, and connecting them to services that are likely to prevent future crises.

Community Services and Supports (CSS)

Children and TAY Full Service Partnership/Wraparound				
Status:	☐New		☒Continuing	
Priority Population:	☒Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	CSS: Full Service Partnership			

Program Description

FSP/Wraparound provides an individualized, family-centered, and team-based approach to care that aims to keep children and their families together. FSP/Wraparound provides a coordinated range of services to support children and youth to stay on track developmentally and improve educational/academic performance, social and emotional skills, and parent and family skills and launch into adulthood.

FSP/Wraparound serves children ages six years old to 21 years old with severe emotional disturbance and/or serious mental illness. Children and youth may be at risk of or are transitioning from out-of-home placement, are engaged with child welfare, and/or juvenile justice, or are at risk of homelessness, incarceration or hospitalization as they transition into adulthood.

FSP/Wraparound is a team-based planning process intended to provide individualized and coordinated family-driven care. FSP/Wraparound should increase the "natural support" available to a family (as they define it) by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships.[20] FSP/Wraparound requires that family, providers, and key members of the child or youth's social support network collaborate to build a creative plan that responds to the particular needs of the child/youth and their support system. FSP/Wraparound services should build on the strengths of each child/youth and their support system and be tailored to address their unique and changing needs. Services may include:

- Mental health treatment, including individual and family/group therapy
- Alternative treatment and culturally specific treatment approaches
- Family support including respite care and transportation to children/youth for their mental health appointments

[20] http://www.cebc4cw.org/program/wraparound/detailed

- Case management to assist the client and, when appropriate, the client's family in accessing needed medical, education, social, vocational rehabilitative and/or other community services
- Supportive services to assist the client and the client's family in obtaining and maintaining employment, housing, and/or educational opportunities
- Referrals and linkages to other community-based providers for other needed social services, including housing and primary care

Goals and Objectives			
Outcome 1:	Reduce out-of-home placements for FSP enrolled children/TAY.		
Outcome 2:	Increase service connectedness for FSP enrolled children/TAY.		
Outcome 3:	Reduce involvement in child welfare and juvenile justice.		
Number to be served FY 2017-18:	80	**Proposed Budget FY 2017-18:**	$840,140
Cost per Person FY 2017-18:	$10,502	**Total Proposed Budget FY 2017-20:**	$2,840,140

Summer Day Camp				
Status:	☐New		☒Continuing	
Priority Population:	☒Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	CSS: General Systems Development			

Program Description

Summer Day Camp aims to reduce the impact of living with serious emotional disturbance and/or serious mental illness during the summer months when children and youth do not have access to school-based behavioral health programs and services.
Summer Day Camp serves children with severe emotional disturbance and TAY with serious mental illness.

Summer Day Camp provides individualized clinical treatment to participants as well as an embedded curriculum to identify campers' strengths, mental and behavioral health issues of concern, and ways in which campers can maximize those strengths to enhance their personal development. The Summer Camp provides transportation for youth in outlying areas to ensure participation by those who might not otherwise be able to participate. Funding for this program will be discontinued after FY 2017 – 2018.

Goals and Objectives

Outcome 1:	Increase service connectedness for Summer Camp participants.
Outcome 2:	Reduce hospitalization during the summer months.

Number to be served FY 2017-18:	30	**Proposed Budget FY 2017-18:**	$33,320
Cost per Person FY 2017-18:	$1,111	**Total Proposed Budget FY 2017-20:**	$33,320

Parent-Child Interaction Therapy (PCIT)				
Status:	☐New	☐Continuing		☒Modified
Priority Population:	☒Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	CSS: General Systems Development			

Program Description

Parent-child Interaction Therapy (PCIT) is an evidence-based, family-centered treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. PCIT combines behavioral therapy, play therapy, and parenting techniques to improve the quality of the parent-child relationship, strengthen parenting skills, and support healthier parent-child interactions. The STAR Center at Behavioral Health houses the PCIT rooms where parents are coached on skills to implement with their children.

The target population of PCIT are parents with children between the ages of two and eight years who are exhibiting challenging, disruptive, and otherwise maladaptive or developmentally inappropriate behaviors.

In the PCIT program parents learn specific skills to establish or strengthen a nurturing and secure relationship with their child while encouraging acceptable behavior and discouraging undesirable behavior. The essential activities within PICT include:

Child Directed Interaction (CDI):

- Parent-child pairs attend treatment sessions together and the parent learns to follow the child's lead in play
- The parent is taught how to decrease the negative aspects of their relationship with their child and to develop positive communication
- The parent is taught and coached to use CDI skills. These skills help the parents give positive attention to the child following positive behavior and ignore negative behavior
- Parents are often given earpiece microphones consisting of a head set with microphone that the therapist wears and an ear receiver that the parent wears to help direct parent communication and behavior

Parent Directed Interaction (PDI):

- Parent-child pairs attend treatment sessions together and the parent learns skills to lead the child's behavior effectively
- The parent is taught how to direct the child's behavior when it is important that the child obey their instruction

• Parents are often given earpiece microphones consisting of a head set with microphone that the therapist wears and an ear receiver that the parent wears to help direct parent communication and behavior[21] PCIT treatment is administered for 20 weekly one-hour sessions, on average, with a trained PCIT mental health clinician. Services are provided in English and Spanish.			
Goals and Objectives			
Outcome 1:	Increase parenting skills, including positive discipline.		
Outcome 3:	Reduce maladaptive behavior and increase pro-social behaviors.		
Outcome 4:	Improve the parent-child relationship.		
Outcome 5:	Decrease frequency and severity of disruptive behaviors.		
Number to be served FY 2017-18:	75	**Proposed Budget FY 2017-18:**	$50,000
Cost per Person FY 2017-18:	$667	**Total Proposed Budget FY 2017-20:**	$150,000

[21] http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed

Prevention and Early Intervention

School Based Services				
Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☒Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	PEI: Prevention			

Program Description

School Based Services are designed to provide students with skills and tools to promote increased mental health, school performance, and healthy relationships and communication. The target population of this program is children and youth who are at risk of developing a mental health problem.

The following are key services and activities within School Based Services:

- **Coping and Support Training (CAST)** is a 12-week program that focuses on building young people's coping skills and talking about the real life challenges of youth life in today's increasingly complex world. CAST focuses on building strategies for coping with academic pressures, handling stressful relationships, managing anger, and emphasizes seeking out support from responsible adults and setting personal life goals.
- **Mindful Schools' Mindful Educators** utilizes a curriculum that teaches mindfulness to K-12 students with the purpose of increasing attention, self-regulation, and empathy. The research-based program allows behavioral health staff to teach and implement mindfulness activities and practices in classrooms, after-school programs, or other settings. The program seeks to improve the student's emotional regulation, focus, and engagement, as well as improve connections with other students. This is a cost-effective way to help students develop skills to decrease stress and anxiety.
- **READY Program prevention** is an effort to provide community wide education and stigma reduction to children (Primarily 5-6th graders). This program partners with local schools and/or their afterschool programs to provide interactive presentations to the children on topics including, cyber bullying, general bullying, health decision making (about substance use) and mindfulness. These topics can be presented on a weekly basis for four weeks or all in one week. Each session is under an hour and uses role-play and activity to ensure engagement by the children.

Goals and Objectives

Outcome 1:	Increase student connectedness and relationship building skills.
Outcome 2:	Increase student coping mechanisms skills.
Outcome 3:	Increase student capacity for seeking help.
Outcome 4:	Decrease depression and anxiety among students.

Number to be served FY 2017-18:	400	**Proposed Budget FY 2017-18:**	$230,740

Cost per Person FY 2017-18:	$588	**Total Proposed Budget FY 2017-20:**	$692,220

Therapeutic Activity Groups for TAY (Tier 1)				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	PEI: Prevention			
Program Description				
Therapeutic Activity Groups (TAG) utilize creative outlets for personal and cultural expression to help youth create meaningful experiences that promote healing, empowerment, wellness, and social development. TAG aims to increase connectedness to community, culture, and increase positive coping and adaptive skills. The target population of TAG is transitional age youth at risk of developing or beginning to experience a mental health challenge. KCBH partners with Beats, Rhymes, and Life, Inc. to provide curriculum for KCBH staff to implement Hip Hop Therapy to involve youth in services through writing lyrics and attending workshops. Youth participate in programing that includes drawing, writing, spoken word, musical, and dance performance.				
Goals and Objectives				
Outcome 1:	Decrease mental health symptoms.			
Outcome 2:	Increase coping and life skills.			
Number to be served FY 2017-18:	80	**Proposed Budget FY 2017-18:**	$73,530	
Cost per Person FY 2017-18:	$919	**Total Proposed Budget FY 2017-20:**	N/A	

Truancy Intervention Program (TIPP)				
Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☒Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	PEI: Prevention			

Program Description

The Truancy Intervention Prevention Program (TIPP) is a collaborative partnership among the School Attendance Review Board (SARB), the Office of Education, the District Attorney's Office, and Kings County Behavioral Health. TIPP was formed to provide families and youth with tools and resources to reduce the incidence of truancy in the community. The goal of TIPP is to reduce youth and family involvement in the criminal justice system, prevent school failure, develop healthier families through skill development and service linkage, and provide tools and resources to eliminate truancy in the community. The target population of TIPP are chronically truant youth.

One of the key activities of TIPP is the Life Strategic Training and Education Program (Life STEPS). Life STEPs is a course that focuses on providing psycho-education to families with truant or chronically absent students on the following topics:

- Importance of being involved in children's education
- Understanding of both parental and child roles
- Setting limits and boundaries
- Substance use, mental health, gangs and criminal activity, and other issues that may affect truancy/chronic absenteeism and children's educational success

Life Steps uses speakers, activities, role-play, and therapy in a group setting. Additionally, the course provides information on how to access resources and services that may be needed by the family.

Goals and Objectives

Outcome 1:	Reduce youth and family involvement in the criminal justice system and prevent school failure.
Outcome 2:	Reduce truancy and chronic absenteeism among youth.
Outcome 3:	Reduce the symptoms of the root causes that contribute to chronic absenteeism.

Number to be served FY 2017-18:	100	**Proposed Budget FY 2017-18:**	$66,000
Cost per Person FY 2017-18:	$660	**Total Proposed Budget FY 2017-20:**	$198,000

Early Intervention Clinical Services				
Status:	☒New	☐Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	PEI: Early Intervention			

Program Description

Early Intervention Clinical Services (EICS) seeks to engage youth early on in the development of a serious mental illness to decrease the severity of symptoms, increase recovery and help youth stay on track developmentally. The target population of EICS is Transitional Age Youth identified by parents, providers, schools, emergency rooms, primary care physicians, child welfare, law enforcement, and juvenile probation that have experienced a first episode of psychosis, mania, depression, or other mental health disorder or are beginning to show signs of developing a serious mental health problem.

Services provided include home, community, and office based clinical services, case management, and other supportive services for the youth and their family. Areas of focus may include vocational/education, housing, medication management, therapy, case management, psychoeducation in individual and group settings. Services provided may include:

- **Person-centered care:** assisted by a care manager who helps clients and family members to navigate among treatment options.
- **Medication/Primary Care:** Communication about the importance of medication and potential value even after symptom improvement is critical in early discussion.
- **Psychotherapy:** Cognitive behavioral therapy as an evidence-based intervention for psychosis.
- **Family Education and Support:** Family psychoeducation so that consumers choose the support people they want involved in their recovery, and families/supports get information that helps them play an active role in the recovery process.
- **Supported Employment and Education:** Fostering autonomy and setting goals, including returning to school or work, developing new interests, meeting new people, and making new friends.

Goals and Objectives

Outcome 1:	Identify and engage youth and family in services.
Outcome 2:	Increase psychosocial outcomes, including education and academic and family involvement.
Outcome 3:	Decrease hospitalizations, involvement with the criminal justice system, truancy, and substance use.

Number to be served FY 2017-18:	0	**Proposed Budget FY 2017-18:**	$0
Cost per Person FY 2017-18:	N/A	**Total Proposed Budget FY 2017-20:**	$50,000

Adults and Older Adults

Kings County Behavioral Health stakeholders envision an **Adult and Older Adult** system that provides a warm and welcoming service delivery experience that promotes recovery and interrupts the cycle of incarceration, hospitalization, and homelessness for individuals with mental health challenges by:

- Providing targeted outreach to identify, engage, and connect people in need to mental health services.
- Considering all of a person's needs and strengths, from initial assessment throughout their treatment.
- Meeting adults "wherever they are at" in the community and in their recovery process.
- Providing recovery oriented mental health services, placing peer professionals throughout the entire system.
- Coordinating between service levels, providing appropriate and timely transitions between levels of care, and helping people navigate and stay engaged in the mental health system.

Community Services and Supports (CSS)

Full Service Partnerships				
Status:	☐New	☒Continuing	☒Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: Full Service Partnerships (FSP)			
Program Description				
Full Service Partnerships (FSP) seek to engage individuals with serious mental illness into intensive, team-based, and culturally appropriate services in the community with a low staff to consumer ratio. FSP provides a "whatever it takes" approach to: Promote recovery and increased quality of life; decrease negative outcomes such as hospitalization, incarceration, and homelessness; and increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports. FSP serves adults 18 and older with serious mental illness who are unserved or underserved and at risk of or experiencing homelessness, incarceration, or hospitalization. FSP provides a full range of clinical and non-clinical services, including: **Clinical Services** • Mental health treatment, including individual and family/group therapy			

- Alternative treatment and culturally specific treatment approaches
- Peer support: Incorporating people with lived experience into a person's treatment plan
- Full spectrum of community services to attain the goals of an individual as identified in the Individual Services and Supports Plan (ISSP)
- Crisis intervention/stabilization services

Non clinical services and supports:

- Supportive services to obtain employment, housing, education, and health care (treatment for co-occurring conditions)
- Referrals and linkages to other community-based providers for other needed social services, including housing and primary care
- Family education services
- Respite care

Goals and Objectives			
Outcome 1:	Promote wellness, recovery, and independent living		
Outcome 2:	Reduce hospitalization, homelessness, and incarceration for adults with serious mental illness.		
Outcome 3:	Support the development of life skills and psychosocial outcomes, including social, educational, and vocational rehabilitative outcomes.		
Number to be served FY 2017-18:	225	**Proposed Budget FY 2017-18:**	$542,450
Cost per Person FY 2017-18:	$7,233	**Total Proposed Budget FY 2017-20:**	$1,627,350

Assertive Community Treatment				
Status:	☒New	☐Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: Full Service Partnerships (FSP)			

Program Description

ACT is a multidisciplinary intensive treatment team approach which includes dedicated psychiatric care, psychotherapy, and intensive case management with connection to the community. ACT treatment reliably decreases hospitalization and incarceration while improving quality of life. The purpose of ACT is to provide individuals, who have had difficulty successfully engaging in lower-level outpatient services, with an intensive, evidence-based program, with low staff to client ratio, that decreases hospitalizations, incarcerations, and homelessness, and increases recovery, quality of life, and other psychosocial outcomes.

Assertive Community Treatment (ACT) serves adults 18 years of age and older with serious mental illness and the highest level of need due to their risk or experience of frequent and repetitive hospitalizations and/or incarcerations, homelessness, or co-occurring disorders.

Assertive Community Treatment serves FSP consumers at the highest level of need. ACT provides the full range of treatment services in the community, including:

- Clinical mental health services including psychiatry and medication support
- Treatment for co-occurring disorders
- Individual and group psychotherapy
- Intensive case management
- Vocational/educational services
- Peer support
- Any other support the individual may need to promote their recovery using a "whatever it takes" approach.

ACT is characterized by: Low client to staff ratios; dedicated, individualized psychiatric care, providing services in the community rather than in the office; shared caseloads among team members; 24-hour staff availability; direct provision of all services by the team (rather than referring consumers to other agencies); peer support and time-unlimited services. The ACT model consistently shows positive outcomes for individuals with psychiatric disabilities.

Goals and Objectives

Outcome 1:	Provide treatment and care that promotes wellness, recovery, and independent living.
Outcome 2:	Reduce hospitalization, homelessness, and incarceration for adults with serious mental illness.

Outcome 3:	Support the recovery of individuals and the development of life skills and psychosocial outcomes, including social, educational, and vocational rehabilitative outcomes.		
Number to be served FY 2017-18:	0	**Proposed Budget FY 2017-18:**	$0
Cost per Person FY 2017-18:	N/A	**Total Proposed Budget FY 2017-20:**	$2,000,000

Collaborative Justice Treatment Court				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

Collaborative Justice Treatment Court (CJTC) aims to divert consumers with mental health and co-occurring disorders from incarceration into treatment by engaging and connecting participants to the services and support they need and reducing the likelihood of future offenses. CJTC provides for three specialty court calendars, including Behavioral Health, Co-occurring Disorders, and Veterans.

CJTC serves individuals whose mental health and/or substance use has led to criminal justice involvement and whose offenses and level of risk are eligible for participation in a specialty court program.

CJTC uses the drug court model with an integrated trauma-informed approach that provides clients with access to a continuum of alcohol and other drug services and mental health treatment. Collaborative courts operate under a collaborative model in which the judiciary, prosecution, defense, probation, law enforcement, mental health, and treatment communities work together to assist individuals so they can recover and go on to live productive lives. Collaborative court offers an alternative to incarceration, while addressing the underlying causes of criminality through providing programming and services that appropriately address the needs of individuals with mental health substance use and co-occurring disorders. In recently published literature, drug courts are developing a solid evidence base, demonstrating their effectiveness in reducing crime, combating substance use addictions, preserving families, and saving taxpayers money.[22]

[22] http://www.nadcp.org/sites/default/files/nadcp/Facts%20on%20Drug%20Courts%20.pdf

CJTC clients are provided with the following services:

- Substance use and mental health treatment;
- Clients transportation support;
- Employment services and job training;
- Case management;
- Relapse prevention;
- Housing support; and
- Peer-to-peer support services.

Goals and Objectives	
Outcome 1:	Reduce substance use and promote recovery among program clients.
Outcome 2:	Improve clients' family functioning outcomes.
Outcome 3:	Reduce recidivism and other crimes related to substance use and mental health challenges.
Outcome 4:	Enhance collaboration and systems integration.

Number to be served FY 2017-18:	80	**Proposed Budget FY 2017-18:**	$312,260
Cost per Person FY 2017-18:	$3,902	**Total Proposed Budget FY 2017-20:**	$924,320

Mental Health Services for Domestic Violence Survivors				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

The Barbara Saville Women's Shelter provides a safe and secure living environment for women and children seeking refuge from domestic violence and/or, who are homeless due to unforeseen circumstances and situations. The Shelter provides case management and linkage services for adults with serious mental illness and children with serious emotional disturbance who have experienced domestic or family violence and are residents of the Barbara Seville shelter.

The program provides mental health and case management services and linkage to other supports to address issues related to mental health, trauma, domestic violence, and homelessness.

Goals and Objectives

Outcome 1:	Identify and engage individuals and families in mental health services.
Outcome 2:	Connect victims of domestic violence to mental health services.
Outcome 3:	Increase self-sufficiency among residents with the goal of moving individuals to permanent, independent housing.

Number to be served FY 2017-18:	50	**Proposed Budget FY 2017-18:**	$143,150
Cost per Person FY 2017-18:	$286	**Total Proposed Budget FY 2017-20:**	$429,450

KARELink				
Status:	☒New	☐Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: Outreach and Engagement			

Program Description

Kings Access to Resources and Enhanced Linkages (KARELink) provides Kings County residents with assistance navigating the various services and resources available in the County. KARELink is a system of referral and linkage that involves collaboration between many Kings County providers and is designed to assist Kings County residents who could benefit from having a personal advocate for accessing any combination of services related to mental health needs, addictions, and/or chronic health conditions. The purpose of KARELink is to provide timely, individualized access to care coordination and services to those in most need.

KARELink serves community members who have difficulty accessing outpatient services or who access care at high levels (e.g., emergency rooms, mental health care in jail) and are considered high cost and high utilizers of various public services. The target population must have one or more of the following: a substance use disorder, mental health issues, or a chronic health condition of diabetes or high blood pressure. Although KARELink can receive referrals from anyone anywhere, the program is designed to target consumers who are exiting from incarceration or hospitalization and meet other criteria.

KARELink provides time-limited, intensive case management services that provide participants with screenings and linkages to immediate assessments, care and comprehensive treatment. Services include:

- Short term recuperative care
- Housing assistance
- Social security and disability advocacy
- Individualized care coordination

Goals and Objectives

Outcome 1:	Reduce instances of incarceration, hospitalization, and homelessness.
Outcome 2:	Increase service connectedness.
Outcome 3:	Reduce need for higher level of care.

Number to be served FY 2017-18:	80	**Proposed Budget FY 2017-18:**	$603,200
Cost per Person FY 2017-18:	$7,540	**Total Proposed Budget FY 2017-20:**	$2,216,000

Intensive Case Management/Intensive Outpatient Program				
Status:	☐New	☒Continuing	☐Modified	
Priority Population:	☒Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	CSS: General System Development			

Program Description

Intensive Case Management/Intensive Outpatient Services (ICM/IOP) provide community based long-term clinical, case management and care across the lifespan. The purpose of ICM/IOP is to engage people in mental health services, promote recovery and quality of life, and reduce the likelihood that individuals served will require higher levels of care. ICM/IOP serves children, youth, adults, and older adults who meet medical necessity for specialty mental health services and are eligible for Medi-Cal.

ICM/IOP provides multidisciplinary, structured services for up to 4 hours per day, up to 5 days per week. ICM/IOP is distinct from FSP in that it is generally office-based rather than community based and consumers engage at a lower level of intensity and lower frequency than they would in FSP. ICM/IOP services include:

- Counseling and therapy
- Case management services
- General rehabilitation
- Medication support

Goals and Objectives

Outcome 1:	Improve functioning and quality of life for consumers who are eligible for specialty mental health services that are not in FSP.
Outcome 2:	Reduce symptoms and impacts of mental illness for consumers who qualify for specialty mental health services.
Outcome 3:	Reduce the need for a higher level of care for consumers.

Number to be served FY 2017-18:	2,088	**Proposed Budget FY 2017-18:**	$1,656,220
Cost per Person FY 2017-18:	$793	**Total Proposed Budget FY 2017-20:**	$2,912,440

Access and Linkage				
Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☒Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Access and Linkage; CSS: Outreach and Engagement			

Program Description

Access and Linkage program (formerly the Access Review Teams) is a program provided by KCBH staff to review all referrals that come into Kings County Behavioral Health and provide screening and linkage to existing services. The purpose of Access and Linkage is to review and ensure linkage to treatment if individuals have been connected to services.

Access and Linkage operates the following services:

- **2-1-1** is a telephone resource that connects callers with a wide array of necessary health and human services resources, including, among other things, mental health treatment and crisis services, substance use treatment programs, transportation, and legal services.
- **Warm Line** is an extension of a service that exists in Tulare County. The Warm Line in Tulare County is a non-emergency, peer-run phone line for anyone seeking support. The Warm Line assists people who need to reach out when having a hard time and offers emotional support and information about mental health resources. They can also refer calls for more intensive services to other agencies in the county. The Warm Line is available 24 hours a day, seven days a week.

Goals and Objectives

Outcome 1:	Increase the number of referrals to existing services.
Outcome 2:	Connect community members to various social services.
Outcome 3:	Create support services to assist community members with various concerns.

