Before the Board of Supervisors
County of San Joaquin, State of California

B-13-202

MOTION: Bestolarides/Ruhstaller//5

Approval of Mental Health Services Act Innovation Work Plan for 2013-2017


I HEREBY CERTIFY that the above order was passed and adopted on 03/12/2013 by the following vote of the Board of Supervisors, to wit:

AYES: Elliott, Bestolarides, Villapudua, Ruhstaller, Vogel

NOES: None

ABSENT: None

ABSTAIN: None

Clerk of the Board of Supervisors
County of San Joaquin
State of California

By: [Signature]

[Stamp]
# EXHIBIT A

## INNOVATION WORKPLAN

### COUNTY CERTIFICATION

<table>
<thead>
<tr>
<th>County Name:</th>
<th>San Joaquin</th>
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<tr>
<th>County Mental Health Director</th>
<th>Project Lead</th>
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<tbody>
<tr>
<td><strong>Name:</strong> Victor Singh</td>
<td><strong>Name:</strong> Lynn Tarrant</td>
</tr>
<tr>
<td><strong>Telephone Number:</strong> (209) 468-8750</td>
<td><strong>Telephone Number:</strong> (209) 468-2392</td>
</tr>
<tr>
<td><strong>Email:</strong> <a href="mailto:vsingham@sjcbhs.org">vsingham@sjcbhs.org</a></td>
<td><strong>Email:</strong> <a href="mailto:ltarrant@sjcbhs.org">ltarrant@sjcbhs.org</a></td>
</tr>
<tr>
<td><strong>Mailing address:</strong></td>
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<tr>
<td>1212 N. California St.</td>
<td>1212 N. California St.</td>
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<tr>
<td>Stockton, CA 95202</td>
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I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and Title 9, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3315(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400 (b)(2).

All documents in the attached Work Plan are true and correct.

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San Joaquin County Behavioral Health Services: Innovation Plan, March 12, 2013.

Page 1
San Joaquin County Behavioral Health Services: Innovation Plan, April 22, 2013.
Page 2
Community meetings were noticed throughout the County via flyers posted in public spaces. Flyers were also posted at all locations known to be frequented by consumers, including all Behavioral Health Services locations. Partner agencies were sent meeting notifications with specific requests to post the flyers in prominent locations at their facilities. E-mail messages were also sent to all stakeholders who had ever provided their contact information for the purpose of receiving updates related to MHSA planning activities, including many consumers, former consumers, parents and caregivers.

The following elements of the Community Program Planning Process contributed to the development of the program design:

<table>
<thead>
<tr>
<th>Month</th>
<th>Activities</th>
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<tbody>
<tr>
<td>May 2012</td>
<td>BHS Annual Action Planning, including Community Focus Groups</td>
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<td></td>
<td>Establishment of CYS Planning Team</td>
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<td>June 2012</td>
<td>CYS Planning Team Retreat</td>
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<td>July 2012</td>
<td>CYS Data Analysis and Review by CYS Planning Team</td>
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<tr>
<td>August 2012</td>
<td>Focus Group with CYS Staff</td>
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<td>Focus Group with Community Partners</td>
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<td>Focus Group with Parents of CYS consumers who have experienced a crisis episode</td>
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<tr>
<td></td>
<td>Interviews with Former CYS Staff</td>
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<td></td>
<td>Interviews with Community Partners</td>
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<tr>
<td></td>
<td>Interviews with CYS consumers who have experienced a crisis episode</td>
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<tr>
<td>September 2012</td>
<td>Interviews with Parents of CYS consumers</td>
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<tr>
<td></td>
<td>Community Input Meeting</td>
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<td></td>
<td>Refinement of Innovation Work Plan by CYS Planning Team and BHS Leadership</td>
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In all, more than 50 consumers, parents, community partners and BHS staff contributed in substantial ways to MHSA innovation planning activities. Participants in community meetings were diverse and representative of the stakeholders targeted through extensive outreach. Two participants were veterans (self-identified) and four program staff represented substance abuse prevention and treatment programs.