Number to be served FY 2017-18:	30,000	**Proposed Budget FY 2017-18:**	$250,000
Cost per Person FY 2017-18:	$5	**Total Proposed Budget FY 2017-20:**	$750,000

Prevention & Early Intervention (PEI)

Senior Access for Engagement (SAFE)				
Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Access and Linkage to Treatment			

Program Description

Senior Access for Engagement (SAFE) reaches out to unserved/underserved populations to identify early symptoms of mental illness and provide appropriate services to prevent the development or progression of mental illness. SAFE serves isolated older adults ages 60 and older at risk of or beginning to experience mental health problems, such as depression, related to aging and isolation. SAFE also serves primary caregivers of older adults with mental illness. Caregivers accessing this service must not be paid for caregiving and must live in a non-licensed setting.

SAFE provides services and referrals to seniors/older adults in the home, at senior centers, nursing homes, assisted living facilities, and other events for older adults. SAFE providers promote psychosocial supports and identify possible signs and symptoms of mental illness and assist them into the appropriate referral for mental health treatment. Specific SAFE services include:

- Visitation to older adults in the home or community to provide social support
- Caregiver support group
- Linkages to Respite for Caregivers
- Referral and linkage to other community-based providers for other needed social services and primary care

SAFE was modified to incorporate the Respite for Caregivers program, which formerly collaborated closely with SAFE. Respite for Caregivers provides assistance and relief to caregivers including assistance in supervision and caregiving and engaging caregivers in activities and social supports to alleviate their stress and promote wellbeing. Services are intended to complement existing family structures to allow seniors to remain in the community as long as possible and avoid unnecessary nursing home and other out-of-home placements. The program also provides some assistance to primary caregivers on the supervision/caregiving of his/her family member

Goals and Objectives

Outcome 1:	Reduce out of home placements for seniors/older adults.
Outcome 2:	Increase service connectedness.
Outcome 3:	Increase socialization and reduce isolation among senior population.

Outcome 4:	Reduce caregiver stress.		
Number to be served FY 2017-18:	250	**Proposed Budget FY 2017-18:**	$222,290
Cost per Person FY 2017-18:	$889	**Total Proposed Budget FY 2017-20:**	$666,870

Prevention and Wellness

Status:	☐New	☒Continuing		☐Modified
Priority Population:	☒Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Prevention			

Program Description

Prevention and Wellness services provides and links consumers to high quality, culturally competent counseling and support group sessions to promote positive approaches to mental health and prevent serious mental health crises. Prevention and Wellness provides clinical services for those who are unlikely to receive services in a traditional environment, including veterans, tribal populations, and undocumented individuals.

Prevention and Wellness provides the following services and activities:

- Individual, group, and family counseling
- Individualized case management
- Referrals to outside agencies for both children and adult clients who may have access to services elsewhere
- Support groups for family members and Veterans

Goals and Objectives

Outcome 1:	Increase service connectedness to outside agencies.		
Outcome 2:	Increase linkages to mental health services for children, youth, adults, and older adults in Kings County.		
Number to be served FY 2017-18:	175	**Proposed Budget FY 2017-18:**	$180,070
Cost per Person FY 2017-18:	$1,029	**Total Proposed Budget FY 2017-20:**	$ 540,210

Community Wide: Outreach and Engagement Education/Training				
Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☒Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Outreach for increasing recognition of early signs of mental illness			

Program Description

Community-Wide Education works to improve the community's ability to recognize and respond to early signs and symptoms of mental illness. The focus of KCBH's community wide education and training strategies include keeping people healthy and getting people the treatment they need early on in the onset to prevent negative consequences that can occur if mental illness is undiagnosed and/or untreated.

Key activities include:

- **Mental Health First Aid (MHFA)** is "the help provided to a person developing a mental health problem or in a mental health crisis." Like traditional first aid, mental health first aid is given until appropriate professional treatment is received or until the crisis resolves."
- **Youth Mental Health First Aid (YMHFA)** is designed to teach youth, parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addiction challenge or is in crisis.
- **Applied Suicide Intervention Skills Training (ASIST)** workshop is a two-day, highly interactive, practice-oriented workshop for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide.
- **Another Kind of Valor** is a daylong training program that addresses how to better serve Veterans and their families. In these trainings, agencies and organizations learn the effects of war on returning veterans and their families, how to engage and work with veterans and their families, and what resources are available for veterans and their families.
- **Safe TALK** is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide.
- **Other Trainings** to support the community of Kings County.

Goals and Objectives

Outcome 1:	Increase community member's knowledge and capacity to recognize and respond to various mental health needs
Outcome 2:	Provide trainings that teach community members how to engage individuals who are experiencing suicide ideation
Outcome 3:	Develop workshops that provide strategies on how to better serve families and veterans

Number to be served FY 2017-18:	200	**Proposed Budget FY 2017-18:**	$150,000
Cost per Person FY 2017-18:	$750	**Total Proposed Budget FY 2017-20:**	$450,000

Community Wide Stigma and Discrimination Reduction

Status:	☐New	☐Continuing	☒Modified	
Priority Population:	☒Children Ages 0 – 17	☒Transitional Age Youth Ages 16 – 24	☒Adult Ages 24 – 59	☒Older Adult Ages 60+
Service Category:	PEI: Stigma and Discrimination Reduction			

Program Description

Kings County utilizes a number of efforts to reduce stigma, increase cultural competency, and increase service connectedness. These efforts include:

- **Media/Social Media:** Use of social marketing websites to share information and educate the public about mental illness.
- **Coordination of a speakers' bureau** that conducts presentations about various issues pertaining to mental illness and stigma.
- **The Kings County Cultural Competency Task Force (CCTF)** includes mental health and substance use disorder providers as well as other local providers from education, faith based entities, businesses, and consumers. The Task Force is made up of community members and partnering agency staff and work on completion of the required State Cultural Competency Plans, annual updates to that plan, setting the training agenda for the year, assisting other providers with their cultural competency plans, practices, and promoting culturally appropriate services throughout Kings County. This effort is accomplished through identification of some of our community provider training needs, recommending trainings, working on anti-stigma and stigma reduction, focusing on underserved populations in Kings County (i.e. LGBTQ Youth, Latinos, Veterans, seniors, Native Americans, ex-offenders, and those living with a mental illness) and promotion of CLAS standards.
- **Cultural Ambassador Program** is a program designed based upon the Promotores Model which uses community-based, peer mental health workers to deliver mental health information to their communities. They serve as connectors between mental health care consumers and providers to promote mental health among traditionally underserved populations.

Goals and Objectives

Outcome 1:	Increase the prevalence of social media to share information and reduce stigma on mental health.
Outcome 2:	Increase knowledge and awareness of mental health and mental health services.
Outcome 3:	Reduce stigma regarding mental health.

Outcome 4:	Increase cultural competency.		
Outcome 5:	Increase access to mental health services for Latino community.		
Number to be served FY 2017-18:	35,000	**Proposed Budget FY 2017-18:**	$12,000
Cost per Person FY 2017-18:	$1	**Total Proposed Budget FY 2017-20:**	$72,000

Suicide Prevention

Status:	☐New	☐Continuing	☐Modified	
Priority Population:	☐Children Ages 0 – 17	☐Transitional Age Youth Ages 16 – 24	☐Adult Ages 24 – 59	☐Older Adult Ages 60+
Service Category:	PEI: Suicide Prevention			

Program Description

Suicide Prevention activities promotes public awareness of prevention issues, improves and expands suicide reporting systems, and promotes effective clinical and professional practices.

Key Services/Activities of suicide prevention include:

- **Reduction and Elimination of Stigma Through Art Targeted Education (RESTATE)** is a stigma and discrimination reduction program designed to educate local high school students about mental health issues through a curriculum that uses media arts to promote awareness and understanding of mental health.
- **The Depression Reduction Achieving Wellness (DRAW)** program is a campus-linked project that addresses the first onset of a psychiatric illness in students through collaboration with an institution of higher education. DRAW provides students with education regarding both the cultivation of wellness approaches and the identification of signs and symptoms of mental illness, short-term low-intensity intervention services, referrals to community-based agencies for more extended or intensive services when needed, and training for college staff on the signs and symptoms of depression.
- **Local Outreach to Suicide Survivors (LOSS)** is a program that dispatches support teams to the location of a suicide to provide resources, support, and hope to friends and family members of the suicide victim.
- **Central Valley Suicide Hotline** is an existing hotline that support individuals experiencing suicide ideation. KCBH will participate in providing this service for Kings County residents.

Goals and Objectives

Outcome 1:	Increase knowledge among high school students around mental health and suicide prevention.
Outcome 2:	Increase service linkages to mental health services for residents at risk of suicide
Outcome 3:	Connect friends and family member of suicide victims to resources and support services

Number to be served FY 2017-18:	1,200	**Proposed Budget FY 2017-18:**	$208,840
Cost per Person FY 2017-18:	$522	**Total Proposed Budget FY 2017-20:**	$626,520

Capital Facilities and Technological Needs (CFTN)

General Feasibility Study for Acquisition Planning

Status:	☒New	☐Continuing

Program Description

Kings County has allocated funding to CFTN to conduct a general feasibility study for acquisition planning. This program intends to assess preexisting infrastructure to determine which facilities can be utilized to create additional space for mental health services. KCBH is leading the stakeholder process and may include the Public Guardian and Veterans Services, Commission on Aging, Health Department, Human Services and other partners, as needed, to develop ideas for how to best utilize potential space for mental health services.

One facility in development is the Avenal One-Stop, which will promote engagement of historically unserved communities into mental health services. Services will be open to the community, including unserved Kings County residents with serious mental illness and children with serious emotional disturbances. The Avenal One-Stop facility will provide integrated and comprehensive services and supports, including:

- Linkages to other County agencies for services such as Medi-Cal enrollment, Cal Fresh, etc.
- Linkages to assistance with housing resources
- Referrals to substance use treatment for individual with co-occurring disorders
- Support groups

KCBH has identified possible locations and is working closely in collaboration with the County Public Health and Human Services Department.

Budget

Proposed Budget FY 2017-18:	$693,398	**Total Proposed Budget FY 2018-19:**	$418,680

Electronic Health Records Implementation & Maintenance

Status:	☐New	☒Continuing

Program Description

KCBH introduced Anasazi to improve the quality of services through its fully functional Electronic Health Record (EHR). The EHR system increases efficiencies in reporting, billing, and

retrieving and storing personal health information. Kings County would also like to pursue software add-ons or enhancements that will integrate outcomes measurement of programs and services with billing reconciliation functions. In order to fulfill that effort, Kings County will look into acquiring billing software. A fully functioning EHR allows for greater integration as well as smoother access to health information for treatment staff, as well as to pave the consumer's path to accessing personal health records. Any acquired property using MHSA Technological Needs funds will be owned and operated by Kings County and will only be used for benefit of Kings County clients.

Proposed Activities for FY 2017-2020

Moving forward with this Three Year Plan, KCBH will utilize Technological Needs funding to:

- Provide ongoing support and maintenance of Anasazi
- Continued acquisition of computers, laptops, smart boards, and other equipment as needed
- Continued acquisition of information or communication services/devices to support current programs use of the Anasazi system
- Acquisition and ongoing support and maintenance of new software add-ons or enhancements that measure outcomes of program and service participation, with a focus on PEI
- Acquisition and ongoing support of new software add-ons or enhancements to conduct full billing reconciliation

Goals and Objectives

Proposed Budget FY 2017-18:	$50,000	**Total Proposed Budget FY 2018-19:**	$100,000

MHSA Innovation Program Plan

The Multiple-Organization Shared Telepsychiatry (MOST) Project

Statement of Need

Kings County is a rural county with a population of nearly 150,000. Our county has a challenging combination of a high poverty rate and a high rate of serious mental illness. Nineteen percent (19%) of residents live in poverty and 38% are Medi-Cal eligible. The rate of adult serious mental illness is the second-highest in California, at 6.9%, and the rate for children is even higher, at 8.0%. The rates of serious mental illness among adults and children in households with incomes below 200% of the poverty level are higher, at 7.9% and 8.9%, respectively. In addition, despite having one of the highest rates of serious mental illness, Kings County, like other rural California counties, has few psychiatrists. There are only two psychiatrists working in our county who serve people eligible for Medi-Cal, offering just 68 hours of service per week to adults and children in a combination of in-person and telepsychiatric care.[23] These psychiatrists work for a single mental health service provider and in our county the average wait time to see a psychiatrist for an initial appointment is 25.6 business days. These challenges are exacerbated in the more remote areas of Kings County, such as the community of Avenal, which is a 37-mile drive or a day-long round-trip bus ride from where psychiatric services are available, in Hanford. This dearth of psychiatric services and their being supplied by a single provider pose an ongoing structural challenge to offering mental health services to all residents in a county with an especially high need for them. We have found that this lack of psychiatric services has led to many people with serious mental illness having to be served in hospital emergency departments or going to jail as a result of their mental illness. A well-known solution to the scarcity of psychiatric services in areas with too few psychiatrists, which has been used in our county and in many other California counties, is telepsychiatry: secure two-way audiovisual communication between a psychiatrist in

[23] There are other psychiatrists in our county who work with specific populations, including Naval Air Station Lemoore base personnel and their families, individuals housed in the jail and juvenile hall, and inmates at three state prisons.

a distant location and a local client in a designated private room, supported by additional staff on site. Research shows it to be highly effective.

Our Project and What Is Innovative About It

1. **We propose not simply to offer telepsychiatry, but to establish a program to enable mental health service providers and county departments to offer telepsychiatry services to their clients in *suites that are used by multiple organizations and are centrally managed and staffed*.**

If not for this project, these organizations would not be able to offer telepsychiatry until years from now, if at all. Moreover, our research shows no indication that this has ever been done before in any California county or elsewhere.

This project will establish telepsychiatry suites in three cities, to be managed by Kings County Behavioral Health. Local organizations will be able to request telepsychiatric services for their clients, and we will schedule their appointments. Kings County Behavioral Health will provide on-site staff support for the telepsychiatrists.

The key benefits to the public are the abilities to see a psychiatrist sooner and to increase their frequency of contact with a psychiatrist, thereby fostering their mental health.

2. **We will include a strong peer support component.**

Paid, trained peer support specialists will be co-located with the telepsychiatry suites. They will provide the patients with transportation, if needed. They will also give the patients other assistance, including new-patient orientations, emotional support, connection to support groups and other resources, and help with navigating the system and advocating for themselves.

A benefit of this project is that it is simple and highly replicable for other California counties.

Details

This project will serve both adults and children. We will begin by opening one suite with two adjacent telepsychiatry rooms at the Kings County Behavioral Health headquarters in the city of Hanford. We anticipate that these suites will operate with two contracted telepsychiatrists, five days a week, for 40 hours a week total – 20 hours for adults and 20 hours for children – with separate days for adults and children. We plan to begin by offering fewer service hours – 10 hours

for adults and 10 hours for children per week – and increase the number of service hours, as needed, to meet demand.

The telepsychiatry suites will have adjoining waiting rooms and separate "quiet rooms" for clients who may be agitated. At each site, there will be a psychiatric technician room where this staff member can communicate directly and confidentially with the psychiatrists in real time. There will be locked rooms for patient records and medication. The medication rooms will have refrigerators for medications that require refrigeration.

In the second phase of the program we will open a telepsychiatry suite in the city of Avenal and in the third phase we will open one in the city of Corcoran. We anticipate that these suites will each operate two days a week to start, one day for adults and one day for children. We will increase the number of service hours, as needed, to meet demand.

Apart from the contracted psychiatrists, staff will include a psychiatric technician (to take vital statistics and send prescriptions to pharmacies), a peer support specialist, and an office assistant at each site. The office assistant will be responsible for scheduling and following up with patients.

The mental health service providers who will utilize the telepsychiatry suites use the same electronic health records system as Kings County Behavioral Health does. It includes a medication tab that enables prescriptions to be sent electronically to pharmacies.

Before appointments with the psychiatrists can be scheduled, the clients must first be evaluated by a licensed clinician. The local mental health service providers can perform this service and, if need be, so can Kings County Behavioral Health.

The clients of the following organizations will receive care in the telepsychiatry suites:

- Aspiranet: Offers Full-Service Partnership (FSP) / Wraparound services for children, located in a building next to the one that will house Kings County Behavioral Health's Hanford telepsychiatry suite.
- Kings County Assertive Community Assessment Team (ACT): In development and soon to be offered by a mental health service provider to be determined, it will provide intensive daily engagement using a team approach and an array of integrated services to meet clients' needs.
- Kings County Public Health Department: A health clinic, located a half-mile from the Hanford telepsychiatry suite building, can send people in mental health crisis to our telepsychiatry suite for care, e.g., women suffering from perinatal mood and anxiety disorder. This Department has additional clinics in Avenal, Corcoran, Kettleman City, and Lemoore, which will also be able to send patients to our telepsychiatry suites.

- Kings County Sheriff's Department / Naphcare: A re-entry program will use telepsychiatry to facilitate the continued psychiatric medication of participating adults and youth during and after their re-entry process.
- Kings View Counseling Services: Offers limited telepsychiatry services, but more are needed, including for crisis response. The crisis response role of these services will benefit our continuum of care, especially in rural areas where access to care is very limited.

We are in the process of applying for Medi-Cal certification. This will provide our path to sustainability.

To ensure cultural responsiveness, we will seek out bilingual, bicultural psychiatrists, psychiatric technicians, office assistants, and peer support specialists to work in the telepsychiatry suites. This is essential, as 36% of Kings County residents speak Spanish at home and 42% of these individuals indicate that they speak English "less than very well."

Kings County Behavioral Health provides mental health services to the unserved and underserved populations of Native Americans and veterans who are unable to be served by other programs. Our county has significant populations of both groups. We will offer them telepsychiatry services.

Learning and Evaluation

This project will deepen shared understanding by measuring the extent to which it achieves the following outcomes:

1. Decreasing wait times to see psychiatrists for initial and follow-up appointments.
2. Increasing patient frequency of contact with psychiatrists.
3. Lowering the number of mental illness crisis hospitalizations.
4. Reducing the number of individuals seen by hospital emergency departments for mental illness.
5. Decreasing the number of individuals with mental illness who enter jail.
6. Having a lower rate of no-shows to telepsychiatric appointments, compared to a similar California county, as a result of this project's strong peer support component.

Our proposal will include a robust evaluation plan to measure whether and to what degree these outcomes are achieved. It will include process and outcome measures, both quantitative and qualitative.

Cost Estimate

The projected budget for MOST is $1,000,000 in FY18/19 and $325,544 in FY19/20.

MHSA Three-Year Expenditure Plan

The documents enclosed in the following section are submitted in compliance with the Mental Health Services Oversight and Accountability Commission's (MHSOAC) *FY 14-15 Through FY 16-17 MHSA Three-Year Program and Expenditure Plan Submittals* (www.mhsoac.ca.gov) instructions for documenting the expenditure of the proposed MHSA programs.[24]

[24] Kings County has expended its WET allocation. WET initiatives will not be included in this Three-Year Plan.

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: KINGS Date: 12/6/17

	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 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	5,770,959	499,794	1,430,150		1,112,078	
2. Estimated New FY2017/18 Funding	6,038,465	1,509,616	377,404			
3. Transfer in FY2017/18[a/]	0					
4. Access Local Prudent Reserve in FY2017/18						0
5. Estimated Available Funding for FY2017/18	11,809,424	2,009,410	1,807,554	0	1,112,078	
B. Estimated FY2017/18 MHSA Expenditures	6,534,840	1,574,990	200,000	0	693,398	
C. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	5,274,584	434,420	1,607,554	0	418,680	
2. Estimated New FY2018/19 Funding	6,160,000	1,540,000				
3. Transfer in FY2018/19[a/]	0					
4. Access Local Prudent Reserve in FY2018/19						0
5. Estimated Available Funding for FY2018/19	11,434,584	1,974,420	1,607,554	0	418,680	
D. Estimated FY2018/19 Expenditures	7,626,380	1,346,390	1,250,000	0	393,680	
E. Estimated FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	3,808,204	628,030	357,554	0	25,000	
2. Estimated New FY2019/20 Funding	6,160,000	1,540,000				
3. Transfer in FY2019/20[a/]	0					

4. Access Local Prudent Reserve in FY2019/20						0
5. Estimated Available Funding for FY2019/20	9,968,204	2,168,030	357,554	0	25,000	
F. Estimated FY2019/20 Expenditures	7,614,220	1,346,390	357,554	0	25,000	
G. Estimated FY2019/20 Unspent Fund Balance	2,353,984	821,640	0	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	2,138,118
2. Contributions to the Local Prudent Reserve in FY 2017/18	0
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	2,138,118
5. Contributions to the Local Prudent Reserve in FY 2018/19	0
6. Distributions from the Local Prudent Reserve in FY 2018/19	0
7. Estimated Local Prudent Reserve Balance on June 30, 2019	2,138,118
8. Contributions to the Local Prudent Reserve in FY 2019/20	0
9. Distributions from the Local Prudent Reserve in FY 2019/20	0
10. Estimated Local Prudent Reserve Balance on June 30, 2020	2,138,118
11. Estimated Local Prudent Reserve Balance on June 30, 2020	

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 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: KINGS Date: 11/30/17

	Fiscal Year 2017/18					
	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. FSP-WRAPAROUND CHILDREN/TAY	840,140	840,140				
2. CHILDREN SERVICES	700,000	300,000		100,000	300,000	
3. ADULTS	900,000	500,000		100,000	300,000	
4. OLDER ADULTS	42,450	42,450				
Non-FSP Programs						
1. GSD-SUMMER DAY CAMP	33,320	33,320				
2. GSD-PARENT CHILD INTERACTION THERAPY (PCIT)	50,000	50,000				
3. GSD-CJTC	607,800	312,160				295,640
4. GSD-INTENSIVE CASE MGMT/INT OUTPT TX	1,656,220	1,656,220				
5. GSD-MHS for DOMESTIC VIOLENCE (Barbara Seville)	143,150	143,150				
6. O&E KARELINK	803,200	603,200				200,000
CSS Administration	1,938,000	1,938,000				
CSS MHSA Housing Program Assigned Funds	116,200	116,200				
Total CSS Program Estimated Expenditures	7,830,480	6,534,840	0	200,000	600,000	495,640
FSP Programs as Percent of Total	0.0%					

	Fiscal Year 2018/19					
	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. FSP-WRAPAROUND CHILDREN/TAY	1,600,000	1,000,000	600000			
2. CHILDREN SERVICES	800,000	300,000		100,000	400,000	
3. ADULTS	1,000,000	500,000		100,000	400,000	
4. OLDER ADULTS	42,450	42,450				
5. FSP-ASSERTIVE COMM TREATMENT-ACT	1,300,000	1,000,000	300,000			
Non-FSP Programs						
1. GSD-PARENT CHILD INTERACTION THERAPY (PCIT)	50,000	50,000				
2. GSD-CJTC	312,160	312,160				
3. GSD-INTENSIVE CASE MGMT/INT OUTPT TX	1,456,220	1,456,220				
4. GSD-MHS for DOMESTIC VIOLENCE (Barbara Seville)	143,150	143,150				
5. O&E KARELINK	1,606,400	806,400				800,000
CSS Administration	1,900,000	1,900,000				
CSS MHSA Housing Program Assigned Funds	116,000	116,000				
Total CSS Program Estimated Expenditures	10,326,380	7,626,380	900,000	200,000	800,000	800,000
FSP Programs as Percent of Total	62.2%					