- Diana White, Cal Works Substance Abuse Prevention Chief Mental Health Clinician
- Becky Fitzgerald, Cal Works Substance Abuse Prevention Supervisor
- Christiane Highfill, Substance Abuse Prevention, Youth Coordinator
- Teresa Villes Reeves, Valley Community Counseling Mental Health and Substance Abuse Treatment program for children and adolescents

More than 50% of participants were consumers, parents or caregivers of consumers, or both.

The ethnic diversity of the group included 19% African-American, 10% Asian American, 10% Hispanic or Latino, 5% Native American, 43% White/Caucasian, and 13% “Mixed or Other race/ethnicity”. Eighty-one percent of participants were female.

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

The CYS Redesign Committee included the following members:

- Azra Khan, BHS Mental Health Clinician III
- Becky Fitzgerald, BHS Mental Health Clinician III
- Carolyn Walters, BHS Mental Health Clinician III
- Diana White, BHS Chief Mental Health Clinician
- Donna Cassetari, BHS Chief Mental Health Clinician
- Fredi Ruth-Levitt, Executive Director, Victor Community Support Services
- Jane Riddle, BHS Administrative Assistant (Parent Partner)
- Kim Saing, BHS Mental Health Clinician III
- Linda Brett, BHS Staff Nurse IV
- Lynn Tarrant, BHS Deputy Director, Children and Youth Services
- Michele Rowland-Bird, BHS Chief Mental Health Clinician
- Pat Hill, BHS Mental Health Clinician III
- Teresa Viles Reed, Valley Community Counseling Services
Focus group discussions included the following individuals:

- Angie Nicholas  BHS Mental Health Clinician (Outpatient)
- Ben Alban  BHS Mental Health Clinician (Outpatient)
- Carolyn Walters  BHS Mental Health Clinician III (Clinical Supervisor)
- Catherine Lee  BHS Mental Health Clinician III (Crisis After-Hours)
- Erica Rabello  BHS Mental Health Clinician (Outpatient)
- Fay Vieira  BHS Mental Health Clinician (Crisis)
- Joanna Bogacs  BHS Mental Health Clinician (Crisis After-Hours)
- Lani Westervelt  Clinician, Valley Community Counseling Services, Tracy
- Mike Sellers  BHS Mental Health Clinician (Foster Care), Veteran
- Mike Tarrango  BHS Mental Health Clinician III (Crisis Supervisor)
- Romy Mann  Clinician, ASPIRA
- Vanessa Felder  BHS Mental Health Outreach Worker/Parent Partner

2 parents of youth who had recently stabilized following a crisis episode

Interviews were conducted with the following individuals:

- Alison Stingle  Office of Education/ Former BHS Mental Health Clinician
- Gary Gunderson  Mary Graham Children’s Shelter
- Jennifer Jones  Women’s Center Youth and Family Services
- Tammy Souza  Office of Education/Former BHS Mental Health Clinician
- Yolanda Roberson  ASPIRA

4 youth recently stabilized following a crisis episode
8 parents of youth who had experienced a crisis episode

Participation in the September 2012 Community Input Meeting included the following individuals:

- Beverly Thompson  Child Abuse Prevention Council of San Joaquin County
- C. Jacobs  Family Member
- Cathy Long  Office of Education
- Devenie Gonsalves  Victor Community Support Services
- Dorothy A.  Family Member
- G. Beauregard  Family Member
- Ger Vang  Lao Family Community Development of Stockton
- Jane Riddle  BHS Administrative Assistant (Parent Partner)
- Jennifer Goetz  Stockton Unified School District
- Julie de Diego  Valley Mountain Regional Center
- Kim Spinelli  Victor Community Support Services
- Kristie Holguin  Office of Education
- L. Mitchell  Family Member
- L. Nelson  Family Member
- Michele Robinson  Family Member
- O. Rodriguez  Community Partnership for Families
- Peg Kruger  Manteca Unified School District
- R. Smalls  Family Member
Planning processes were guided by and recommendations were made by the San Joaquin County Mental Health and Substance Abuse Board:

- Kathi Gardner, Public Interest, Chair
- Gertie Kandris, Family Member
- Tasso Kandris, Family Member
- Steve McCormick
- Tosh Saruwatari, Family Member
- Laura Stanley, Public Interest
- Cary Martin, Public Interest, Veteran
- Sylvia Torres, Consumer
- Frances Hernandez, Family Member
- Larry Ruhstaller, Board of Supervisors

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

**Draft Plan Review**

San Joaquin County’s Innovation Plan concept was reviewed by the San Joaquin County Mental Health and Substance Abuse Board (MHSAB) on December 12, 2012. More than thirty members of the public were in attendance at the meeting, including 21 consumers/family members. The Draft Innovation Plan was distributed and reviewed with the MHSA Planning Stakeholder Steering Committee on January 8, 2013. The Final Draft was also presented at the MHSAB on January 16, 2013.

Copies of the plan were made available to the public for review and comment.

**Final Stakeholder Review and Public Hearing:**

San Joaquin County’s Innovation Plan was posted on the County’s MHSA website for 30 day stakeholder review on January 15, 2013. Notices of the posting were sent to the MHSA stakeholder list, which currently includes contact information for any individual ever involved in MHSA planning.
Notices of the plan availability were posted in English, Spanish, and Cambodian with instructions on how to request an interpreter to help review the Innovation Plan.

Following a thirty day review period, a public hearing was convened by the MHSAB on February 20, 2013. The final approved plan was submitted to the County Board of Supervisors on March 12, 2013.

The following recommendations for edits were made during the 30 day review process or during the public hearing:

Recommendation 1: Include more information on Functional Family Therapy and components of the treatment approach. Additional information is included in the final version regarding FFT and the three phases of treatment. (page 8-9)

Recommendation 2: Address known disproportionalities, the importance of cultural competency and the role of parent partners and peer mentors. Additional information is included in the final version on disproportionate minority contact in San Joaquin County and the importance of culturally competent parent partners and peer mentors. (page 9)

Additional recommendations included minor edits for clarity.
Exhibit C

INNOVATION WORK PLAN NARRATIVE

County Name: San Joaquin

Work Plan Name: Adapting Functional Family Therapy

Purpose of Proposed Innovation Project (check all that apply)

☐ INCREASE ACCESS TOUnderserved Groups

☒ INCREASE QUALITY OF Services, Including BETTER OUTCOMES

☒ PROMOTE INTERAGENCY COLLABORATION

☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

Adapt Functional Family Therapy (FFT): Assess whether a peer-based adaptation to functional family therapy improves family engagement and retention in FFT and contributes to better long-term outcomes for the family as measured on the Child Adolescent Needs Survey (CANS).

San Joaquin County Behavioral Health Services, in partnership with San Joaquin County Probation Department, and two community based organizations, propose an adaptation to the functional family therapy model to include the use of parent partners and peer mentors for both pre-engagement and post discharge interventions to increase the quality of services to be more inclusive of peer contributions and improve outcomes associated with retention and long-term benefits to the families. Additionally, this project will help promote interagency collaboration through the development of interagency operating procedures for referral, case management, and the coordination of additional resources amongst partner providers.

Functional family therapy (FFT) is an outcomes driven practice developed by Dr. James Alexander for youth, aged 11-18, at risk for and/or presenting with delinquency, violence, substance use, conduct disorder, oppositional defiant disorder, or disruptive behavior disorder. Functional family therapy is typically provided under the direction of a mental health clinician or social worker though probation officers are accepted practitioners. Treatment goals are typically met within 8-15 sessions and generally no more than 26 for serious situations. The treatment model is described as follows:

Phase One- Engage and motivate the youth and their families by decreasing the negativity and blame. Rather than ignoring powerful negative experiences (abandonment, abuse, depression and cultural isolation) FFT acknowledges and incorporates the powerful feelings into successful ways to engage and motivate for change. Parent partners and youth mentors will be utilized to support family’s engagement into Phase One treatment.
Phase Two-Change Behavior: Reduce and eliminate problem behaviors and accompanying family relational patterns through individualized behavior change interventions. FFT integrates a strong cognitive component into systematic skill training in family communication, parenting, problems solving and conflict management.