	Fiscal Year 2019/20					
	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. FSP-WRAPAROUND CHILDREN/TAY	1,600,000	1,000,000	600000			
2. CHILDREN SERVICES	800,000	300,000		100,000	400,000	
3. ADULTS	1,000,000	500,000		100,000	400,000	

4. OLDER ADULTS	42,450	42,450				
5. FSP-ASSERTIVE COMM TREATMENT-ACT	1,500,000	1,000,000	500,000			
Non-FSP Programs						
1. GSD-PARENT CHILD INTERACTION THERAPY (PCIT)	50,000	50,000				
2. GSD-CJTC	300,000	300,000				
3. GSD-INTENSIVE CASE MGMT/INT OUTPT TX	1,456,220	1,456,220				
4. GSD-MHS for DOMESTIC VIOLENCE (Barbara Seville)	143,150	143,150				
5. O&E KARELINK	1,606,400	806,400				800,000
CSS Administration	1,900,000	1,900,000				
CSS MHSA Housing Program Assigned Funds	116,000	116,000				
Total CSS Program Estimated Expenditures	10,514,220	7,614,220	1,100,000	200,000	800,000	800,000
FSP Programs as Percent of Total	64.9%					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: KINGS Date: 11/30/17

	Fiscal Year 2017/18					
	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. SCHOOL BASED SERVICES	230,740	230,740				
2. TAG FOR TAY - TIER 1	73,530	73,530				
3. TRUANCY INTERVENTION PREV/LIFE STEP (TIPP)	66,000	66,000				
4. RESPITE FOR CAREGIVERS	81,520	81,520				
5. PREVENTION & WELLNESS	180,070	180,070				
PEI Programs - Early Intervention						
6 EARLY INTERVENTION CLINICAL SVCS	0	0				
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
7. COMMUNITY WIDE O&E OR TRAINING	150,000	150,000				
PEI Programs - Stigma and Discrimination Reduction						
8. COMMUNITY WIDE STIGMA/DISCRIM RED	12,000	12,000				
PEI Programs - Access and Linkage to Treatment						
9. SENIOR ACCESS FOR ENGAGEMENT (SAFE)	222,290	222,290				
10. ACCESS LINKAGE	250,000	250,000				
PEI Programs - Suicide Prevention						
11. SUICIDE PREVENTION	208,840	208,840				
PEI Programs - Improve Timely Access to Services for Underserved Populations						

	0					
PEI Administration	500,000	200,000		300,000		
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,874,990	1,574,990	0	300,000	0	0

	Fiscal Year 2018/19					
	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. SCHOOL BASED SERVICES	230,740	230,740				
2. TRUANCY INTERVENTION PREV/LIFE STEP (TIPP)	66,000	66000				
3. RESPITE FOR CAREGIVERS	81,520	81,520				
4. PREVENTION & WELLNESS	180,070	180,070				
PEI Programs - Early Intervention						
5. EARLY INTERVENTION CLINICAL SVCS	25,000	25,000				
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
6. COMMUNITY WIDE O&E OR TRAINING	150,000	150,000				
PEI Programs - Stigma and Discrimination Reduction						
7. COMMUNITY WIDE STIGMA/DISCRIM RED	12,000	30,000				
PEI Programs - Access and Linkage to Treatment						
8. SENIOR ACCESS FOR ENGAGEMENT (SAFE)	222,290	222,290				
9. ACCESS LINKAGE	250,000	250,000				
PEI Programs - Suicide Prevention						
10. SUICIDE PREVENTION	208,840	208,840				
PEI Programs - Improve Timely Access to Services for Underserved Populations	0					

PEI Administration	500,000	200,000		300,000		
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,826,460	1,526,460	0	300,000	0	0

	Fiscal Year 2019/20					
	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. SCHOOL BASED SERVICES	230,740	230,740				
3. TRUANCY INTERVENTION PREV/LIFE STEP (TIPP)	66,000	66000				
3. RESPITE FOR CAREGIVERS	81,520	81,520				
4. PREVENTION & WELLNESS	180,070	180,070				
PEI Programs - Early Intervention						
5. EARLY INTERVENTION CLINICAL SVCS	25,000	25,000				
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
6. COMMUNITY WIDE O&E OR TRAINING	150,000	150,000				
PEI Programs - Stigma and Discrimination Reduction						
7. COMMUNITY WIDE STIGMA/DISCRIM RED	12,000	30,000				
PEI Programs - Access and Linkage to Treatment						
8. SENIOR ACCESS FOR ENGAGEMENT (SAFE)	222,290	222,290				
9. ACCESS LINKAGE	250,000	250,000				
PEI Programs - Suicide Prevention						
10. SUICIDE PREVENTION	208,840	208,840				
PEI Programs - Improve Timely Access to Services for Underserved Populations	0					
PEI Administration	500,000	200,000		300,000		
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,826,460	1,526,460	0	300,000	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: KINGS Date: 11/30/17

	Fiscal Year 2017/18					
	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. YOUTH LED RESILIENCY/INN EVALUATIONS	200,000	200,000				
INN Administration	0					
Total INN Program Estimated Expenditures	200,000	200,000	0	0	0	0

	Fiscal Year 2018/19					
	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. YOUTH LED RESILIENCY/INN EVALUATIONS	200,000	200,000				
2. TELESITE	1,000,000	1,000,000				
INN Administration	50,000					
Total INN Program Estimated Expenditures	1,250,000	1,200,000	0	0	0	0

	Fiscal Year 2019/20					
	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. TELESITE	325,544	325,544				
INN Administration	50,000					
Total INN Program Estimated Expenditures	375,544	325,544	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: KINGS Date: 11/30/17

	Fiscal Year 2017/18					
	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. Capital Facilities	643,398	643,398				
CFTN Programs - Technological Needs Projects						
1. EHR Record Implementation & Maintenance	50,000	50,000				
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	693,398	693,398	0	0	0	0

	Fiscal Year 2018/19					
	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. Capital Facilities	368,680	368,680				
CFTN Programs - Technological Needs Projects						
1. EHR Record Implementation & Maintenance	25,000	25,000				
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	393,680	393,680	0	0	0	0

	Fiscal Year 2019/20					
	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. Capital Facilities	0	0				
CFTN Programs - Technological Needs Projects						
11. EHR Record Implementation & Maintenance	25,000	25,000				
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	25,000	25,000	0	0	0	0

Appendices

Appendix A. Key Informant Interview Subjects

County Staff

Kings County Public Health, Deputy Director

Kings County Sherriff's Department/Hanford Police, School Resource Officer

Public Guardian & Veterans Services Office, department head and staff

Kings County Public Guardian and Veterans Service Officer

Deputy Veterans' Service Officer/Public Guardian

Hanford Elementary School District, Assistant Superintendent, Special Services

Reef-Sunset Unified School District, Director of Student Services

Kings County Human Services, Assistant Director

Kings County Board of Supervisors, Supervisor

Community Providers and Stakeholders

Santa Rosa Tribal Social Services/Tachi Yokut, Director of the Social Services Department

Champion's Recovery Alternative Programs, Inc., Executive Director

Kings Community Action Organization, Executive Director

Kings View, Program Manager, Children's System of Care

Kings View Counseling Services, Program Manager of Adult Services

Owens Valley Career Development Center, Case Counselor, Hanford Office

Consumers' family members

Appendix B. Community Meeting Materials

Community Meeting Flyers

KINGS COUNTY behavioral health

Mary Anne Ford Sherman | Director of Behavioral Health | (559) 852-2382

Mental Health • Prevention and Early Intervention• Substance Use Disorders Prevention and Treatment

Kings County Behavioral Health (KCBH) invites you to provide your feedback:

Upcoming Community Meetings

Mental Health Services Act (MHSA)
Three-Year Program & Expenditure Plan

We will present the findings from Kings County's MHSA plan for 2014 – 2017; gather information about community strengths and needs; and discuss the plan for Kings County's MHSA Three-Year Program & Expenditure plan for 2017 – 2020. Please consider attending any of these meetings:

Behavioral Health Advisory Board (BHAB) May 22, 2017	Avenal Community Meeting May 22, 2017	Corcoran Community Meeting May 23, 2017
12:00 pm- 1:30 pm Hanford	6:00 pm- 7:30 pm Avenal	6:00 pm- 7:30 pm Corcoran
Kings County Behavioral Health 460 Kings County Drive, Suite 101 Hope Room	**Avenal Elementary School** 400 S. 1st Ave	**Technology Learning Center** 1101 Dairy Ave

Please join us!

Community Meetings are open to the public. We look forward to hearing your input on the programs and strategies for the MHSA Three-Year Program & Expenditure plan. Food will be provided.

RDA

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

Integrity • Mindfulness
Trustworthy
Respect • Innovation

460 Kings County Dr., Suite 101 • Hanford CA 93230 • (559) 852-2444 • Fax (559) 589-6916

kcbh.org

KINGS COUNTY behavioral health

Mary Anne Ford Sherman | Director of Behavioral Health | (559) 852-2382

Mental Health • Prevention and Early Intervention• Substance Use Disorders Prevention and Treatment

El departamento de Salud Mental del Condado de Kings les invita a proveer su opinión:

En nuestra próxima reunión comunitaria

El Plan de programas y gastos para los tres años de la ley de Servicios de Salud Mental (MHSA)

Vamos a presentar los resultados de la ley de servicios de salud mental del plan 2014- 2017; Reunir información sobre las fortalezas y necesidades de nuestra comunidad; discutir el plan para el programa y gastos de la ley de servicios de salud mental para el 2017- 2020. Por favor de considerar en atender cualquiera de nuestras juntas:

Behavioral Health Advisory Board (BHAB) May 22, 2017	Reunión de la comunidad de Avenal May 22, 2017	Reunión de la comunidad de Corcoran May 23, 2017
12:00 pm- 1:30 pm **Hanford**	**6:00 pm- 7:30 pm** **Avenal**	**6:00 pm- 7:30 pm** **Corcoran**
Kings County Behavioral 460 Kings County Drive, Suite 101 Hope Room	**Avenal Elementary School** 400 S. 1st Ave	**Technology Learning Center** 1101 Dairy Ave

¡Por favor, acompáñenos!

Las reuniones de la comunidad son para el público. Queremos escuchar su opinión sobre nuestros programas y estrategias para el plan y gastos de tres años de la Ley de Servicios de Salud Mental. Se les proporcionará comida.

RDA

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

Integrity • Mindfulness
Trustworthy
Respect • Innovation

460 Kings County Dr., Suite 101 • Hanford CA 93230 • (559) 852-2444• Fax (559) 589-6916

kcbh.org

Community Meeting Demographic Forms

MHSA Community Planning Process Focus Groups
Participant Information

1. Do you identify yourself as a consumer or a family member of a consumer of mental health services?
   - ☐No
   - ☐Consumer
   - ☐Family Member
   - ☐Both

2. Do you identify as a service provider?
   - ☐No
   - ☐Yes

3. What is your stakeholder affiliation?
   - ☐County government agency
   - ☐City Government Agency
   - ☐State Government Agency
   - ☐Community-based organization
   - ☐Law Enforcement
   - ☐Education agency
   - ☐Social service agency
   - ☐Veterans or Veterans Organizations
   - ☐Provider of mental health services
   - ☐Provider of alcohol and other drug services
   - ☐Medical or health care organization
   - ☐ Tachi-Yokut Community Representative
   - ☐Other:_____

4. Please indicate your age range:
   - ☐Under 16
   - ☐16-24
   - ☐25-59
   - ☐60 and older

5. Please indicate your gender:
   - ☐Female
   - ☐Male
   - ☐Transmale/transman
   - ☐Transfemale/transwoman
   - ☐Intersex
   - ☐Genderqueer
   - ☐Prefer not to answer
   - ☐Other: _____

6. What is your race/ethnicity?
   - ☐White/Caucasian
   - ☐African American/Black
   - ☐Hispanic /Latino
   - ☐Asian or Pacific Islander
   - ☐American Indian/Native Alaskan
   - ☐Multi-Race
   - ☐Other: _____

7. In which part of Kings County do you live?
   - ☐ Armona
   - ☐ Avenal
   - ☐ Corcoran
   - ☐ Hanford Southside
   - ☐ Home Garden Old/New
   - ☐ Island District
   - ☐ Halls Corner
   - ☐ Hanford
   - ☐ Hardwick
   - ☐ Kettleman City
   - ☐ Kingsburg
   - ☐ Lakeside
   - ☐ Laton
   - ☐ Lemoore
   - ☐ NAS Lemoore
   - ☐ Riverdale
   - ☐ Santa Rosa Rancheria
   - ☐ Stratford
   - ☐Other:_____

8. Is English your preferred language?
   ☐Yes ☐No

   If you answered "no," what is your preferred language?_____

Proceso de planificación de programas comunitarios de MHSA

Información de participantes para grupos de discusión

9. ¿Se identifica a sí mismo como un consumidor o un miembro de la familia de un consumidor de servicios de salud mental?
   - ☐No
   - ☐Consumidor
   - ☐Miembro de la familia
   - ☐Consumidor y miembro de la familia

10. ¿Te identificas como un proveedor de servicios?
    ☐No ☐Sí

11. ¿Cuál es su afiliación?
    - ☐Agencia gubernamental del condado
    - ☐Agencia gubernamental de la ciudad
    - ☐ Agencia gubernamental del estado
    - ☐ Organización basada en la comunidad
    - ☐ La policía
    - ☐ Agencia de educación
    - ☐ Agencia de servicios sociales
    - ☐ Organización de veteranos
    - ☐ Proveedor de servicios de salud mental
    - ☐ Proveedor de servicios de alcohol y drogas
    - ☐ Organización médica o de la atención de salud
    - ☐ Tachi-Yokut representante de la comunidad
    - ☐ Otra organización:_____

12. Por favor, indique su rango de edad:
    - ☐Menos de 16 años
    - ☐16-24 años
    - ☐25-59 años
    - ☐60 o más mayor

13. Por favor, indique su género:
    - ☐ Femenino
    - ☐ Masculino
    - ☐Transmasculino/ hombre transgénero
    - ☐Transfemenino/ mujer transgénero
    - ☐ "Intersex"
    - ☐ "Genderqueer"
    - ☐Prefiero no especificar
    - ☐Otro género:_____

14. ¿Cuál es su raza/origen étnico? (marque todas que correspondan)
    - ☐ Blanco/Caucásico
    - ☐ Afro Americano/Negro
    - ☐ Hispano/Latino
    - ☒ Asiático o Isleño del Pacífico
    - ☐ Indio Americano/Nativo de Alaska
    - ☐ Multi-racial
    - ☐ Otra raza/origen étnico:
      _____

15. ¿En qué parte del condado de Kings vives?
    - ☐ Armona
    - ☐ Avenal
    - ☐ Corcoran
    - ☐ Hanford Southside
    - ☐ Home Garden Old/New
    - ☐ Island District
    - ☐ Halls Corner
    - ☐ Hanford
    - ☐ Hardwick
    - ☐ Kettleman City
    - ☐ Kingsburg
    - ☐ Lakeside
    - ☐ Laton
    - ☐ Lemoore
    - ☐ NAS Lemoore
    - ☐ Riverdale
    - ☐ Santa Rosa Rancheria
    - ☐ Stratford
    - ☐Otro lugar:_____

16. ¿Es ingles su idioma preferido?
    ☐ Sí ☐No
    Si respondió no, ¿cuál es tu idioma preferido?
    _____

Community Meeting Feedback Forms

Thank you for your involvement in the Community Program Planning (CPP) Process for Kings County's Mental Health Services Act *Three-Year Program & Expenditure Plan*. We would like to hear about your experience with the CPP process. Your feedback will help us understand what we did well and what we can improve upon in the future. Please help us by taking a few minutes to fill out this anonymous feedback form.

Based on your experience with the MHSA Community Program Planning Process, please check how much you agree with the following statements.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The needs assessment accurately captures the mental health needs in Kings County.				
2. The needs assessment data and proposed programs reflect my opinions/ideas about how to improve mental health services.				
3. The proposed programs will strengthen mental health services in Kings County.				
4. The proposed programs are in alignment with MHSA values.				
5. The community planning process is in alignment with MHSA values.				

	Poor	Fair	Good	Excellent
6. Overall, how would you rate the quality of facilitation throughout this planning process?				

7. Please share any comments you have about the proposed programs or the community program planning process:

Thank you!

Tarjeta de comentario tarjeta anónima sobre la planificación de los programas y la ley de servicios de salud mental (MHSA)

Gracias por su participación en el proceso de planificación de los programas y la ley de servicios de salud mental (MHSA) de Kings County. Nos gustaría saber mas de su experiencia con el proceso de planificación. Sus comentarios nos ayudarán a entender lo que hicimos bien y lo que podemos mejorar en el futuro. Por favor tómese unos minutos para completar este tarjeta de comentario anónima.

Basado en su experiencia con el proceso de planificación del programa comunitario MHSA, por favor marque como se sienta acuerda de las siguientes afirmaciones.

	Muy en desacuerdo	En desacuerdo	De acuerdo	Muy de acuerdo
8. La evaluación de necesidades refleja con precisión las necesidades de salud mental en Kings County.				
9. Los programas y servicios propuestos refleja mis opiniones e ideas acerca de cómo mejorar los servicios de salud mental.				
10. Los programas y servicios propuestos fortalecerán los servicios de salud mental en Kings County.				
11. El plan propuesto está alineado con los valores de la MHSA.				
12. El proceso de planificación de los programas de la comunidad está alieneado con los valores de la MHSA.				

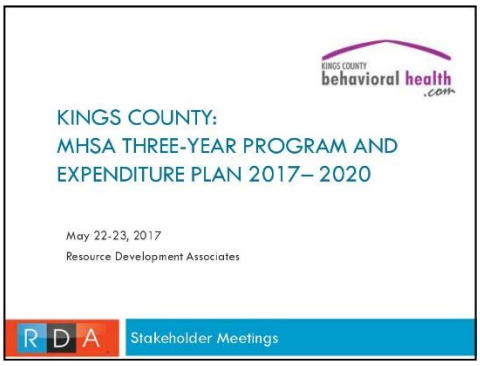
	Malo	Pasable	Bueno	Excelente
13. En general, ¿cómo calificaría la calidad de la facilitación a través de este proceso de planificación?				

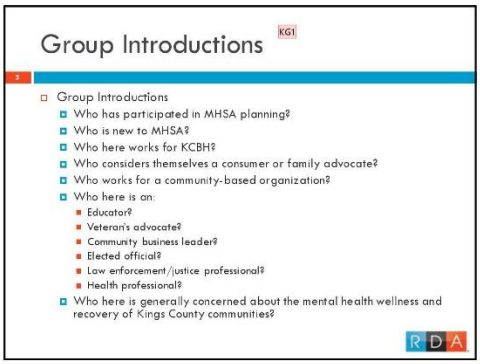
14. Por favor comparta cualquier comentario que tenga acerca de los programas y servicios propuestos o sobre el proceso de planificación de la comunidad:

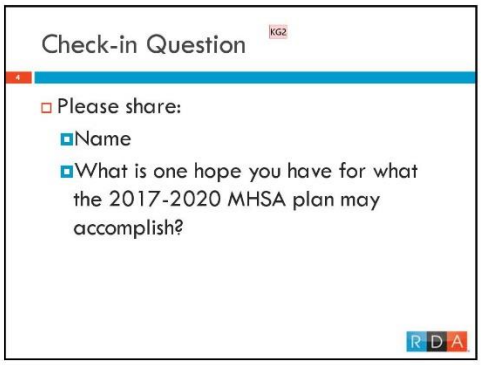
Gracias!

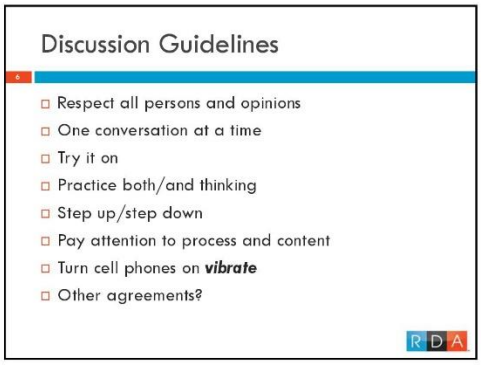
Community Meeting Presentation

12/20/2017









7

Overview of MHSA and Community Planning Process

MHSA Overview

8

HISTORY

Mental Health Services Act (Proposition 63) passed November 2, 2004

FUNDING SOURCE

1% income tax on income over $1 million

PURPOSE

To ***expand and transform*** mental health services in California

MHSA Components

9

- **CSS: Community Services & Supports**
  - Outreach and direct services for children, TAY, adults and older adults with the most serious mental health needs
- **PEI: Prevention & Early Intervention**
  - Prevention services to promote wellness and prevent the development of mental health problems
  - Early intervention services to screen and intervene with early signs of mental health
- **CFTN: Capital Facilities & Technology Needs**
  - Infrastructure development to support the implementation of an electronic health record and appropriate facilities for mental health services.
- **WET: Workforce Education & Training**
  - Support to build, retain, and train a competent public mental health workforce
- **INN: Innovation**
  - Funding to test new approaches that may improve access, collaboration, and/or service outcomes for un, under, and inappropriately served populations.

MHSA 3-Year Program & Expenditure Plan

10

Plan Purpose:

The purpose of the MHSA 3-Year Program & Expenditure Plan is to document the community's vision for addressing mental illness through each of the MHSA components.