Phase Three-Generalize changes across problem situations by increasing the family’s capacity to utilize multi-systemic community resources adequately and engage in relapse prevention.

Within California, only one jurisdiction, Sutter County, has probation officers trained in FFT and outcomes associated with family retention suggest opportunities for improving the Behavioral Health / Probation Model of joint FFT.

The use of parent partners and peer mentors during a pre-engagement phase will help support the readiness of families to engage in the intensive intervention, leading to improved retention outcomes. Parent partners and peer mentors will also continue to engage families for six-to-twelve months following completion of the FFT intervention to provide long-term informal support for families and youth.

Cultural competency is an integral component of the added value parent partners and peer mentors will bring to the FFT model. Within San Joaquin County there is an identified disproportionality in the number of African American and Latino youth referred to Juvenile Probation and in the number of African American and Native Americans referred to Behavioral Health Services compared to the general population. As feasible parent partners and peer mentors will be recruited from communities with high proportions of juvenile justice or foster care involved youth.

Parent partners and peer mentors will be assigned to approximately one-half of the families served, establishing an internal comparison group for evaluation. Inclusion of parent partners and peer mentors in service delivery will ensure that services are client and family driven. On a program level, the inclusion of parent partners and peer mentors in overall program outcomes ensures the program integrity of client and family driven care.

The CANS will be included as an assessment tool to identify and refer families into the FFT program and to conduct a long-term post intervention assessment to determine if the positive outcomes experienced by the family during the intervention are retained at follow-up and to determine whether the use of parent partners and peer mentors has led to more significant or more sustained positive outcomes.

Finally, San Joaquin County Behavioral Health Services proposes to develop an annual learning community of regional FFT providers including local county partners as well as probation and mental health providers from neighboring counties. Through this learning community we hope to establish what works in building a multi-agency FFT team and whether any other interventions and trainings appear to support positive outcomes.
Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page.)

Goal 1: Increase the quality of services, including better outcomes

Parents and families of children and youth struggling with serious emotional disorders, delinquency, violence, and substance abuse often express frustration about the complexity of the social service system and their inability to access resources or make informed decisions about recommendations made, given the information and knowledge they have about the nature of their child’s diagnosis or the extent of their needs. Specifically parents in interviews, focus groups, and community meetings expressed frustration with the manner and content of the information provided within clinical interventions, while simultaneously expressing strong appreciation for the informal assistance of parent partners or other peer resources which allows them the time and space to talk through their own fears and concerns about mental health issues. Parents and other family members expressed a strong need to have others “who have been through it” help them process their experiences and help them develop an understanding of their own contributions to treatment interventions.

The functional family therapy adaptation will take the existing FFT model and add the following:

- Parent partners and youth mentors will provide pre-engagement work with families who have been identified through CANS or Probation intake as benefitting from FFT intervention. Pre-engagement will make sure that both youth and families have accepted that there are problems and are ready to try an intervention to help.
- Parent partners and youth mentors will provide non-clinical support and encouragement concurrent to intervention and will provide continued engagement post-discharge through informal, non-clinical conversations and home visits.

Expected Outcomes/Primary Change:

- At least 70% of families referred to the adapted FFT model will successfully complete the intervention in the first year, 80% in the following two years.
- Assessments will show measurable improvements in child and family outcomes, six months post discharge as measured by the CANS.
- Parents and family members will be more comfortable with the information provided by the clinical team and feel more confident in their contributions to treatment.
**Goal 2: Promote Interagency Collaboration**

Parents and families also expressed frustration regarding the multiple, uncoordinated services and interventions that are being received by their children, along with a frustration that by the time help was offered it was too late and that the problems were too big for parents and caregivers to figure out what to do and how to respond to the competing directions of multiple system partners.

Clinicians and other partner stakeholders also expressed their concerns with service provision, citing concerns that there are few family-based interventions that take a whole systems approach to addressing the holistic needs of children and youth, as well as late coordination between system partners. As one clinician indicated, “by the time Therapeutic Behavioral Services (TBS) or SB 163 Wrap-around program services are being considered we are already exploring out-of-home placement options.”

San Joaquin County proposes a unique FFT collaboration in which eight providers from four different agencies will commit to a three- year training and clinical consultation for implementation of the FFT project which will both build the capacity of multiple agencies to provide family therapy as well as develop protocols and habits for interagency communication and coordination. Finally, by embedding family-based interventions within the juvenile probation division this project will further Probation’s own goals of developing a climate of positive youth development and early intervention. Parent partners and youth mentors will be standing members in all aspects of interagency collaboration, both at the service delivery level and program level.

The functional family therapy model will be implemented in a multi-agency collaboration that will:

- *Link* behavioral health clinicians and probation officers in a joint approach to providing early family-based interventions with children and youth who are at risk of increased engagement.
- *Develop coordinated protocols* for referral, communication, and coordination for children and youth dually-engaged by probation and behavioral health for early interventions.
- *Ensure ongoing consumer and family voice* in the provision of service delivery and review of program outcomes, including ongoing development of all protocols, practices of service delivery, and interagency collaboration.

**Expected Outcomes/Primary Change:**

- Four public and private agencies will improve their capacity to coordinate, collaborate and align their approach to working with at-risk youth and families.
- Each agency will become more family focused and driven as reflected in the increase of more parent partners and youth mentors.
The FFT Project supports and is consistent with the six MHSA General Standards, as described below:

**Cultural Competence:** By balancing the decision-making role of clinicians with a heightened role for trusted peer supports, the FFT adaptation will bring balance to the perspectives and cultural orientations that impact a family and youth’s commitment to care and recovery. Parent Partners and youth mentors will provide the professional providers with ongoing consultation and guidance through the eyes of the client and family experience.

**Consumer-Driven Mental Health System:** Parent partners and youth mentors will enrich service delivery and on-going learning. A culture shift allowing youth and families to act in this central role is expected to empower and engage families in need while transforming the delivery of treatment services from within. The ongoing consultation and guidance of the parent partners and youth mentors will help to solidify the cultural shift throughout the program with the intent that this will begin to change the philosophical view of service provision to be more consumer and family driven.

**Family-Driven Mental Health System:** FFT will help build the capacity of the children’s mental health system to provide expanded opportunities for family therapy. The inclusion of parent partners as peer mentors will help ensure that the voices of parents and caregivers help drive the interventions.

**Wellness, Recovery and Resilience Focus:** The essence of parent partner and youth mentor activities will be engagement and education, with a strong emphasis on developing the skills of adolescents, parents and caregivers to take control of their own recovery and wellbeing. Attention to the needs and concerns of each family member will help each one recognize their role in strengthening the family.

**Community Collaboration:** Coordinating the implementation and training of the FFT providers with multiple provider agencies will foster improved communication and collaboration between the partner agencies. The inclusion of parent partners and youth mentors in all interagency collaboration will increase the philosophy of consumer and family driven care throughout multiple systems and providers.

**Integrated Service Experience:** The addition of parent partners and peer mentors to the treatment team will help youth and families learn about and access a full range of services provided throughout the community, from others “who have been there.” The creation of a multi-agency FFT provider team will help ensure that the best knowledge of services and resources of multiple agencies is shared amongst the FFT providers for the benefit of engaged families.
**Contribution to Learning**

Describe how the Innovation Project is expected to contribute to learning including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length – one page)

**Goal 1: Increase the quality of services, including better outcomes**

Innovation: Modify/adapt FFT to include parent partners and youth mentors.

Learning question:

- Will families and youth receiving the adapted FFT model demonstrate better outcomes than families and youth receiving functional family therapy as usual?

FFT is a short-term behavioral intervention, designed to identify and support the risk and protective factors that impact the youth and his or her environment. The approach is predicated upon understanding therapeutic interventions from a family systems approach. The core basis of FFT is the relationship between the practitioner and the family as they move from building engagement and motivation for change towards learning new behaviors and generalizing these skills towards the broader community environment. The proposed adaptation will ask whether incorporating peers into the treatment process will help improve retention in treatment and help sustain outcomes for the long term.