Community Planning Process

11

The MHSA intends that there be a **meaningful stakeholder process** to provide subject matter expertise to the **development of plans focused on utilizing the MHSA funds at the local level,** including participation from:

- Adults and seniors with severe mental illness
- Families of children, adults, and seniors with severe mental illness
- Providers of mental health services
- Law enforcement agencies
- Education agencies
- Social services agencies
- Veterans and representatives from veterans organizations
- Providers of alcohol and drug services
- Health care organizations
- Other important interests

Planning Principles

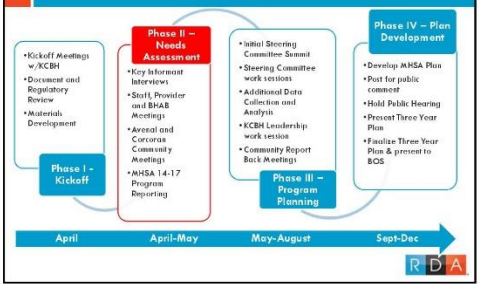
12

- Create a 3-year MHSA plan that:
  - Is integrated with other initiatives
  - Is realistic and feasible
  - Builds upon previous accomplishments
  - Measures success
  - Aligns with the spirit of the MHSA and complies with current regulations

Roles and Responsibilities

- **Community Stakeholders/Steering Committee: Collaborator**
  - Contribute to the shared understanding of community mental health needs
  - Develop proposed programs and services for the 3-year MHSA plan
- **KCBH: Administrator**
  - Outreach and convene stakeholders for the CPP
  - Provide information and contribute to plan development
  - Implement the 3-year MHSA plan
- **Board of Supervisors: Approver**
  - Approve the MHSA plan prior to MHSOAC submission
- **RDA: Planner/Facilitator**
  - Engage stakeholders in a participatory CPP process that aligns with MHSA Values
  - Develop a needs assessment and MHSA plan that is grounded in the needs of un, under, and inappropriately served populations
  - Draft a technically compliant MHSA Plan to best serve mental health needs of the community

MHSA Planning Activities and Timeline



15 MHSA Findings 14-17

Key Accomplishments 2014-2017

KCBH Strengthened partnerships and collaboration

- Convened faith-based leadership group
- Developed Whole Person Care collaborative
- Strengthened partnership with justice agencies
- Leveraged relationships with social services/child welfare and juvenile justice for Continuum of Care reform
- Increased collaboration with Adventist Health
- Created new partnership with Stars Behavioral Health and Crestwood Behavioral Health

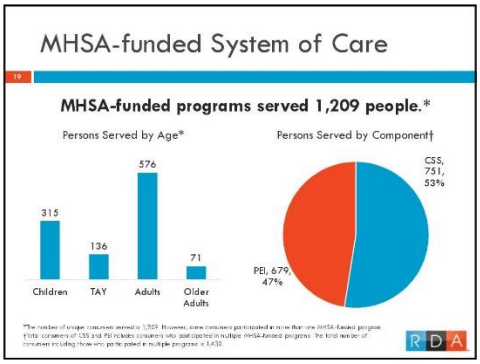
Key Accomplishments 2014-2017

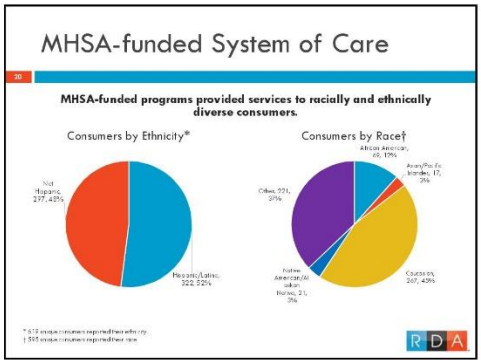
KCBH Enhanced Programs and Services

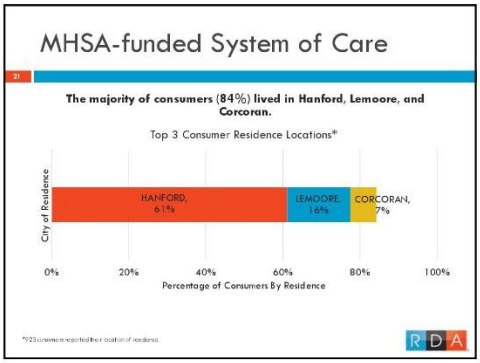
- Aligned programs and services with the MHSA and its values
- Enhanced crisis continuum of services
- Coordinated care for people across systems
- Increased services for un/underserved populations
- Increased use of evidence based practices
- Moved services into the communities where people need them

Challenges/Lessons Learned

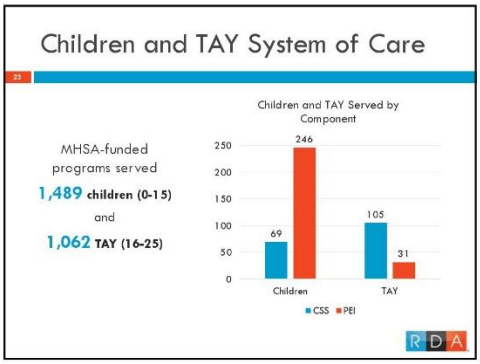
- Challenges knowing in advance the level of referrals/demand for services
  - Created challenges planning for where to place staff
- Hard to recruit and train clinicians to serve families when and where it is needed
  - Challenge finding staff for after-hour programs or outlying areas

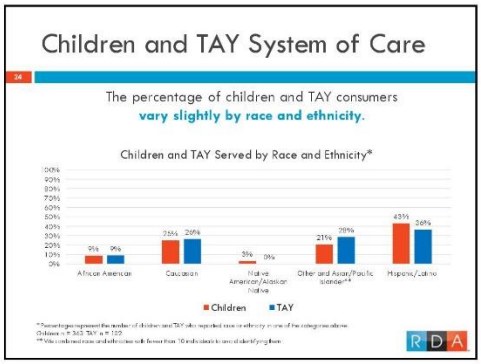

MHSA-funded System of Care
19
MHSA-funded programs served 1,209 people.*
Persons Served by Age*
315
136
576
71
Children
TAY
Adults
Older Adults
Persons Served by Component†
CSS, 751, 53%
PEI, 679, 47%


MHSA-funded System of Care
20
MHSA-funded programs provided services to racially and ethnically diverse consumers.
Consumers by Ethnicity*
Consumers by Race†


MHSA-funded System of Care
21
The majority of consumers (84%) lived in Hanford, Lemoore, and Corcoran.
Top 3 Consumer Residence Locations*
City of Residence
HANFORD, 61%
LEMOORE, 16%
CORCORAN, 7%
0%
20%
40%
60%
80%
100%
Percentage of Consumers By Residence


22
Children and TAY


Children and TAY System of Care
23
MHSA-funded programs served
1,489 children (0-15)
and
1,062 TAY (16-25)
Children and TAY Served by Component
246
69
105
31
Children
TAY
CSS
PEI


Children and TAY System of Care
24
The percentage of children and TAY consumers vary slightly by race and ethnicity.
Children and TAY Served by Race and Ethnicity*
African American
Caucasian
Native American/Alaskan Native
Other and Asian/Pacific Islander**
Hispanic/Latino
Children
TAY

	Program Name	Ages Served	Description	Provider	# Served
CSS	**Children's FSP**	0-16	**Full Service Partnership (FSP)** to provide services for children with the highest level of mental health need.	KCBH, Family Builders, Kings View	246
	Summer Day Camp	6- 15	**Summer Day Camp** services to reduce the impact of living with a serious mental illness during the summer months when there is no access to school-based services.	Kings View	159
PEI	**Early Intervention Clinical Services**	0-18	**Early Intervention Clinical Services (EICS)** is a cluster of three programs for children and families • Truancy Intervention Prevention Program (TIPP) • Life Strategic Training and Education Program • Parent-Child Interaction Therapy (PCIT)	KCBH	912
	Universal Developmental Screening	0-5	**Universal Developmental Screenings** detect social, emotional, and developmental delays for young children.	KCBH	584
	School Based Services	Not available	**School Based Services** are designed to promote positive school outcomes for youth at risk of or in the early stages of mental illness	KCBH	595

	Program Name	Ages Served	Program Description	Provider	# Served
CSS	**TAY FSP**	17-25	**Full Service Partnership (FSP)** provides services for transition age youth with the highest level of mental health need.	KCBH, Family Builders, Kings View Counseling	138
	Therapeutic Activity Groups (Tier 2 and 3)	12-24	**Therapeutic Activity Groups (Tier 2 and 3)** provide Hip Hop Therapy to youth with an established mental illness.	KCBH, BRL	Not Available
PEI	**Therapeutic Activity Groups (Tier 1)**	12-24	**Therapeutic Activity Groups (Tier 1)** use Hip Hop Therapy focused on outreach, prevention and assessment for youth at-risk of developing a mental illness	KCBH, BRL	Not Available

27 Adult and Older Adult

Adult and Older Adult System of Care

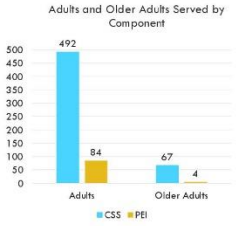
28

MHSA-funded programs served

576 adults (26-59)

and

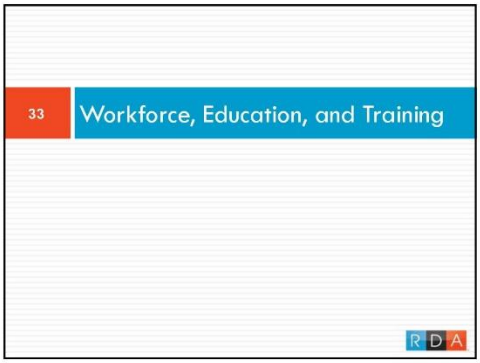
71 older adults (60+)



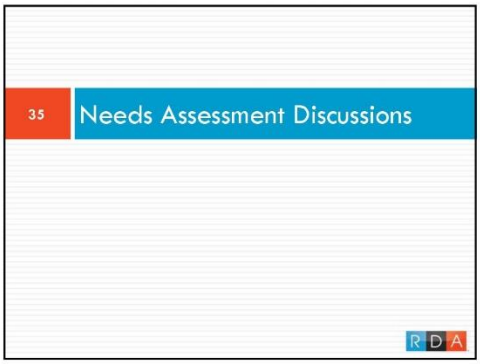
	Program Name	Ages Served	Description	Provider	# Served
CSS	**Children's FSP**	0-16	**Full Service Partnership (FSP)** to provide services for children with the highest level of mental health need.	KCBH, Family Builders, Kings View	246
	Summer Day Camp	6- 15	**Summer Day Camp** services to reduce the impact of living with a serious mental illness during the summer months when there is no access to school-based services.	Kings View	159
PEI	**Early Intervention Clinical Services**	0-18	**Early Intervention Clinical Services (EICS)** is a cluster of three programs for children and families • Truancy Intervention Prevention Program (TIPP) • Life Strategic Training and Education Program • Parent-Child Interaction Therapy (PCIT)	KCBH	912
	Universal Developmental Screening	0-5	**Universal Developmental Screenings** detect social, emotional, and developmental delays for young children.	KCBH	584
	School Based Services	Not available	**School Based Services** are designed to promote positive school outcomes for youth at risk of or in the early stages of mental illness	KCBH	595

	Program Name	Ages Served	Description	Provider	# Served
CSS	**Adult FSP**	18-59	Adult Full Service Partnership (FSP) aims to reduce the impact of living with serious mental illness and provide stability in the lowest level of care by providing the full range of community services and collaborating with consumers to reach their wellness and recovery goals.	KCBH, Kings View Counseling	485
	Older Adult FSP	60 and over	Older Adult Full Service Partnership (FSP) aims to reduce the impact of living with serious mental illness and provide stability in the lowest level of care by providing the full range of community services and collaborating with consumers to reach their wellness and recovery goals.	KCBH, Kings View Counseling	73
	CJTC Services	N/A	Collaborative Justice Treatment Court (CJTC) aims to divert individuals with severe emotional disturbance/serious mental illness, or with co-occurring mental health and substance abuse disorders, from incarceration into treatment.	KCBH	203
	Oak Wellness (ECHO)	TAY, Adults & OA	The Empowering Consumers to Help Others (ECHO) program at the Oak Wellness Center relies on the lived experience of peers to reduce the impact of living with serious mental illness and promote wellness, recovery, and resiliency.	Kings View	581
	MH Services for Domestic Survivors	Any age	The Mental Health Services for Domestic Violence Survivors program provides mental health services to address the trauma of mental illness and the dislocation of homelessness for women and children at the Barbara Saville Women's Shelter.	Barbara Saville Women's Shelter	N/A
PEI	**Respite for Caregivers**	N/A	Respite for Caregivers provides assistance and relief to primary caregivers of older adults with mental illness.	Kings Commission on Aging	362
	Senior Access for	60 and over	Senior Access for Engagement (SAFE) reaches out to diverse/underserved populations to identify early	Kings Commission	5,362

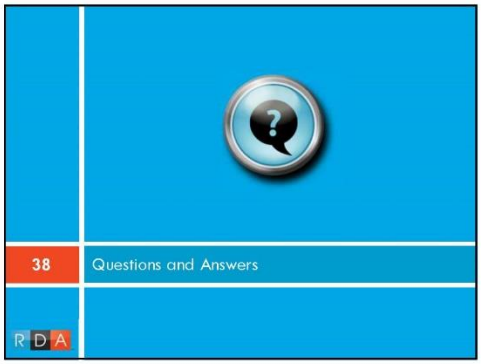
	Program Name	Description	Provider	# Served
CSS	Community Integration FSP	Full Service Partnership (FSP) Community Integration provides services to reduce the impact of living with serious emotional disturbance or severe mental illness, while also increasing the level of participation and involvement of ethnically diverse, impaired, and underserved persons	KCBH	667
PEI	Community Wide Prevention (CCTF)	The focus of KCBH's community wide prevention strategies include prevention and early intervention efforts to effectively serve King County community members	KCBH	N/A
	211/Linkages and Referrals Portal	This portal works to assist individuals who do not meet the 5150 criteria but may need additional mental health support by being directed to the most appropriate programs and services	KCBH	N/A
	Community Capacity Building	N/A	N/A	N/A
CFTN	Continued Capital Facilities Support	This program ensures that Kings County Behavioral Health Capital Facilities investments are placed into CSS and PEI programs to assure that consumers, family members, and staff have the facilities they need to provide adequate mental health services	KCBH	N/A
	Feasibility for Courthouse	The County planned to conduct a feasibility study to determine the appropriateness and optimal utilization of the Kings County Court space for mental health services	KCBH	52



WET	Program Name	Program Description	Provider	# Served
	Cultural Ambassador Training Program	This program aims to help develop stronger collaboration between mental health providers and the communities they serve and improve quality of care. The program emphasizes understanding the cultural needs in serving Native Americans, Tachi-Yokut, Latino, veterans, and other underserved consumers.	Kings County Behavioral Health (KCBH),CCTF, Fresno State University, National Latino Behavioral Health Assoc. California Institute for Behavioral Health Solutions, Santa Rosa Rancheria, On-Trak, California Youth Connection	204
	WET Coordination and MH Professional Dev	This program coordinates professional development opportunities for mental health professionals to increase the supply of qualified, culturally competent mental health staff and clinicians.	KCBH	125
	Mental Health Workforce Pathways	Mental Health Workforce Pathways is intended to expand the supply of diverse and culturally competent mental health staff and to inform local youth from unserved or underserved communities about	KCBH, Kings County Probation Department	35




Next Steps
Steering Committee Summit
Steering Committee Meetings
Develop Plan
Community Report Back
RDA


38
Questions and Answers
RDA


THANK YOU!
RDA
Resource Development Associates

Appendix C. Steering Committee #1 Materials

Community Engagement Feedback Form

Thank you for your involvement in the Community Program Planning (CPP) Process for Kings County's Mental Health Services Act *Three-Year Program & Expenditure Plan*. We would like to hear about your experience with the CPP process. Your feedback will help us understand what we did well and what we can improve upon in the future. Please help us by taking a few minutes to fill out this anonymous feedback form.

Based on your experience with the MHSA Community Program Planning Process, please check how much you agree with the following statements.

	Strongly Disagree	Disagree	Agree	Strongly Agree
15. The needs assessment provides an accurate overview of our communities' strengths, needs, and gaps.				
16. The community planning process and discussion reflects my ideas and perspectives about how to strengthen mental health services in our County.				
17. There was adequate time for discussion and questions.				
18. The information and activities in this meeting allowed us to move forward in the CPP process.				
19. The community planning process is in alignment with MHSA values.				

20. Are there specific issues or topics that are important to consider with the Steering Committee?

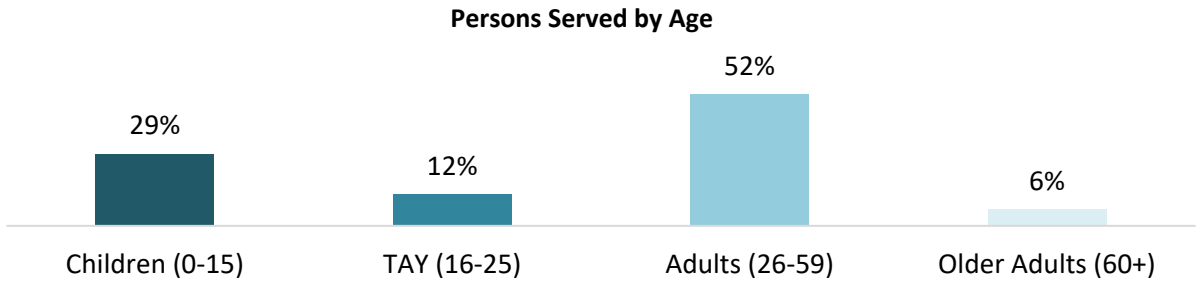
Thank you!

MHSA Data

Kings County MHSA-Funded System of Care FY 2014-15 through FY 2015-16

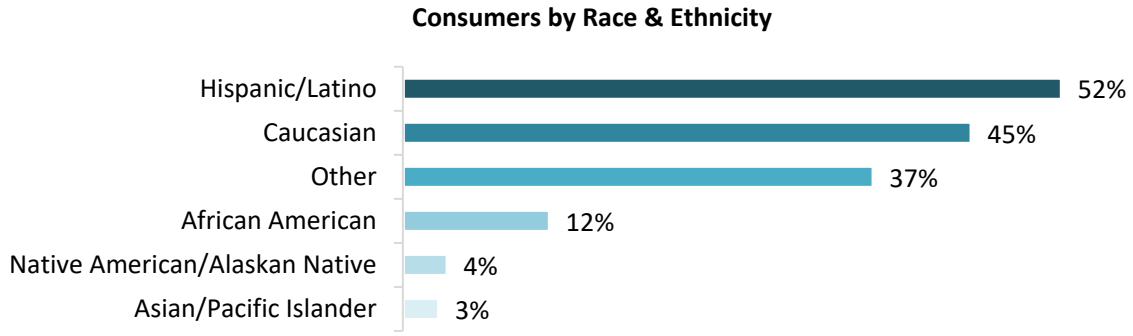
Consumers Served Overall

MHSA-funded programs provided direct services to **10,918** people in FY 2014-15 through FY 2015-16.



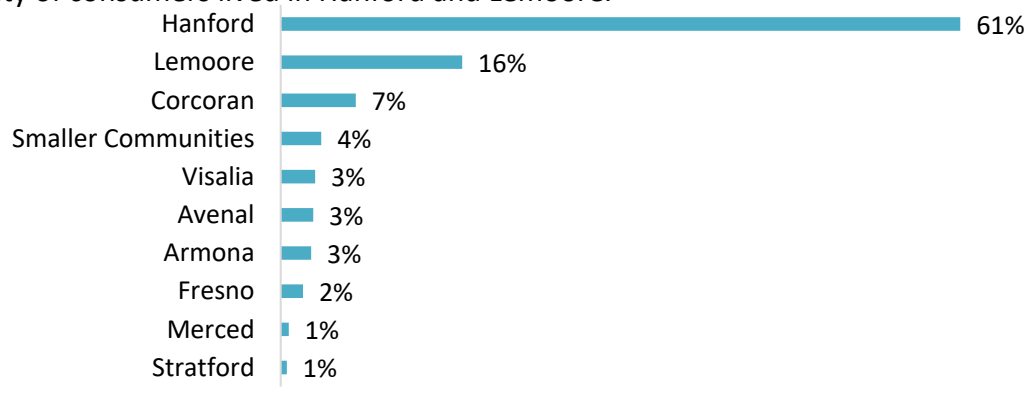
Persons Served by Component | CSS: 53% PEI: 47%

Demographics



Consumer Residency

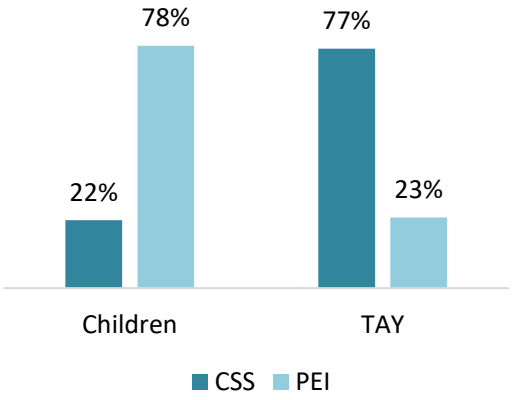
The majority of consumers lived in Hanford and Lemoore.



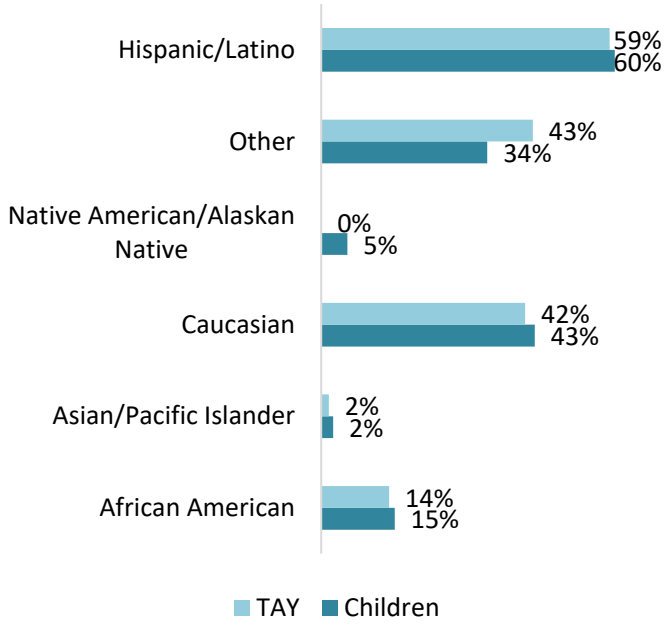
Children and TAY

MHSA-funded programs served **3,852** children & TAY.

Children and TAY Served by MHSA Component



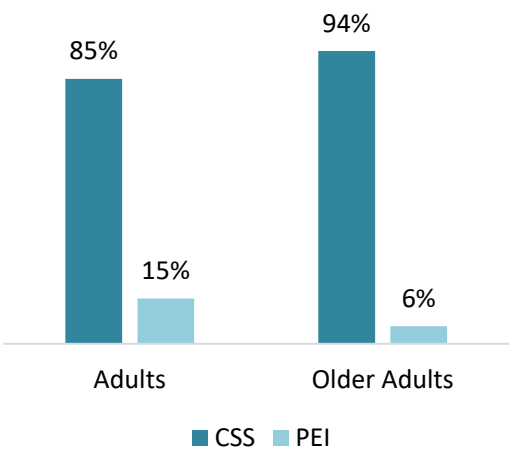
Children and TAY Served by Race & Ethnicity



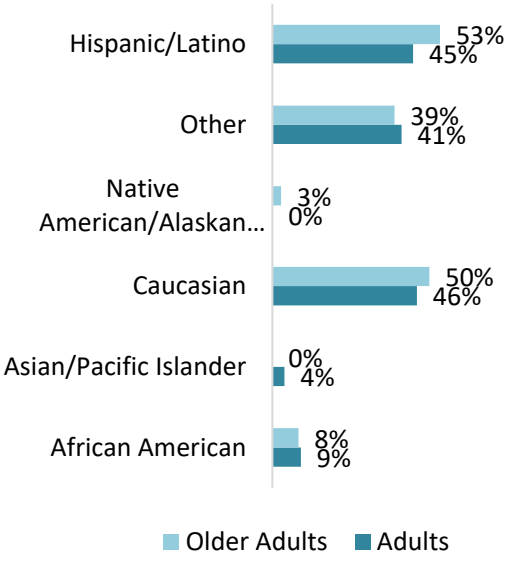
Adult and Older Adults

MHSA-funded programs served 7,066 Adults & Older Adults.

Adults and Older Adults Served by MHSA Component



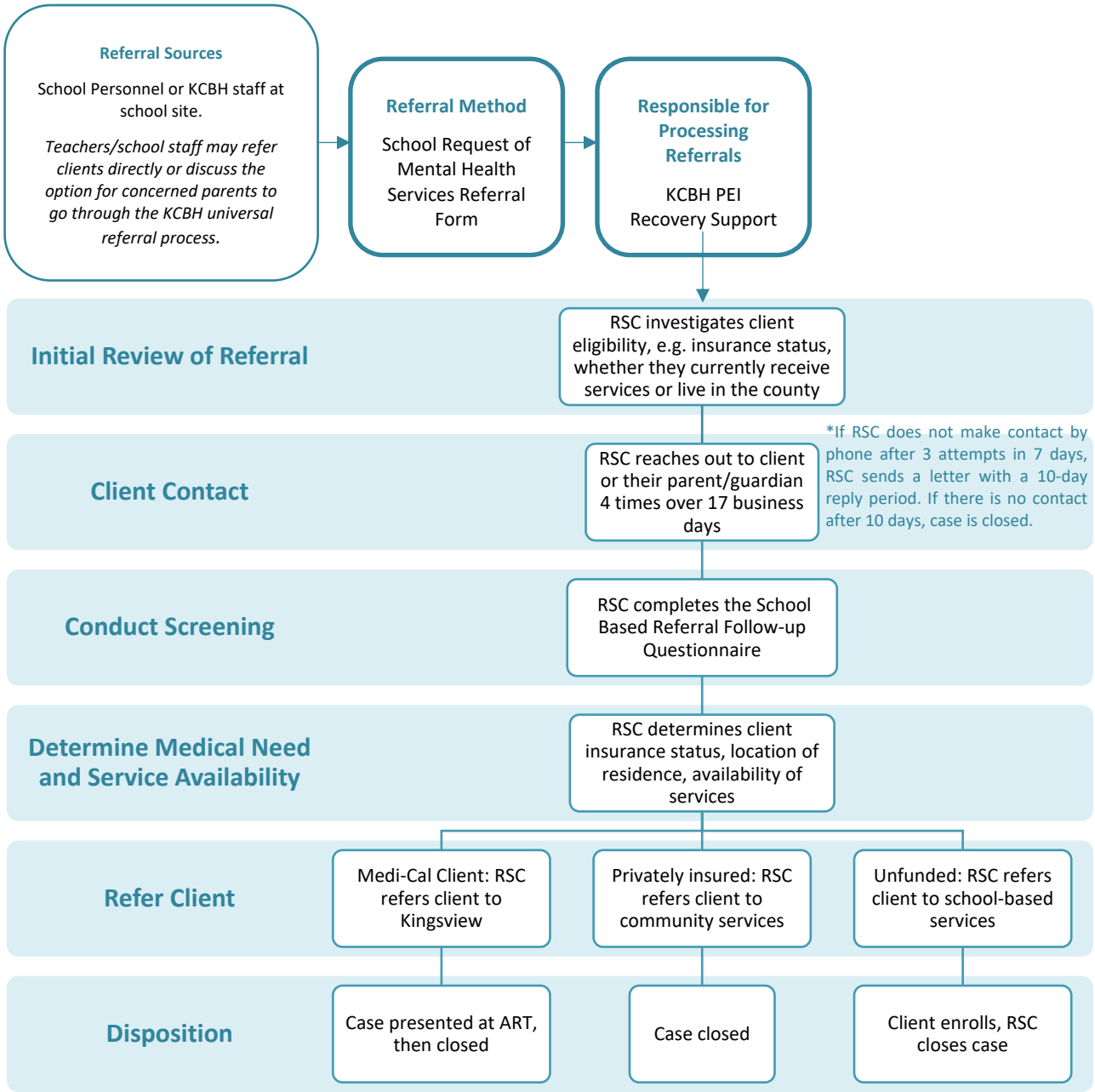
Adults and Older Adults Served by Race and Ethnicity



Referral Process

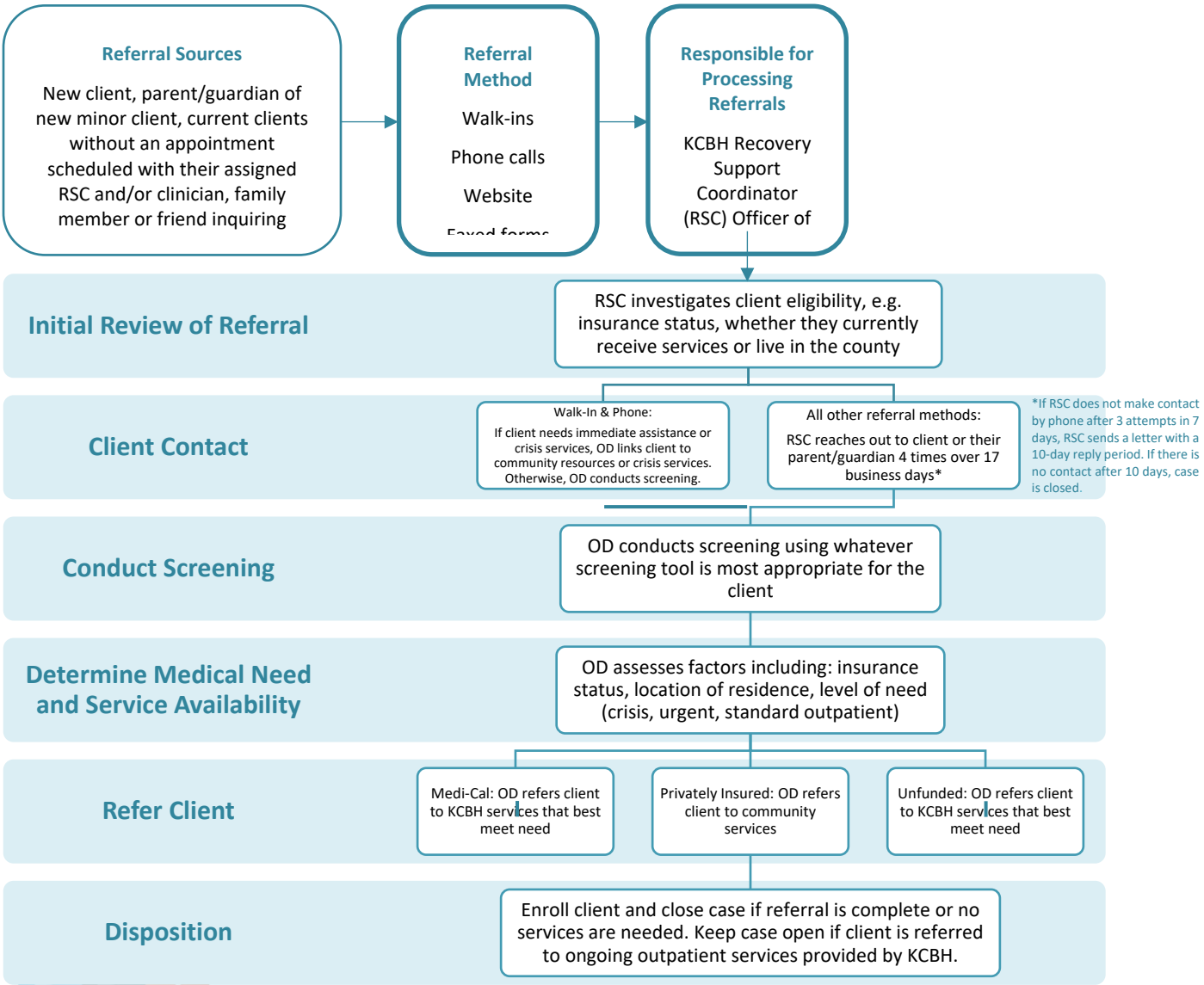
School-Based Request for Mental Health Services

This diagram represents a high-level overview of the current referral process. The actual process is more complex with many potential scenarios. There are many school districts, and they each have different resources and services for students with mental health needs. The MHSA planning process can inform the referral process and policies to facilitate access for consumers.



Universal Behavioral Health Service Referrals

This diagram represents a high-level overview of the current referral process. It shows entry into the behavioral health system and is not intended to reflect all care transitions. People and their loved ones may seed out services in a variety of ways, and there are different responses based on their need for services including crisis, emergency, urgent, and standard outpatient services. Consumers may also enter the system through referrals from other agencies and providers. The MHSA planning process can inform the referral process and policies to facilitate access for consumers.



Group Activity Worksheets

Group Activity Worksheet: Assessment of MHSA Services

Instructions: Please identify a Reporter and a Scribe (it can be one person). At the end of this activity, the designated reporter will present your ideas to the larger group.

Activity Overview: The main purpose of this exercise is to evaluate your current MHSA services to see what aspects are working and what might need to be changed. Try to reach consensus if possible, if not, include everyone's perspective. Please spend time discussing before filling out this form. Use as much space as you need, and feel free to attach an additional page. Note: There are no wrong answers.

Please circle one: Children/TAY Adults/Older Adults

Domain	Strengths to keep	Modifications/ adjustments to make	Problems to solve
Outreach and Engagement			
Access and Referrals			

Domain	Strengths to Keep	Modifications/ adjustments to make	Problems to solve
Mental Health Services- PEI			
Mental Health Services- CSS			
Crisis			

Group Activity Worksheet: Developing Your Mission

Instructions: Please identify a Reporter and a Scribe (it can be one person). At the end of this activity, the designated reporter will present your ideas to the larger group.

Activity Overview: The main purpose of this exercise is to evaluate your current MHSA programs to see what is working and what might need to be changed. Try to reach consensus if possible, if not, include everyone's perspective. Please spend time discussing before filling out this form. Use as much space as you need, and feel free to attach an additional page. Note: There are no wrong answers.

Please circle one: **Children/TAY** **Adults/Older Adults**

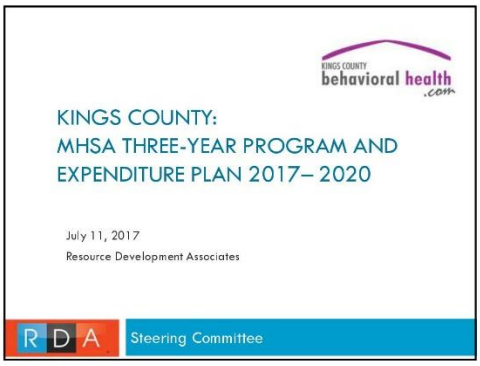
CAUSE: Who are we hoping to help? What problem do we need to solve?

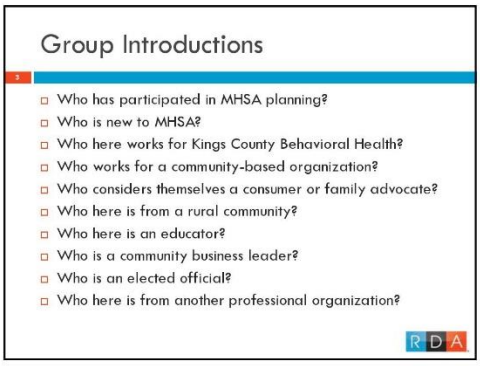
ACTION: How are we hoping to accomplish this? What are we actually hoping to do?

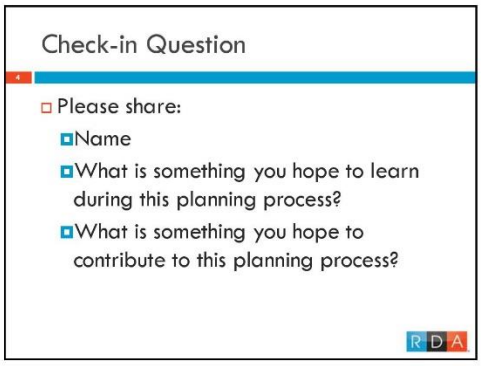
IMPACT: What are we hoping to accomplish? How will we know that it worked?

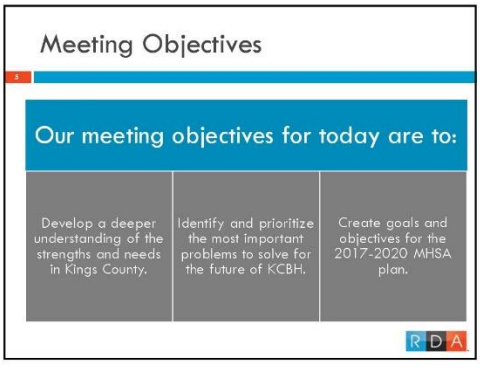
Presentation

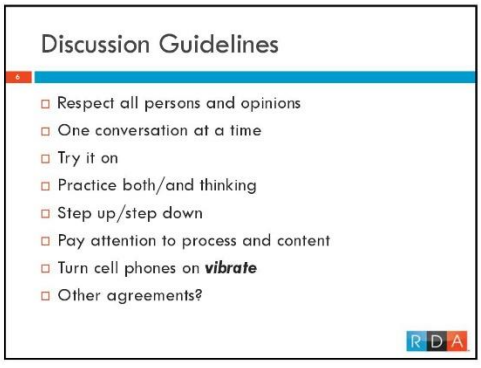
12/20/2017











7

Overview of MHSA and Community Planning Process

MHSA Overview

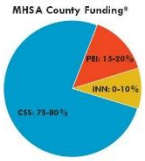
HISTORY
Mental Health Services Act (Proposition 63) passed November 2, 2004

FUNDING SOURCE
1% income tax on income over $1 million

PURPOSE
To ***expand and transform*** mental health services in California

MHSA Components

- **CSS: Community Services & Supports**
  - Outreach and direct services for children, TAY, adults and older adults with SED/SMI
- **PEI: Prevention & Early Intervention**
  - Prevention services to prevent the development of mental health problems
  - Early intervention services to screen and intervene with early signs of mental health issues
- **CFTN: Capital Facilities & Technology Needs**
  - Infrastructure to implement an electronic health record and support MH facilities
- **WET: Workforce Education & Training**
  - Support to build, retain, and train a competent public mental health workforce
- **INN: Innovation**
  - Funding to test new approaches that may improve access, collaboration, and/or service outcomes for un-, under-, and inappropriately-served populations



*Counties received 10-year allocations for WET and CFTN activities

MHSA Community Planning Process

The MHSA intends that there be a **meaningful stakeholder process** to provide subject matter expertise to the **development of plans focused on utilizing the MHSA funds at the local level,** including participation from community stakeholders.

The community planning process should work to create a 3-year MHSA plan that:

- Is integrated with other initiatives
- Is realistic and feasible
- Builds upon previous accomplishments
- Measures success
- Aligns with the spirit of the MHSA and complies with current regulations

Roles and Responsibilities

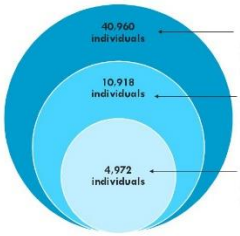
- **Steering Committee**
  - Develop proposed programs and services for the 3-year MHSA plan
- **Community Stakeholders**
  - Contribute insight, share experiences, provide recommendations
- **Kings County Behavioral Health**
  - Implement 2017-2020 MHSA Plan
- **Board of Supervisors**
  - Approve 2017-2020 MHSA Plan
- **Resource Development Associates**
  - Plan and facilitate MHSA Needs Assessment

MHSA Planning Activities and Timeline

13 Who has been served?

2014-2017 Service Findings

14



All MHSA-funded services
All direct and/or indirect services, and activities such as public information campaigns

All direct services
Only direct services that range from intensive ongoing services to one-time or lower-touch services

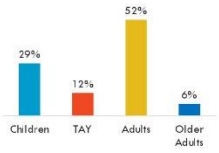
Ongoing direct services
Only direct services that are either more intensive or ongoing

MHSA-Funded System of Care

15

MHSA-funded programs provided direct services to 10,918 people in FY 2014-15 through FY 2015-16.

Persons Served by Age



Persons Served by Component

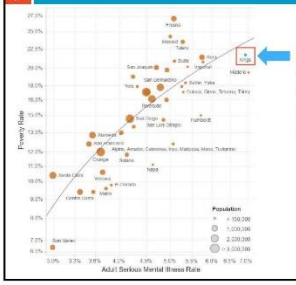
CSS: 53%

PEI: 47%

16 Needs Assessment Findings

Kings County Overview

17



Kings County
Population: 152,982
Poverty Rate: 21.7%
Adult SMI: 6.9%
Psychiatrists/100k: 6.5

Accomplishments and Ongoing Barriers

18

	Accomplishments	Ongoing Barriers
Outreach and Engagement	• Expanded outreach efforts in the community	• Need for more culturally responsive outreach
Access and Referrals	• Revised referral processes • Increased service access in rural communities	• Ongoing need to simplify referral process and ensure feedback loop and warm handoffs • Ongoing rural challenges (e.g. limited transportation; psychiatric care)
Mental health services	• Refined roles and responsibilities in the process of strengthening clinical service availability • Developed and implemented plan to improve mental health services	• Ongoing need for services when/where they are needed • Refinements to clinical services • Continue to implement mental health services
Crisis	• Enhanced crisis continuum of services	• Crisis services still in implementation phase
Partnership development	• Increased services in rural communities	• Need to continue effort around service integration

Outreach and Engagement Efforts

- KCBH outreach includes website, digital billboard, radio ads, and partnership with National Cine-Media
- 2-1-1: telephone and web-based resource to connect to services
- Array of services to:
  - Encourage and promote collaborative outreach and support efforts to Kings County communities
  - Provide suicide prevention services
  - Target stigma and discrimination reduction

Outreach and Engagement

Progress	Areas For Growth
Promoted awareness of 2-1-1 through a campaign	Identify proactive and targeted outreach efforts for individuals, families, and communities in need
Conducted outreach to all school districts on KCBH referrals	Conduct outreach in culturally relevant and accessible locations
Strengthened tribal relationships	Create more culturally relevant outreach materials
Created partnerships and collaboration with multiple agencies which strengthened referral process	Increase stigma reduction programs across systems to increase visibility among diverse groups
	Create systems to measure outreach efforts

Access and Referrals

Progress	Areas for Growth
Simplified referral process	Increase partners' awareness of referral process
Provided referral training to staff in all local school districts	Ensure follow-up and tracking of referrals
	Share referral outcomes with referring parties

Access and Referrals – Rural Areas

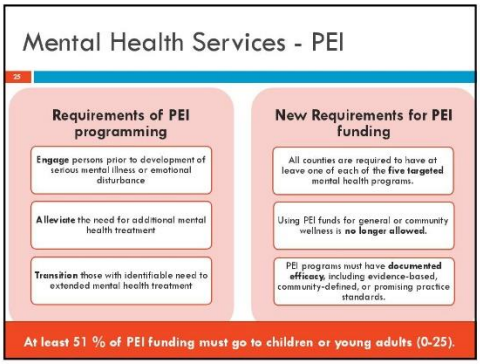
Progress	Areas For Growth
Placed staff in outlying, rural areas	Match the demand in rural areas with capacity
Participated in Avenal needs assessment	Consider culturally responsible and feasible ways to meet the needs of the community
Committed to work with the community and be creative in meeting the community	

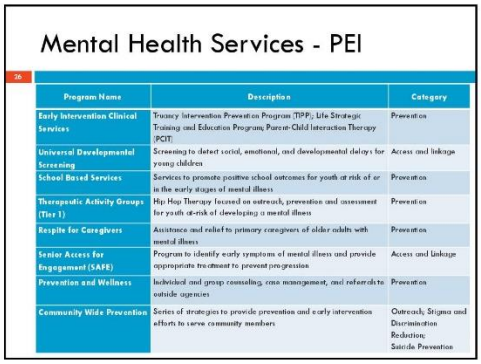
Mental Health Services

Progress	Areas For Growth
Implemented innovative practice with Beats, Rhymes, and Life (BRL)	Develop mechanisms for level of care determination
Redefined expectations of Wraparound; secured service provider with expertise to implement Wraparound to fidelity	Establish communication and referral pathways between crisis and ongoing mental health programs
Improved clinical services:	Re-design FSP program for adults with plan to release RFP for provider
Clarified roles & responsibilities in clinical care	Increase step down services post-crisis
Added certain services to align with MHSA regulations	Measure efficacy of services
Clarified roles between KCBH and FSP provider	

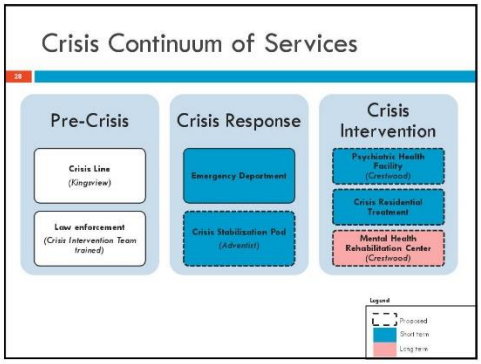
Mental Health Services - CSS

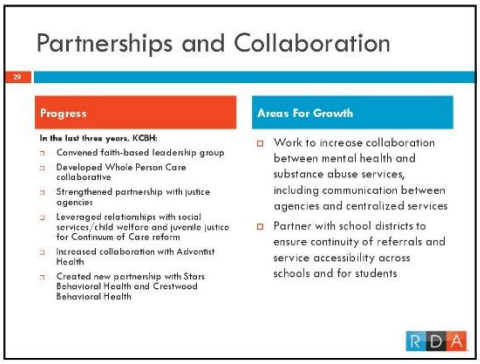
CSS Funding Categories	System of Care		Providers
	Children/youth	Adult/Older Adult	
Full Service Partnerships (FSP)	Wraparound	Assertive Community Treatment	Children/youth: *Aspiranet*
		Full Service Partnership	Adults: *TBD* (RFP out)
System Development (SD)	Intensive Case Management/Intensive outpatient program Case Management/Intensive outpatient program		*Kingsview*
Outreach & Engagement (OE)			

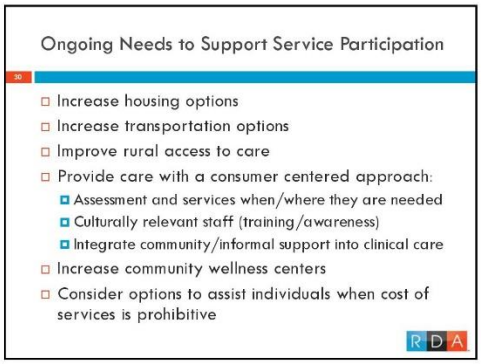

Mental Health Services - PEI
25
Requirements of PEI programming
Engage persons prior to development of serious mental illness or emotional disturbance
Alleviate the need for additional mental health treatment
Transition those with identifiable need to extended mental health treatment
New Requirements for PEI funding
All counties are required to have at leave one of each of the five targeted mental health programs.
Using PEI funds for general or community wellness is no longer allowed.
PEI programs must have documented efficacy, including evidence-based, community-defined, or promising practice standards.
At least 51 % of PEI funding must go to children or young adults (0-25).


Mental Health Services - PEI
26
Program Name
Description
Category
Early Intervention Clinical Services
Truancy Intervention Prevention Program (TIPP); Life Strategic Training and Education Program; Parent-Child Interaction Therapy (PCIT)
Prevention
Universal Developmental Screening
Screening to detect social, emotional, and developmental delays for young children
Access and linkage
School Based Services
Services to promote positive school outcomes for youth at risk of or in the early stages of mental illness
Prevention
Therapeutic Activity Groups (Tier 1)
Hip Hop Therapy focused on outreach, prevention and assessment for youth at-risk of developing a mental illness
Prevention
Respite for Caregivers
Assistance and relief to primary caregivers of older adults with mental illness
Prevention
Senior Access for Engagement (SAFE)
Program to identify early symptoms of mental illness and provide appropriate treatment to prevent progression
Access and Linkage
Prevention and Wellness
Individual and group counseling, case management, and referrals to outside agencies
Prevention
Community Wide Prevention
Series of strategies to provide prevention and early intervention efforts to serve community members
Outreach; Stigma and Discrimination Reduction; Suicide Prevention

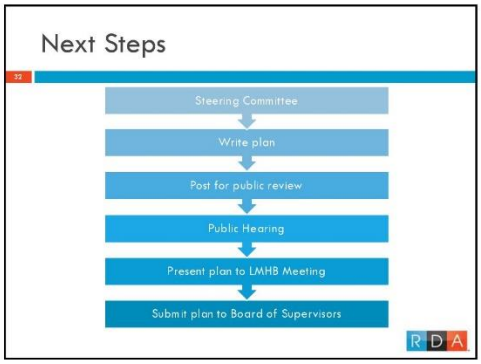

Crisis Services
27
Progress
Enhanced crisis continuum of services
SB82 funded CRT
Crestwood's MHRC/PHF
Psychiatric Pod at Adventist Health
Areas For Growth
Consider ways to expand geographic reach of crisis services
Enhance Crisis Intervention Team (CIT) training for law enforcement
Develop processes and procedures for how:
New crisis services will work together
Referral process into and between services
Stakeholder education around new crisis services (what they do and who they serve)
RDA


Crisis Continuum of Services
28
Pre-Crisis
Crisis Line (Kingsview)
Law enforcement (Crisis Intervention Team trained)
Crisis Response
Emergency Department
Crisis Stabilization Pod (Adventist)
Crisis Intervention
Psychiatric Health Facility (Crestwood)
Crisis Residential Treatment
Mental Health Rehabilitation Center (Crestwood)
Legend
Proposed
Short term
Long term


Partnerships and Collaboration
29
Progress
In the last three years, KCBH:
Convened faith-based leadership group
Developed Whole Person Care collaborative
Strengthened partnership with justice agencies
Leveraged relationships with social services/child welfare and juvenile justice for Continuum of Care reform
Increased collaboration with Adventist Health
Created new partnership with Stars Behavioral Health and Crestwood Behavioral Health
Areas For Growth
Work to increase collaboration between mental health and substance abuse services, including communication between agencies and centralized services
Partner with school districts to ensure continuity of referrals and service accessibility across schools and for students
RDA


Ongoing Needs to Support Service Participation
30
Increase housing options
Increase transportation options
Improve rural access to care
Provide care with a consumer centered approach:
Assessment and services when/where they are needed
Culturally relevant staff (training/awareness)
Integrate community/informal support into clinical care
Increase community wellness centers
Consider options to assist individuals when cost of services is prohibitive
RDA


31
Next Steps
R D A


Next Steps
32
Steering Committee
Write plan
Post for public review
Public Hearing
Present plan to LMHB Meeting
Submit plan to Board of Supervisors
R D A


THANK YOU!
R D A
Resource Development Associates

Appendix D. Steering Committee #2 Materials

PEI Planning Worksheet

Type of PEI Program: _____

Who is the target population or audience?
What are their needs?
How would they be identified?

What kinds of services or approaches would be included?
What type of staff would work in the program?
How would people learn about the program?
What are you trying to accomplish? How would you know if it's working?

Children, Youth, and Family Worksheet

What are the key needs to be addressed? Consider issues related to access, service delivery, crisis response, coordination/collaboration, and culturally relevant service providers.

Of the existing MHSA programs, which programs or services are working well? Which address the needs you identified in question #1?

Continued on backside

What changes would you make to existing programs? What would need to be added or modified? What need or gap would the changes address?

Which existing MHSA programs should be removed?

What new programs or strategies would need to be implemented (if any) to address the identified needs?

Reminder: Please review worksheet to determine whether vision goals for KCBH are capable of being accomplished.

Adult/ Older Adult Worksheet

What are the key needs to be addressed? Consider issues related to access, service delivery, crisis response, coordination/collaboration, and culturally relevant service providers.

Of the existing MHSA programs, which programs or services are working well? Which address the needs you identified in question #1?

Continued on backside

What changes would you make to existing programs? What would need to be added or modified? What need or gap would the changes address?

Which existing MHSA programs should be removed?

What new programs or strategies would need to be implemented (if any) to address the identified needs?

Reminder: Please review worksheet to determine whether vision goals for KCBH are capable of being accomplished.

Vision Statements

Kings County Behavioral Health stakeholders envision a behavioral health system that is rooted in evidence-based practices and provides timely, culturally and linguistically competent, person-centered, and trauma-informed services throughout the entire County.

*Kings County Behavioral Health stakeholders envision a **Children, Youth, and Family** system that provides a full spectrum of services — from prevention and early intervention through clinical and crisis supports — and responds to the unique needs of children, youth, and their families by:*

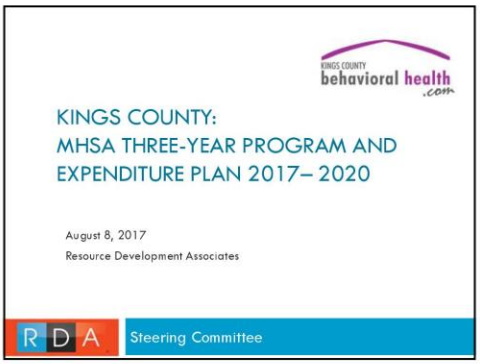
- Identifying and engaging children and youth with mental health challenges in appropriate and timely mental health services.
- Providing services that are available when and where children and youth already are, during hours when children and youth can attend.
- Providing adequate support to prevent children, youth, and their families from becoming involved in the juvenile justice and child welfare systems, making efforts to keep children and youth at home and avoiding unnecessary out of home placements.
- Providing crisis services when children, youth, and families need them, wherever they are, and connecting them to services that are likely to prevent future crises.

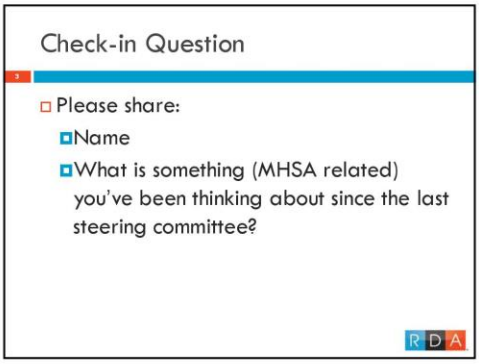
*Kings County Behavioral Health stakeholders envision an **Adult and Older Adult** system that provides a warm and welcoming service delivery experience that promotes recovery and interrupts the cycle of incarceration, hospitalization, and homelessness for individuals with mental health challenges by:*

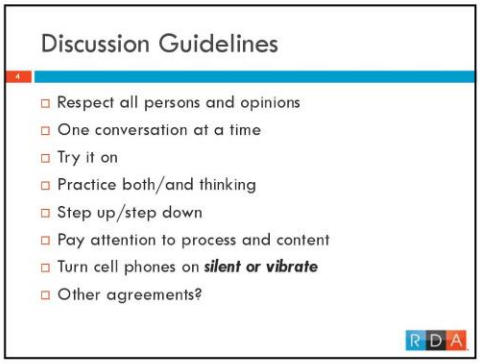
- Providing targeted outreach to identify, engage, and connect people in need to mental health services.
- Considering all of a person's needs and strengths, from initial assessment throughout their treatment.
- Meeting adults "wherever they are at" in the community and in their recovery process.
- Providing recovery oriented mental health services, placing peer professionals throughout the entire system.
- Coordinating between service levels, providing appropriate and timely transitions between levels of care, and helping people navigate and stay engaged in the mental health system.

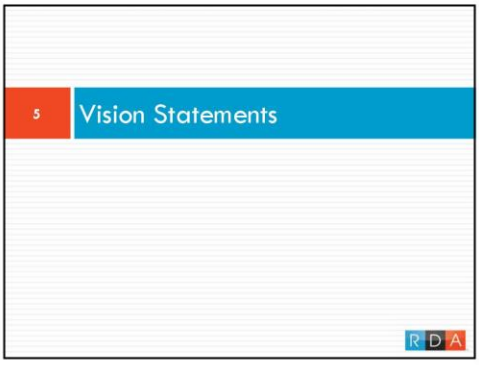
Presentation

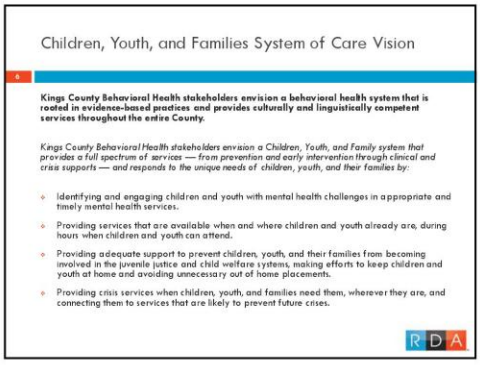
12/20/2017











Adult/Older Adult System of Care Vision

7

Kings County Behavioral Health stakeholders envision a behavioral health system that is rooted in evidence-based practices and provides culturally and linguistically competent services throughout the entire County.

*Kings County Behavioral Health stakeholders envision an **Adult and Older Adult** system that provides a warm and welcoming service delivery experience that promotes recovery and interrupts the cycle of incarceration, hospitalization, and homelessness for individuals with mental health challenges by:*

- Providing targeted outreach to identify, engage, and connect people in need to mental health services.
- Considering all of a person's needs in service delivery, from initial assessment throughout their treatment.
- Meeting adults "wherever they are at" in the community and in their recovery process.
- Providing recovery oriented mental health services, placing peer professionals throughout the entire system.
- Coordinating between service levels, providing appropriate and timely transitions between levels of care, and helping people navigate and stay engaged in the mental health system.

RDA

8 Children, Youth, and Families System of Care

RDA

Children/TAY Services

9

MHSA Component	Services
CSS Full Service Partnership	• Wraparound Services (Aspiranet) – Children/TAY FSP • Therapeutic Activity Group for TAY (Tier 2 and 3) • FSP Community Integration
CSS General System Development	• Summer Day Camp
CSS Outreach & Engagement	• Avenal One-Stop
PEI Prevention	• Early Intervention Clinical Services • School Based Services • Self Injury Prevention • Prevention and Wellness • Therapeutic Activity Groups for TAY (Tier 1) • Universal Developmental Screening

RDA

10 Adult/Older Adult System of Care

RDA

Adults/Older Adult Services

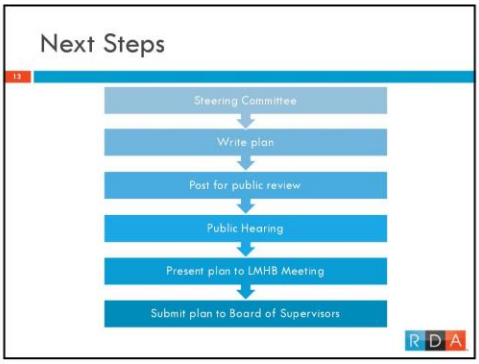
11

	Adults/Older Adults
CSS Full Service Partnership	• Full Service Partnerships for Adults • Full Service Partnerships for Older Adults • Assertive Community Treatment - proposed
CSS General System Development	• Collaborative Justice Treatment Court (CJTC) • Empowering Consumers to Help Others (ECHO) - Oak Wellness Center • Mental Health Services for Domestic Violence Survivors - Barbara Seville • Intensive Case Management/Intensive Outpatient Program • Crisis Residential Treatment - new
CSS Outreach & Engagement	• Whole Person Care (CARELink) - new
PEI Prevention	• Respite for Caregivers • Prevention and Wellness

RDA

12 Next Steps

RDA


Next Steps
13
Steering Committee
Write plan
Post for public review
Public Hearing
Present plan to LMHB Meeting
Submit plan to Board of Supervisors
RDA


THANK YOU!
RDA
Resource Development Associates

Appendix E. Steering Committee #3 Materials

WET and CFTN Worksheets

Workforce Education & Training (WET) Worksheet

1. What are the key WET needs to be addressed? Consider issues related to cultural competency and a workforce that reflects the communities they serve.

2. What are some ways to strengthen the pipeline from the **community** to the mental health workforce? Consider engaging people with lived experience, peer mentors, and family members.

3. What are some ways to strengthen the pipeline from **school** to the mental health workforce? Consider engaging those in high school and college who may pursue clinical training.

4. What training is needed to enhance the cultural competency of current mental health staff?

Capital Facilities and Technology Needs (CFTN) Worksheet

1. What **new** technology and infrastructure would need to be implemented to address any identified needs?

2. How can we use technology to support information sharing such as mobile access and telemedicine?

3. What **changes** would you make to existing technological systems and physical infrastructures? What would need to be added or modified? What need or gap would the changes address?

Program Descriptions

Children and Transition Aged Youth

Program	Description	Proposed Changes
CSS: Full Service Partnership		
Wraparound Services - Children/TAY FSP	FSP provides a coordinated and intensive range of culturally appropriate mental health assessments, case management, treatment, and support to children with severe emotional disturbance and TAY with serious mental illness by addressing impairment in self-care, school/community functioning, and family relationships that pose a risk of removal from the home.	**No change to description (implementation changes to align services to description)**
CSS: General System Development		
Summer Day Camp	Summer Day Camp aims to reduce the impact of living with severe emotional disturbance and serious mental illness for children and youth by providing mental health treatment, prosocial development, and meaningful activities during the summer months when there is no access to school-based services.	**Minor change** Review cost of the program vs. how many people are being served
Parent-Child Interaction Therapy (PCIT)	Parent-Child Interaction Therapy (PCIT) is an innovative and effective early intervention therapy for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. The PCIT program is a family centered approach with a combination of behavioral therapy, play therapy, and parenting techniques.	**No change**
PEI: Prevention		
Prevention and Wellness	KCBH's Prevention and Wellness Services seek to provide accessible, high quality, and culturally competent counseling and support group sessions to promote positive approaches to mental health and prevent serious mental health crisis.	**Minor changes** • Consider developing more groups and safe spaces for youth • Discuss with Executive team what will be included in program
School Based Services	School Based Services are designed to promote positive school outcomes for youth at risk of or in the early stages of mental illness by supporting positive school interactions and reducing youth and family involvement in the criminal justice system. KCBH's School Based Services encompasses the following programs: • **Therapeutic School Based Services** (for non-Medi-Cal eligible students): Non-licensed clinician(s) provide services on campus to students whom the school has identified needing continued care or counseling. The clinician provides services during school on site, and for the duration of summer school. • **Coping and Support Training (CAST)** is a 12-week program that focuses on building young people's coping skills and talking about the real life challenges of youth life in today's increasingly complex world. • **Mindful Schools' Mindful Educators** utilizes a curriculum that teaches mindfulness to K-12 students with the purpose of increasing attention, self-regulation, and empathy. The research-based program allows behavioral health staff to teach and implement mindfulness activities and practices in classrooms, after-school programs, or other settings. The program seeks to improve the student's emotional regulation, focus, and engagement, as well as improve connections with other students. This is a cost effective way to help students develop skills to decrease stress and anxiety. • **READY Program Prevention**	**Modification** • Consider integrating bullying prevention and stress reduction programs into curricula • Consider developing mental health education events/strategies for parents/ caregivers • Mindful Schools and READY moved from Community Wide
Therapeutic Activity Groups for TAY (Tier 1)	The Therapeutic Activity Groups (or TAGs) integrate therapeutic youth development, media literacy, social skills development, and social justice frameworks into an intensive program of up to 5 weeks designed to foster individual and collective psychosocial development of Transition Age Youth (TAY). The TAGs will facilitate a process where TAY have the opportunity to develop social skills, and learn and experience trust, safety, mutual aid, positive self-expression, emotional regulation, self-efficacy, and accountability to support youth at risk of developing a mental illness.	**No change**
Truancy Intervention Prevention Program (TIPP)	Truancy Intervention Prevention Program (TIPP) is a collaborative partnership among the School Attendance Review Board (SARB), the Office of Education, the District Attorney's Office, and KCBH. TIPP was formed to provide families and youth with tools and linkages to resources to address the factors that contribute to truancy and chronic absenteeism.	**No change**
Life Strategic Training and Education Program (Life Steps)	Life Steps is a one-day course that provides psycho-education to families with truant or chronically absent students on the following topics: the importance of being involved in children's education; the understanding of both parental and child roles; setting limits and boundaries; substance abuse, mental health, gangs/criminal activity, discipline and child abuse and other issues that impact truancy/chronic absenteeism and children's educational success.	**No change**
PEI: Early Intervention		
Early Intervention Clinical Services	Early Intervention Clinical Services (EICS) is a first major mental health episode program (depression, mania, psychosis). Individuals will be identified by providers, schools, emergency rooms, primary care physicians, law enforcement, and juvenile probation. Services provided will include clinical services, rehabilitation, family treatment and education, home-based services, case management, support groups (individual and family), medication management, and collateral/consult. The goals of this program are to: • Reduce hospitalizations, incarceration, homelessness, and school dropout rates • Increase service connectedness • Increase completion of goals	**New program**

Adult and Older Adult

Program	Description	Proposed Changes
CSS: Full Service Partnership		
Assertive Community Treatment	Assertive Community Treatment (ACT) is a multidisciplinary team approach with assertive outreach in the community that reliably decreases hospitalization while improving psychosocial outcomes and quality of life.	**New program** Develop an ACT team capable of serving 50 clients
Full Service Partnerships for Adults and Older Adults	Adult and Older Adult Full Service Partnership (FSP) aims to improve outcomes in mental health, homelessness, housing, incarceration, and hospitalization for those living with serious mental illness by providing the full range of community services and collaborating with consumers to reach their wellness and recovery goals.	**No Change (Focus on aligning implementation with description)**
CSS: General System Development		
Crisis Residential Treatment	Crisis Residential Treatment (CRT) is a temporary alternative for people experiencing a mental health crisis who might otherwise face voluntary or involuntary commitment. CRT provides crisis stabilization, medication monitoring, and evaluation to determine the appropriate care within a framework of peer support and trauma-informed approaches to recovery.	**New program**
Collaborative Justice Treatment Court (CJTC)	Collaborative Justice Treatment Court (CJTC) aims to divert individuals with severe emotional disturbance/serious mental illness, or with co-occurring mental health and substance abuse disorders, from incarceration into treatment by engaging and connecting participants to the services and support they need.	**No change**
Empowering Consumers to Help Others (ECHO) - Oak Wellness Center	Empowering Consumers to Help Others (ECHO) promotes the consumer's potential for recovery and the value of peer supports by providing a safe, welcoming, and supportive environment for consumers to engage in socialization, recovery-focused activities, enrichment activities, and support groups with the aid of other consumers.	**No change**
Intensive Case Management/ Intensive Outpatient Program	Intensive Case Management (ICM) provides community based long-term care for severely mentally ill people who do not require immediate admission. Intensive outpatient is multidisciplinary, structured services provided at a greater frequency and intensity than routine outpatient treatment. Generally up to 4 hours per day, up to 5 days per week.	**No change**
Mental Health Services for Domestic Violence Survivors (Barbara Seville)	The Mental Health Services for Domestic Violence Survivors program provides mental health services, case management, and linkage to address the trauma of mental illness and the dislocation of homelessness for women and children at the Barbara Saville Women's Shelter.	**No change**
CSS: Outreach & Engagement		
KARELink	KARELink serves adults with substance use and/or mental health conditions with a comprehensive approach to reduce recidivism and inappropriate emergency service usage through linkages to immediate care, integrative screenings and assessment, and comprehensive treatment.[1]	**New Program**
PEI: Prevention		
Respite for Caregivers	Respite for Caregivers provides assistance and relief to primary caregivers of older adults with mental illness. Services are intended to complement existing family structures to allow seniors to remain in the community as long as possible.	**Minor changes** Consider increasing services to reach more caregivers
Support Groups	Family Support Group; Veterans Support Group (Part of Prevention and Wellness?)	No change to program (moved from Community-Wide)
PEI: Access and Linkage to Treatment		
Senior Access for Engagement (SAFE)	Senior Access for Engagement (SAFE) reaches out to unserved/underserved populations to identify early symptoms of mental illness and provide appropriate treatment to prevent progression.	**No change**

Community Wide Services

Program	Description	Proposed Changes
	PEI: Prevention	
Avenal One-Stop	Avenal One-Stop will integrate needed services and supports that promote engagement of historically unserved communities into mental health services. It will also incorporate services that address physical health, mental health, employment, basic needs such as food, clothing, and shelter, and education.	• New program
	PEI: Outreach for increasing recognition of early signs of mental illness	
Community Wide Outreach & Education or Training	• Mental Health First Aid • Youth Mental Health First Aid • Applied Suicide Intervention Skills Training (ASIST) • Another Kind of Valor • Safe Talk • Crisis Intervention Training • Other training (to support trainings such as Self-Injury prevention outreach to child welfare)	**No changes to program** (moved from Community Wide) **New program** Safe Talk
	PEI: Stigma and discrimination reduction	
Community Wide Stigma and Discrimination Reduction	• Social media efforts • Coordination of a speakers' bureau that conducts presentations about various issues pertaining to mental illness and stigma • Anti-stigma advocacy before local public bodies engaged in decision-making that affects mental health treatment and services • The Kings County Cultural Competency Task Force (CCTF) • Latino Mental Health Literacy Program	**Modification** Expand speakers' bureau to cover specific topics **New program** Latino Mental Health Literacy
	PEI: Access and linkage to treatment	
Access and Linkage	• 211 • Access and Linkage Program (Formerly Access Review Teams (ART) • Warm Line (modeled after Tulare County)	**Modification** Changes to Access and Linkage Program **New program** Warm Line
	PEI: Suicide Prevention	

Suicide Prevention Task Force	• Tulare and Kings County Suicide Prevention Task Force (SPTF)
	  ○ Reduction and Elimination of Stigma Through Art Targeted Education (RESTATE)
	  ○ The Trevor Project
	  ○ Depression Reduction Achieving Wellness (DRAW)
	  ○ Local Outreach to Suicide Survivors (LOSS)
	  ○ Student Mental Health Network (SMHN)
	  ○ Central Valley Suicide Hotline
		No changes (moved from Community Wide)
		
		Remove
		Student Mental Health Network (SMHN)

Notes:

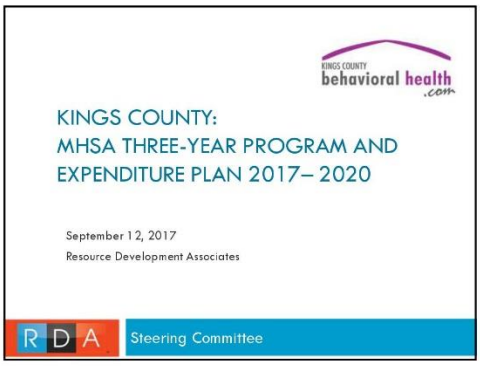
- Steering Committee wants to direct CSS: GSP funds to specific cultural, geographic programs for Native Americans and Veterans. Add to plan.

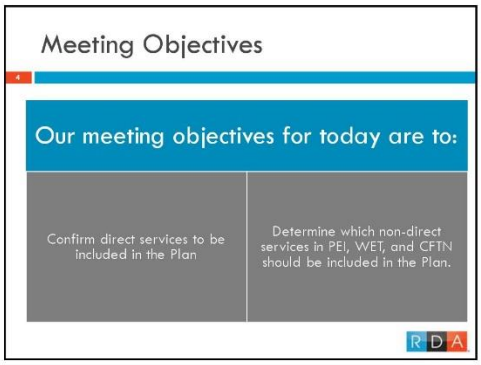
Programs being removed:

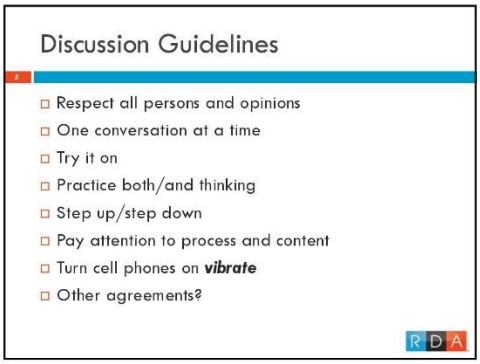
- Universal Development Screening (CYF)
- Therapeutic Activity Group Tier 2 & 3 (CYF)
- Youth mentoring/ambassador program
- FSP: Community Integration (integrated into FSP)
- Satellite Clinic Expansion

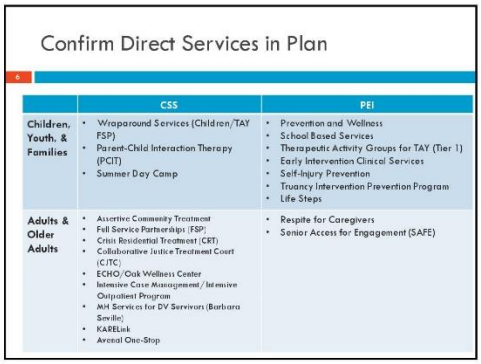
Presentation

12/20/2017





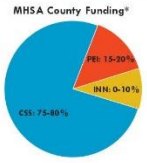




7 Quick review of PEI, WET, and CFTN

MHSA Components

- **CSS: Community Services & Supports**
  - Outreach and direct services for children, TAY, adults and older adults with SED/SMI
- **PEI: Prevention & Early Intervention**
  - Prevention services to prevent the development of mental health problems
  - Early intervention services to screen and intervene with early signs of mental health issues
- **CFTN: Capital Facilities & Technology Needs**
  - Infrastructure to implement an electronic health record and support MH facilities
- **WET: Workforce Education & Training**
  - Support to build, retain, and train a competent public mental health workforce
- **INN: Innovation**
  - Funding to test new approaches that may improve access, collaboration, and/or service outcomes for un-, under-, and inappropriately-served populations



*Counties received separate 10-year allocations for WET and CFTN activities

Prevention & Early Intervention (PEI)

Purpose	Prevent the development of serious mental illness or severe emotional disturbance and alleviate the need for more intensive treatment.
Population Served	Persons at risk of or prior to onset or development of serious mental illness/severe emotional disturbance
Funding Categories	• Prevention • Early intervention • Outreach of increasing recognition of early signs of mental illness • Stigma and discrimination reduction • Access and linkage to treatment • Suicide prevention
Funding	• 10-15% of total MHSA Allocation • At least 51% must be dedicated to individuals 0-25

Prevention & Early Intervention (PEI)

Requirements of PEI programming

- **Engage** persons prior to development of serious mental illness or emotional disturbance
- **Alleviate** the need for additional mental health treatment
- **Transition** those with identifiable need to extended mental health treatment

New Requirements for PEI funding

- All counties are required to have at leave one of each of the **five targeted** mental health programs.
- Using PEI funds for general or community wellness is **no longer allowed.**
- PEI programs must have **documented efficacy**, including evidence-based, community-defined, or promising practice standards.

At least 51 % of PEI funding must go to children or young adults (0-25).

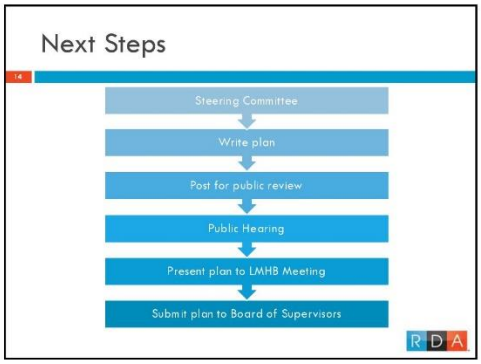
Workforce Education & Training (WET)

Purpose	Develop and provide programs that enhance the recovery-oriented treatment skills of staff ***already working in*** the public mental health system or ***recruit*** people to work in mental health.
Population Served	Current and prospective public mental health system employees, contractors and volunteers
Funding Categories	• Mental health career pathways • Financial incentive programs • Workforce staffing support • Residency and internship programs • Training and technical assistance
Funding	• Counties received one-time allocation of funds • WET funds must be spent by FY 2017-18

Capital Facilities and Technological Needs (CFTN)

Purpose	Acquire, construct, and or renovate facilities that provide services and treatment for people with serious mental illnesses or that provide administrative support to the public mental health system.
Population Served	Consumers, providers, employees
Funding Categories	• Capital facilities • Technology needs
Funding	• Counties received one-time allocation of funds • CFTN funds must be spent by FY 2017-18 • CFTN projects that benefit populations beyond the mental health system must include revenues from other funding sources so the net cost to MHSA is reflective of the benefit received by the MH system


13
Next Steps
RDA


Next Steps
14
Steering Committee
Write plan
Post for public review
Public Hearing
Present plan to LMHB Meeting
Submit plan to Board of Supervisors
RDA


THANK YOU!
RDA
Resource Development Associates

Appendix F. Community Report Back Meeting Materials

Community Engagement Feedback Forms

Thank you for your involvement in the Community Program Planning (CPP) Process for Kings County's Mental Health Services Act *Three-Year Program & Expenditure Plan*. We would like to hear about your experience with the CPP process. Your feedback will help us understand what we did well and what we can improve upon in the future. Please help us by taking a few minutes to fill out this anonymous feedback form.

Based on your experience with the MHSA Community Program Planning Process, please check how much you agree with the following statements.

	Strongly Disagree	Disagree	Agree	Strongly Agree
21. The needs assessment accurately captures the mental health needs in Kings County.				
22. The needs assessment data and proposed programs reflect my opinions/ideas about how to improve mental health services.				
23. The proposed programs will strengthen mental health services in Kings County.				
24. The proposed programs are in alignment with MHSA values.				
25. The community planning process is in alignment with MHSA values.				

	Poor	Fair	Good	Excellent

26. Overall, how would you rate the quality of facilitation throughout this planning process?				

27. Please share any comments you have about the proposed programs or the community program planning process:

Thank you!

Tarjeta de comentario tarjeta anónima sobre la planificación de los programas y la ley de servicios de salud mental (MHSA)

Gracias por su participación en el proceso de planificación de los programas y la ley de servicios de salud mental (MHSA) de Kings County. Nos gustaría saber mas de su experiencia con el proceso de planificación. Sus comentarios nos ayudarán a entender lo que hicimos bien y lo que podemos mejorar en el futuro. Por favor tómese unos minutos para completar este tarjeta de comentario anónima.

Basado en su experiencia con el proceso de planificación del programa comunitario MHSA, por favor marque como se sienta acuerda de las siguientes afirmaciones.

	Muy en desacuerdo	En desacuerdo	De acuerdo	Muy de acuerdo
28. La evaluación de necesidades refleja con precisión las necesidades de salud mental en Kings County.				
29. Los programas y servicios propuestos refleja mis opiniones e ideas acerca de cómo mejorar los servicios de salud mental.				
30. Los programas y servicios propuestos fortalecerán los servicios de salud mental en Kings County.				
31. El plan propuesto está alineado con los valores de la MHSA.				
32. El proceso de planificación de los programas de la comunidad está alieneado con los valores de la MHSA.				

	Malo	Pasable	Bueno	Excelente
33. En general, ¿cómo calificaría la calidad de la facilitación a través de este proceso de planificación?				

34. Por favor comparta cualquier comentario que tenga acerca de los programas y servicios propuestos o sobre el proceso de planificación de la comunidad:

Gracias!

Flyers

KINGS COUNTY behavioral health kcbh.org

Mental Health • Prevention and Early Intervention • Substance Use Disorders Prevention and Treatment

Kings County Behavioral Health (KCBH) invites you to provide your feedback:

Upcoming Community Meetings

Mental Health Services Act (MHSA)
Three-Year Program & Expenditure Plan

We will review the findings from Kings County's community needs assessment, report on the MHSA Three-Year Program & Expenditure plan for 2017 – 2020, and gather suggestions from you. Please consider attending any of these meetings:

Corcoran Community Meeting Monday, November 6th	Hanford Community Meeting Tuesday, November 7th	Avenal Community Meeting Tuesday, November 7th
6:00 -7:30 pm Corcoran, CA	11:30 am - 1:00 pm Hanford, CA	6:00 pm - 7:30 pm Avenal, CA
Corcoran Unified School District Technology Learning Center 1101 Dairy Avenue	**Kings Behavioral Health** Hope Room 460 Kings County Drive Suite 101	**Reef-Sunset Unified School District** Board Room 205 North Park Avenue

Please join us!

Community Meetings are open to the public. We look forward to hearing your input on the programs and strategies for the MHSA Three-Year Program & Expenditure plan. Food will be provided.

RDA

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

450 Kings County Dr., Suite 104 • Hanford CA 93230 • (559) 852-2376 • Fax (559) 589-6916

KINGS COUNTY behavioral health hcbh.org

Mental Health • Prevention and Early Intervention • Substance Use Disorders Prevention and Treatment

El departamento de Salud Mental de Kings County le invita cordialmente a la:

Reunión de la comunidad

Para El Plan de Programa y Gastos de Tres Años de la ley de servicios de salud mental (MHSA)

Vamos a reseñar los resultados de la evaluación de las necesidades de la comunidad incluyendo las programas y servicios propuestas para mejorar los servicios de salud mental y reportar el plan 2017 – 2020 de gastos y programas para Kings County's MHSA. Por favor, considere atender a cualquiera de estas justas:

Reunión de la comunidad de Corcoran Lunes, 6 de noviembre	Reunion de la comunidad de Hanford Martes, 7 de noviembre	Reunión de la comunidad de Avenal Martes, 7 de noviembre
6:00 pm- 7:30 pm Corcoran, CA	11:30 am - 1:00 pm Hanford, CA	6:00 pm - 7:30 pm Avenal, CA
Corcoran Unified School District Technology Learning Center 1101 Dairy Avenue	Kings County Behavioral Health Hope Room, Suite 101 460 Kings County Drive	Reef-Sunset Unified School District Board Room 205 North Park Avenue

¡Por favor, acompáñenos!

Las reuniones son para el público. Queremos escuchar sus opiniones sobre las programas e ideas para el plan de gastos y programas para el Kings County MHSA. Se proporcionará comida.

RDA

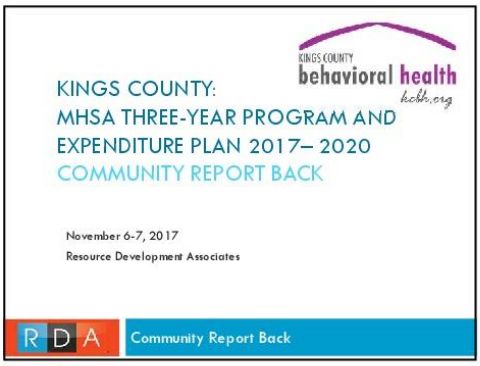
MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

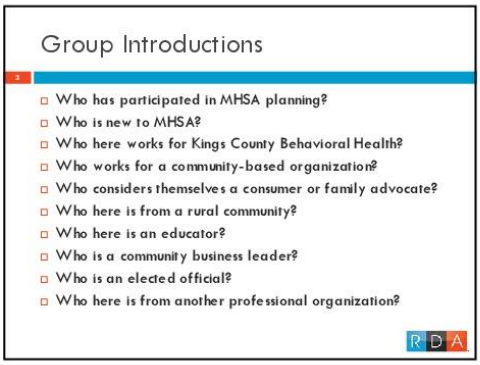
WELLNESS · RECOVERY · RESILIENCE

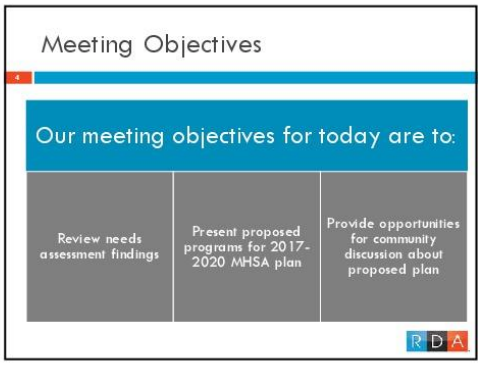
450 Kings County Dr., Suite 104 • Hanford CA 93230 • (559) 852-2376 • Fax (559) 589-6916

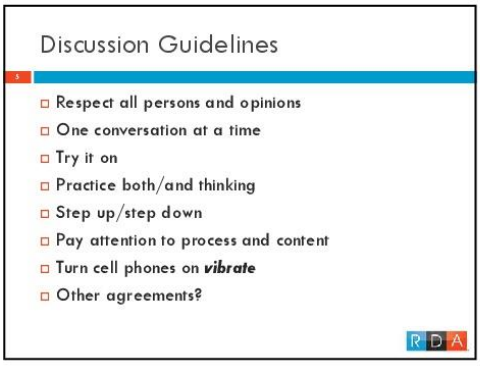
Presentation

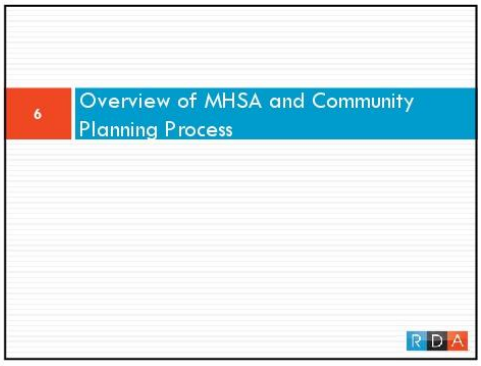
12/20/2017











MHSA Overview

HISTORY

Mental Health Services Act (Proposition 63) passed November 2, 2004

FUNDING SOURCE

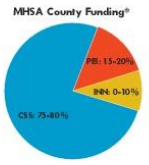
1% income tax on income over $1 million

PURPOSE

To ***expand and transform*** mental health services in California

MHSA Components

- **CSS: Community Services & Supports**
  - Outreach and direct services for children, TAY, adults and older adults with SED/SMI
- **PEI: Prevention & Early Intervention**
  - Prevention services to prevent the development of mental health problems
  - Early intervention services to screen and intervene with early signs of mental health issues
- **CFTN: Capital Facilities & Technology Needs**
  - Infrastructure to implement an electronic health record and support MH facilities
- **WET: Workforce Education & Training**
  - Support to build, retain, and train a competent public mental health workforce
- **INN: Innovation**
  - Funding to test new approaches that may improve access, collaboration, and/or service outcomes for un-, under-, and inappropriately-served populations



*Counties received 10-year allocations for WET and CFTN activities

MHSA Community Planning Process

The MHSA intends that there be a **meaningful stakeholder process** to provide subject matter expertise to the **development of plans focused on utilizing the MHSA funds at the local level**, including participation from community stakeholders.

The community planning process intended to create a 3-year MHSA plan that:

- Is integrated with other initiatives
- Is realistic and feasible
- Builds upon previous accomplishments
- Measures success
- Aligns with the spirit of the MHSA and complies with current regulations

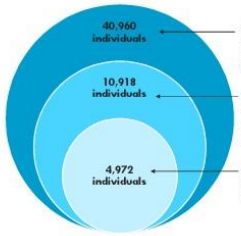
Roles and Responsibilities

- **Steering Committee**
  - Developed proposed programs and services for the 3-year MHSA plan
- **Community Stakeholders**
  - Contribute insight, share experiences, provide recommendations
- **Kings County Behavioral Health**
  - Implement 2017-2020 MHSA Plan
- **Board of Supervisors**
  - Approve 2017-2020 MHSA Plan
- **Resource Development Associates**
  - Plan and facilitate MHSA Needs Assessment

MHSA Planning Activities and Timeline

12 Needs Assessment Findings

2014-2017 Service Findings



All MHSA-funded services
All direct and/or indirect services, and activities such as public information campaigns

All direct services
Only direct services that range from intensive ongoing services to one-time or lower-touch services

Ongoing direct services
Only direct services that are either more intensive or ongoing

Accomplishments and Ongoing Barriers

	Accomplishments	Ongoing Barriers
Outreach and Engagement	• Expanded outreach efforts in the community	• Need for more culturally responsive outreach
Access and Referrals	• Revised referral processes • Increased service access in rural communities	• Ongoing need to simplify referral process and ensure feedback loop and warm hand offs • Ongoing rural challenges (e.g. limited transportation; psychiatric care)
Mental health services	• Refined roles and responsibilities in the process of strengthening clinical service availability • Developed and implemented plan to improve mental health services	• Ongoing need for services when/where they are needed • Refinements to clinical services • Continue to implement mental health services
Crisis	• Explored crisis continuum of services	• Crisis services still in planning phase
Partnership development	• Increased services in rural communities	• Need to continue effort around service integration

Outreach and Engagement

Progress
- Promoted awareness of 2-1-1 through a campaign
- Conducted outreach to all school districts on KCBH referrals
- Strengthened tribal relationships
- Created partnerships and collaboration with multiple agencies which strengthened referral process

Areas For Growth
- Identify proactive and targeted outreach efforts for individuals, families, and communities in need
- Conduct outreach in culturally relevant and accessible locations
- Create more culturally relevant outreach materials
- Increase stigma reduction programs across systems to increase visibility among diverse groups
- Create systems to measure outreach efforts

Access and Referrals

Progress
- Simplified referral process
- Provided referral training to staff in all local school districts

Areas for Growth
- Increase partners' awareness of referral process
- Ensure follow-up and tracking of referrals
- Share referral outcomes with referring parties

Access and Referrals – Rural Areas

Progress
- Placed staff in outlying, rural areas
- Participated in Avenal needs assessment
- Committed to work with the community and be creative in meeting the community

Areas For Growth
- Match the demand in rural areas with capacity
- Consider culturally responsible and feasible ways to meet the needs of the community

Mental Health Services

Progress
- Implemented innovative practice with Beats, Rhymes, and Life (BRL)
- Secured new service provider with expertise to implement Wraparound to fidelity
- Improved clinical services:
  - Clarified roles & responsibilities in clinical care
  - Added certain services to align with MHSA regulations

Areas For Growth
- Develop mechanisms for level of care determination
- Establish communication and referral pathways between crisis and ongoing mental health programs
- Implement FSP program for adults to align with model
- Measure efficacy of services

Crisis Services

19

Progress

- Examined opportunities to strengthen crisis continuum of services

Areas For Growth

- Consider ways to expand geographic reach of crisis services
- Develop processes and procedures for how:
  - New services will work together to prevent crisis

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Partnerships and Collaboration

20

Progress

In the last three years, KCBH:

- Convened faith-based leadership group
- Supported the development of the Whole Person Care collaborative
- Strengthened partnership with justice agencies
- Leveraged relationships with social services/child welfare and juvenile justice for Continuum of Care reform
- Increased collaboration with Adventist Health

Areas For Growth

- Work to increase collaboration between mental health and substance abuse services, including communication between agencies and centralized services
- Partner with school districts to ensure continuity of referrals and service accessibility across schools and for students

RDA

Ongoing Needs to Support Service Participation

21

- Increase housing options
- Increase transportation options
- Improve rural access to care
- Provide care with a consumer centered approach:
  - Assessment and services when/where they are needed
  - Culturally relevant staff (training/awareness)
  - Integrate community/informal support into clinical care
- Increase community wellness centers
- Consider options to assist individuals when cost of services is prohibitive

RDA

22 Overview of Proposed Programs

RDA

System of Care Goals: Children and Youth

23

This plan envisions a system that provides a full spectrum of services-from **prevention and early intervention** through clinical and crisis supports-and responds to the unique needs of children, youth and their families by:

- **Identifying and engaging** children and youth with mental health challenges in appropriate and timely mental health services.
- **Providing services** that are available when and where children and youth already are, during hours when children and youth can attend.
- **Providing adequate support** to prevent children, youth, and their families from becoming involved in the juvenile justice and child welfare systems, making efforts to keep children and youth at home and avoiding unnecessary out of home placements.
- **Providing crisis services** when children, youth, and families need them, wherever they are, and connecting them to services that are likely to prevent future crises.

RDA

Proposed Programs for Children/TAY

24

CSS		Program Name	Program Description	Status
	Full Service Partnership	Wraparound Services-Children/TAY FSP	Provides the full range of clinical and case management services that are individualized, family-centered, and team based to care for children/TAY with the most serious mental health needs.	Continuing with a new provider
	General Systems Development	Summer Day Camp	Provides services to children and youth with serious mental health needs during the summer months when children/youth do not have access to services.	Continued through Summer 2017
	General Systems Development	Parent-Child Interaction Therapy (PCIT)	Provides a combination of behavioral therapy, play therapy, and parenting techniques using a family-based approach for young children exhibiting challenging or developmentally inappropriate behaviors.	Continuing
	General Systems Development	Intensive Case Management/Intensive Outpatient Program	Provides clinical and case management services in an outpatient setting for children with serious emotional disturbance and youth with serious mental illness.	Continuing

Proposed Programs for Children/TAY

25

PEI		Program Name	Program Description	Status
	Prevention	School Based Services	Consists of three school-based programs that provide training and interactive presentations to increase coping skills in children/youth at risk of developing a mental health problem.	Continuing
	Prevention	Therapeutic Activity Groups	Partners with Beats, Rhymes, and Life, Inc. to provide a curriculum for KCBH staff to implement Hip Hop Therapy to increase coping skills in youth at risk of developing a mental illness.	Continuing
	Prevention	Truancy Intervention Program	Provides youth and their families with tools and resources to reduce truancy, including training and linkage to resources.	Continuing
	Early Intervention	Early Intervention Clinical Services	Provides clinical, case management, and other support services to youth that have experienced a first episode of psychosis, mania, depression, or other mental health disorder or are beginning to show signs of a serious mental illness.	New

Adult System of Care Goals

26

This system provides a warm and welcoming service delivery experience that promotes for individuals **recovery and interrupts the cycle of incarceration, hospitalization, and homelessness** with mental health challenges by:

- **Providing targeted outreach** to identify, engage, and connect people in need to mental health services.
- **Considering all of a person's needs and strengths,** from initial assessment throughout their treatment.
- **Meeting adults "wherever they are at"** in the community and in their recovery process.
- **Providing recovery oriented mental health services,** placing peer professionals throughout the entire system.
- **Coordinating between service levels,** providing appropriate and timely transitions between levels of care, and helping people navigate and stay engaged in the mental health system

RDA

Proposed Programs for Adults/Older Adults

27

CSS		Program Name	Program Description	Status
	Full Service Partnership	Assertive Community Treatment	Provides a full range to treatment services in the community, using a multidisciplinary, team-based approach with assertive outreach, to meet the needs of adults with the most serious mental health needs.	New
	Full Service Partnership	Full Service Partnership for Adults/Older Adults	Provides the full range of clinical, case management, and support services; using an individualized team-based approach; to meet the needs of adults with serious mental illness.	Continuing
	General System Development	Collaborative Justice Treatment Court	Uses the drug court model to connect eligible individuals with mental health/substance use and criminal justice involvement to a continuum of services and supports.	Continuing
	General System Development	Intensive Case Management/Intensive Outpatient Program	Provides clinical and case management services in an outpatient setting for adults and older adults with serious mental illness.	Continuing

Proposed Programs for Adults/Older Adults

28

CSS		Program Name	Program Description	Status
	General System Development	Empowering Consumers to Help Others (ECHO):Oak Wellness Center	Provides an array of consumer-driven services and social/recreational programs for individuals with serious mental illness who choose to include peer support in their recovery plan.	Continuing
	General System Development	Mental Health Services for Domestic Violence Survivors	Provides case management services, referral and linkage to individuals with mental illness who have experienced violence and are residents at the Barbara Seville shelter.	Continuing
	Outreach and Engagement	KARE Link	Provides time-limited, intensive case management and linkage for individuals who have a substance use disorder, mental health issues, or a chronic health condition, with a focus on re-entry to community from jail.	New
PEI	Access and Linkage to Treatment	Senior Access for Engagement (SAFE)	Provides services, such as visitation and support groups, and referrals to older adults who are at risk or beginning to experience mental health problems, such as depression, related to aging and isolation. Also provides respite to caregivers of SAFE participants.	Continuing
	Prevention	Prevention and Wellness	Provides services and linkage to individuals who may be unlikely to receive services in other settings, such as Veterans, Native Americans, and undocumented individuals.	Continuing

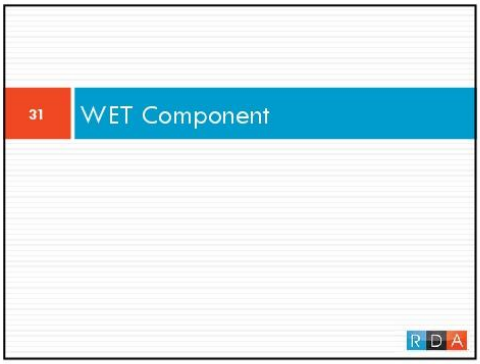
29 Community Wide

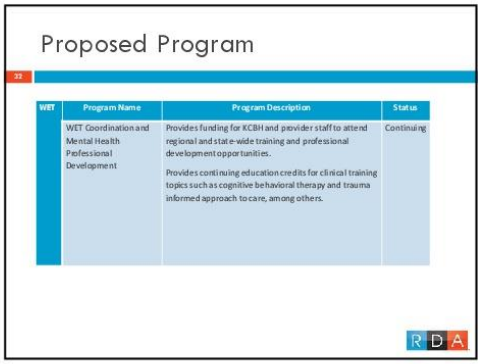
RDA

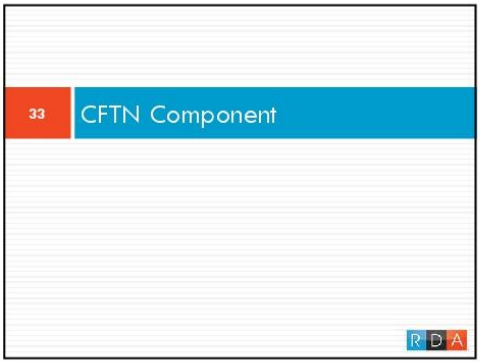
Proposed Programs

30

PEI	Category	Program Name	Program Description	Status
	Prevention	Avenal One-Stop	Provides co-located services, resources, and referrals to to the community of Avenal. Services will include linkage to County services, such as Medi-Cal enrollment and housing resources, and referrals for clinical services.	New
	Outreach	Outreach and Engagement/Training	Provides an array of training programs to improve the community's ability to recognize and respond to signs and symptoms of mental illness.	Continuing
	SDL	Stigma and Discrimination Reduction	Uses a a number of effort such as social media, a task force, presentations, and a community-based peer program to decrease stigma and increase connection to mental health services, especially for traditionally underserved populations.	Continuing with a new Peer Program
	A&L	Access and Linkage	Uses a series of activities, such as 211 (a telephone resource to connect callers to services) and a Warm Line (a peer run phone service) to provide linkage to existing services.	Continuing with a new Warm Line
	Suicide Prevention	Suicide Prevention Task Force	Promotes public awareness of suicide prevention efforts including an array of programs that provide support to individuals who may be experiencing depression or at risk of suicide.	Continuing


31
WET Component


Proposed Program
32
WET
Program Name
Program Description
Status
WET Coordination and Mental Health Professional Development
Provides funding for KCBH and provider staff to attend regional and state-wide training and professional development opportunities.
Provides continuing education credits for clinical training topics such as cognitive behavioral therapy and trauma informed approach to care, among others.
Continuing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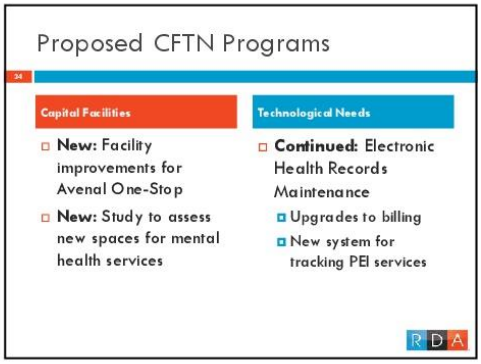
CFTN Component


Proposed CFTN Programs
34
Capital Facilities
New: Facility improvements for Avenal One-Stop
New: Study to assess new spaces for mental health services
Technological Needs
Continued: Electronic Health Records Maintenance
Upgrades to billing
New system for tracking PEI services


35
Next Steps


Next Steps
36
Post for public review
Present plan to BHAB Meeting/Public Hearing
Submit plan to Board of Supervisors

Appendix G: Public Posting

Notice of Public Posting

The Sentinel
Lee Central California Newspapers
P.O. Box 9
Hanford, CALIFORNIA 93232
PHONE 888-790-0915
Sentinel_Finance@lee.net

KINGS CO BEHAVIORAL HEALTH
450 KINGS COUNTY DR STE 104
HANFORD, CA 93230

ORDER NUMBER 77934

Publication- The Hanford Sentinel

State of California

County of Kings

I am a citizen of the United States and a resident of the county forsaid; I am over the age of eighteen years, and not a part to or interested in the above-entitled matter. I am the principal clerk of The Hanford Sentinel, a newspaper of general circulation, printed and published daily in the city of Hanford, County of Kings, and which newspaper has been adjudged a newspaper of general circulation by the superior court of the County of Kings, State of California, under the date of October 23, 1951, case number 11623.

That I know from my own personal knowledge the notice, of which the annexed is a printed copy (set in type not smaller than nonpareil), has been published in each regular and entire issue of said nespaper and not in any supplement thereof on the following dates, to wit:

PUBLISHED ON: 12/21/2017, 12/22/2017, 12/23/2017, 12/26/2017, 12/27/2017, 12/28/2017, 12/29/2017

TOTAL AD COST:	483.65
FILED ON:	12/29/2017

I certify (or declare) under penalty of perjury that the foregoing is true and correct.

Dated at Kings County, California

This Day 29th of December, 2017

Signature MARIE DAVIES

AD#77934

Public Notice

To all interested stakeholders, Kings County Behavioral Health (KCBH), in accordance with the Mental Health Services Act (MHSA), is publishing this Notice of 30-Day Public Comment Period and Notice of Public Hearing regarding the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Years 2017-2020.

THE PUBLIC REVIEW AND COMMENT PERIOD begins Saturday, December 23, 2017 and ends at 5:00 p.m. on Sunday, January 21, 2017. Interested persons may provide written comments during this public comment period. Written comments and/or questions should be addressed to KCBH, Attn: Katie Arnot, MHSA Coordinator, 460 Kings County, Suite 101, Hanford, CA 93230 or emailed to Katie.arnot@co.kings.ca.us.

A PUBLIC HEARING will be held by the Kings County Behavioral Health Advisory Board on Monday, January 22, 2018 at 12:00 noon, in the Hope Room located at 460 Kings County Drive, Suite 101, Hanford, CA, for the purpose of receiving further public comment on the MHSA Three-Year Program and Expenditure Plan for Fiscal Years 2017-2020.

To review the MHSA Three-Year Program and Expenditure Plan for Fiscal Years 2017-2020, visit the KCBH website at http://www.kcbh.org/public-notices. Printed copies of the MHSA Three-Year Program and Expenditure Plan for Fiscal Years 2017-2020 are available to read at the circulation desk of County Branch Libraries and in the public waiting area of KCBH at 460 Kings County Drive, Suite 101, Hanford. To obtain copies by mail, or to request an accommodation or translation of the document into other languages or formats, call the MHSA Coordinator at (559) 852-2317 by Friday, January 12, 2018.

Published December 21, 22, 23, 26, 27, 28, 29, 2018

RECEIVED
JAN 04 2018
By

KINGS COUNTY behavioral health kcbh.org

Mental Health • Prevention and Early Intervention • Substance Use Disorders Prevention and Treatment

Lisa D. Lewis, PhD | Director of Behavioral Health | (559) 852-2444

MENTAL HEALTH SERVICES ACT (MHSA) THREE-YEAR PROGRAM AND EXPENDITURE PLAN FOR FISCAL YEARS 2017-2020 NOTICE OF 30 DAY PUBLIC COMMENT PERIOD and NOTICE OF PUBLIC HEARING

To all interested stakeholders, Kings County Behavioral Health (KCBH), in accordance with the Mental Health Services Act (MHSA), is publishing this Notice of 30-Day Public Comment Period and Notice of Public Hearing regarding the above-entitled document.

I. THE PUBLIC REVIEW AND COMMENT PERIOD begins Saturday, December 23, 2017 and ends at 5:00p.m.on Sunday, January 21, 2017. Interested persons may provide written comments during this public comment period. Written comments and/or questions should be addressed to KCBH, Attn: Katie Arnst, MHSA Coordinator, 460 Kings County, Suite 101, Hanford, CA 93230. Please use the attached comment form.

II. A PUBLIC HEARING will be held by the Kings County Behavioral Health Advisory Board on Monday, January 22, 2018 at 12:00 noon, in the Hope Room located at 460 Kings County Drive, Suite 101, Hanford, CA, for the purpose of receiving further public comment on the MHSA Three-Year Program and Expenditure Plan for Fiscal Years 2017-2020.

III. To review the MHSA Three-Year Program and Expenditure Plan for Fiscal Years 2017-2020, follow this link to the KCBH website: http://www.kcbh.org/public-notices

IV. Printed copies of the MHSA Three-Year Program and Expenditure Plan for Fiscal Years 2017-2020 are available to read at the circulation desk of County Branch Libraries and in the public waiting areas of KCBH at 460 Kings County Drive, Suite 101, Hanford.

To obtain copies by mail, or to request an accommodation or translation of the document into other languages or formats, call the MHSA Coordinator at (559) 852-2317 by Friday, January 12, 2018.

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460 Kings County Dr. Suite 101 · Hanford CA 93230

kcbh.org

Public Comment Form

KINGS COUNTY behavioral health kcbh.org

Mental Health • Prevention and Early Intervention • Substance Use Disorders Prevention and Treatment

Lisa D. Lewis, PhD | Director of Behavioral Health | (559) 852-2444

Mental Health Services Act (MHSA) 30-Day Public Comment Form
Public Comment Period: December 23, 2017 – January 21, 2018

Document Posted for Public Review and Comment:

MHSA 3-Year Program and Expenditure Plan for Fiscal Years 2017-2020
This document is posted on the Internet at:
http://www.kcbh.org/public-notices

PERSONAL INFORMATION (optional)

Name: _____

Agency/Organization: _____

Phone Number: _____ Email address: _____

Mailing address: _____

What is your role in the Mental Health Community?

- ☐ Client/Consumer
- ☐ Family Member
- ☐ Educator
- ☐ Social Services Provider
- ☐ Mental Health Service Provider
- ☐ Law Enforcement/Criminal Justice Officer
- ☐ Probation Officer
- ☐ Other (specify) _____

Please write your comments below:

If you need more space for your response, please feel free to submit additional pages.
After you complete this comment form, please return it to KCBH before 5:00 P.M. on January 21, 2017, in one of four ways:

- Email this form or your written comments to Katie Arnst, KCBH MHSA Coordinator: Katie.arnst@co.kings.ca.us
- Fax this form to (559) 589-6928, Attn: MHSA Coordinator
- Mail this form to KCBH, Attn: MHSA Coordinator, 460 Kings County Drive, Ste 101, Hanford, CA 93230
- Hand deliver this form to KCBH, Attn: MHSA Coordinator, 460 Kings County Drive, Ste 101, Hanford, CA 93230

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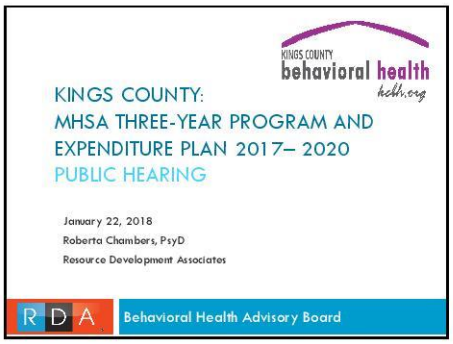
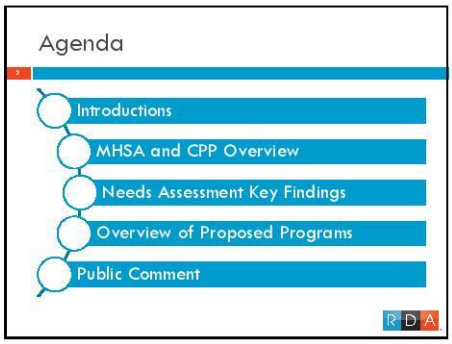
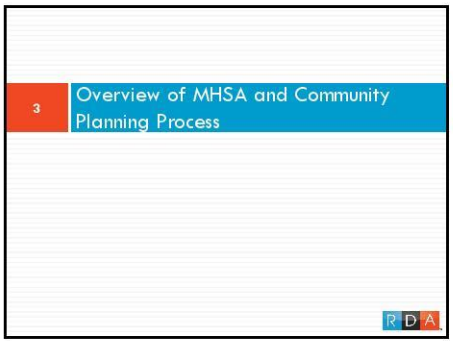
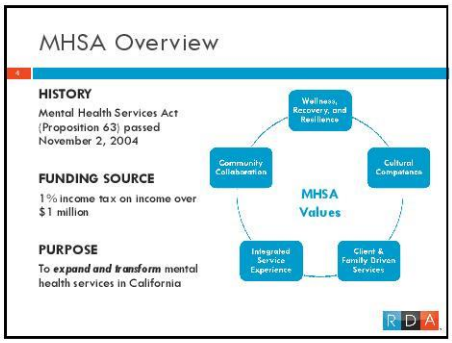
Public Hearing Presentation

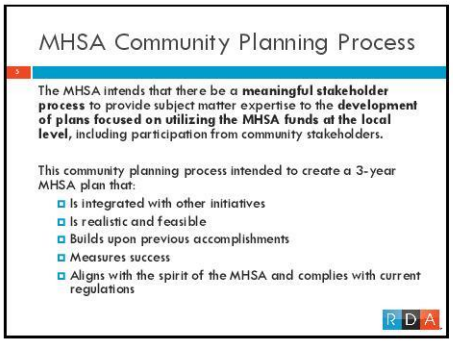
1/25/2018

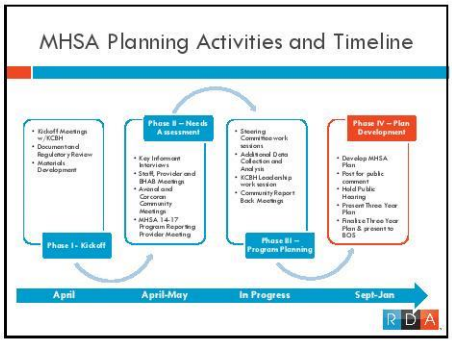












Community Planning Process

7

The planning team carried out a set of community meetings and information-gathering activities to engage stakeholders across Kings County. In total, **115 individuals participated in the Community Planning Process.**

Activity	Date
Planning Process Refinement	
Kickoff Meeting	April 18, 2017
Needs Assessment	
Key Informant Interviews	April - May 2017
Community meetings	May 22, 2017 - May 23, 2017
Plan Development	
Steering Committee Meetings (3)	July 11, 2017; August 8, 2017; September 12, 2017
Full Service Partnership Work Session	August 24, 2017
KCBH Executive Committee Meeting	September 28, 2017
Community Report-back Meetings	November 6, 2017 - November 7, 2017
Public Review Process	
30-Day Review Period	December 23, 2017 - January 21, 2018
Public Hearing	January 22, 2018
BOS Plan Approval	January 23, 2018

RDA

Roles and Responsibilities

8

- **Steering Committee**
  - Developed proposed programs and services for the 3-year MHSA plan
- **Community Stakeholders**
  - Contributed insight, shared experiences, provided recommendations
- **Kings County Behavioral Health**
  - Implement 2017-2020 MHSA Plan
- **Board of Supervisors**
  - Approve 2017-2020 MHSA Plan
- **Resource Development Associates**
  - Planned and facilitated MHSA Needs Assessment

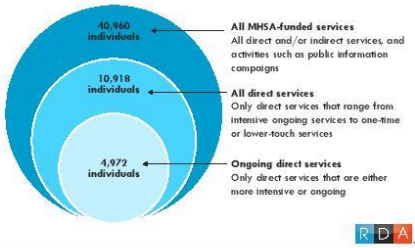
RDA

9 Needs Assessment Findings

RDA

2014-2017 Service Findings

10



RDA

Accomplishments and Ongoing Barriers

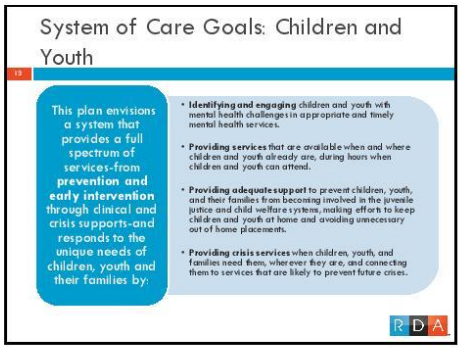
11

	Accomplishments	Ongoing Barriers
Outreach and Engagement	[redacted]	• Need for more culturally responsive outreach
Access and Referrals	• Revised referral processes • Increased service access in rural communities	• Ongoing need to simplify referral process and ensure feedback loop and warm handoffs • Ongoing rural challenges (e.g. limited transportation; psychiatric care)
Mental health services	• Refined roles and responsibilities in the process of strengthening clinical service availability • Developed and implemented plan to improve mental health services	• Ongoing need for services when/where they are needed • Refinements to clinical services • Continue to implement mental health services
Crisis	• Explored crisis continuum of services	• Crisis services still in planning phase
Partnership development	[redacted]	• Need to continue effort around service integration

RDA

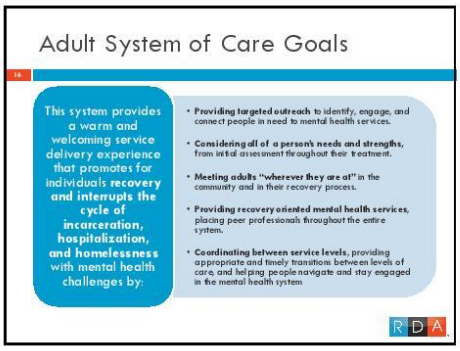
12 Overview of Proposed Programs

RDA



CSS		Program Name	Program Description	Status
	Full Service Partnership	FSP/Wraparound - Children/TAY	Provides the full range of clinical and case management services that are individualized, family-centered, and team based to care for children/TAY with the most serious mental health needs.	Continuing with a new provider
	General Systems Development	Summer Day Camp	Provides services to children and youth with serious mental health needs during the summer months when children/youth do not have access to services.	Continued through Summer 2017
	General Systems Development	Parent-Child Interaction Therapy (PCIT)	Provides a combination of behavioral therapy, play therapy, and parenting techniques using a family-based approach for young children exhibiting challenging or developmentally inappropriate behaviors.	Continuing
	General Systems Development	Intensive Case Management/ Intensive Outpatient Program	Provides clinical and case management services in an outpatient setting for children with serious emotional disturbance and youth with serious mental illness.	Continuing

PEI		Program Name	Program Description	Status
	Prevention	School Based Services	Consists of three school-based programs that provide training and interactive presentations to increase coping skills in children/youth at risk of developing a mental health problem.	Continuing
	Prevention	Therapeutic Activity Groups	Partners with Beats, Rhymes, and Life, Inc. to provide a curriculum for KCBH staff to implement Hip Hop Therapy to increase coping skills in youth at risk of developing a mental illness.	Continuing
	Prevention	Truancy Intervention Program	Provides youth and their families with tools and resources to reduce truancy, including training and linkage to resources.	Continuing
	Early Intervention	Early Intervention Clinical Services	Provides clinical, case management, and other support services to youth that have experienced a first episode of psychosis, mania, depression, or other mental health disorder or are beginning to show signs of a serious mental illness.	New



CSS		Program Name	Program Description	Status
	Full Service Partnership	Assertive Community Treatment	Provides a full range to treatment services in the community, using a multidisciplinary, team-based approach with assertive outreach, to meet the needs of adults with the most serious mental health needs.	New
	Full Service Partnership	Full Service Partnership for Adults/Older Adults	Provides the full range of clinical, case management, and support services; using an individualized team-based approach; to meet the needs of adults with serious mental illness.	Continuing
	General System Development	Collaborative Justice Treatment Court	Uses the drug court model to connect eligible individuals with mental health/substance use and criminal justice involvement to a continuum of services and supports.	Continuing
	General System Development	Intensive Case Management/ Intensive Outpatient Program	Provides clinical and case management services in an outpatient setting for adults and older adults with serious mental illness.	Continuing

CSS		Program Name	Program Description	Status
	General System Development	Empowering Consumers to Help Others (ECHO):Oak Wellness Center	Provides an array of consumer-driven services and social/recreational programs for individuals with serious mental illness who choose to include peer support in their recovery plan.	Continuing
	General System Development	Mental Health Services for Domestic Violence Survivors	Provides case management services, referral and linkage to individuals with mental illness who have experienced violence and are residents at the Barbara Seville shelter.	Continuing
	Outreach and Engagement	KARELink	Provides time-limited, intensive case management and linkage for individuals who have a substance use disorder, mental health issues, or a chronic health condition, with a focus on re-entry to community from jail.	New
PEI	Access and Linkage to Treatment	Senior Access for Engagement (SAFE)	Provides services, such as visitation and support groups, and referrals to older adults who are at risk or beginning to experience mental health problems, such as depression, related to aging and isolation. Also provides respite to caregivers of SAFE participants.	Continuing
	Prevention	Prevention and Wellness	Provides services and linkage to individuals who may be unlikely to receive services in other settings, such as	Continuing

Category	Program Name	Program Description	Status
Prevention	Avenal One-Stop	Provides co-located services, resources, and referrals to to the community of Avenal. Services will include linkage to County services, such as Medi-Cal enrollment and housing resources, and referrals for clinical services.	New
Outreach	Outreach and Engagement/Training	Provides an array of training programs to improve the community's ability to recognize and respond to signs and symptoms of mental illness.	Continuing
SDR	Stigma and Discrimination Reduction	Uses a a number of efforts such as social media, a task force, presentations, and a community-based peer program to decrease stigma and increase connection to mental health services, especially for traditionally underserved populations.	Continuing with a new Peer Program
A&L	Access and Linkage	Uses a series of activities, such as 211 (a telephone resource to connect callers to services) and a Warm Line (a peer run phone service) to provide linkage to existing services.	Continuing with a new Warm Line
Suicide Prevention	Suicide Prevention Activities	Promotes public awareness of suicide prevention efforts including an array of programs that provide support to individuals who may be experiencing depression or at risk of suicide.	Continuing