Specifically, the adaptation will use parent partners and peer mentors to help engage and recruit families who have otherwise expressed reluctance to participate in family therapy by helping to de-stigmatize the therapy process and fears invoked by the phrase “mental health.” The use of parent partners and peer mentors is anticipated to improve agreement to participate and retention in the program compared to the rates of participation and retention as documented by neighboring counties and in published studies.

Additionally, parent partners and peer mentors will continue to remain in contact and support youth and families for at least six months following the completion of the FFT treatment process. It is anticipated that the continued support of the parent partners and peer mentors will help to reinforce the behaviors practiced in therapy and prevent a re-escalation. Post-intervention effectiveness will be measured by comparing results of the CANS at discharge and at six months following discharge to see if stability has been maintained or improved over time.

Overall youth and family outcomes will be tracked and compared to national studies to determine if there appears to be a significant advantage in using parent partners and youth peer mentors concurrent to FFT.
Goal 2: Promote interagency collaboration

Innovation: Leverage the three-year FFT training process as a method to improve coordination and communication amongst community partners.

Learning question:

- Can the structured training and fidelity monitoring of FFT serve as an instrument to help promote interagency collaboration?

FFT can be implemented in teams no greater than eight and represents a substantial commitment in both staff time and organizational resources. The full training and fidelity monitoring model is three years in length and requires weekly individual and group supervision sessions totaling three hours for each participant per week. Despite well-documented positive outcomes when implemented with fidelity both the training cost as well as the long-term commitment required has prevented FFT from being widely adapted.

BHS is proposing to leverage the three-year FFT training process as a method to improve coordination and collaboration. By providing both the training processes, as well as funding for partner agencies to support an FFT practitioner, BHS will build a broad collaborative team of FFT providers that includes parent partners and youth mentors in both service delivery and interagency collaboration.

This collaborative team will work closely together, engage in a multi-year training and supervision process, and will collectively help create within their agencies cultures, practices, and protocols supportive of FFT and consumer and family driven service delivery. An annual learning community will be convened to both celebrate successes and to identify the operational challenges across agencies and county systems that stymie coordination and effectiveness of FFT. Parent partners and youth mentors will be included in the annual learning community in order to ensure the ongoing cultural shift in increasing consumer and family voice in all levels of service delivery.

By the end of the three year training period, it is hypothesized that the core partners will have a stronger working relationship as measured by more joint operating procedures, resource sharing (such as partnering on grants or embedding staff within partner agencies), and demonstrate more effective collaboration outside of the FFT project.
Timeline
Outline the timeframe within which the Innovation project will operate including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length – one page)

Implementation / Completion Dates: July 1, 2013 – June 30, 2017

<table>
<thead>
<tr>
<th>Major Tasks and Activities</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
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<tbody>
<tr>
<td>● Refine Innovation Plan</td>
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<td>● Approved by Mental Health Services Oversight and Accountability Commission and the San Joaquin County Board of Supervisors</td>
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<td>● Develop staff training, tools, and protocols</td>
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<td>● Revisit and revise protocols</td>
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<td>● MOUs with Interagency partners</td>
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<td>● Begin hiring process</td>
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<td>● Conduct staff trainings on the use of CANS and FFT</td>
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<td><strong>Goal 1: Implement FFT Adaptation</strong></td>
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<td>○ Begin FFT sessions</td>
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<td>○ Develop and begin use of protocols that routinely incorporate parent partners and peer mentors into FFT engagement retention and follow-up.</td>
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<td>○ Begin universal CANS assessment process</td>
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<td>○ Convene annual learning communities to assess operational successes and challenges</td>
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<td><strong>Goal 2: Improve interagency collaboration</strong></td>
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<td>○ Identify and prioritize challenges to be addressed</td>
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<td>○ Develop interagency protocols on the use of FFT, including early identification and referral protocols</td>
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<td>○ Refine operations and county-wide approaches to early identification and intervention for at-risk youth and families</td>
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<td>● Investigate Learning Questions</td>
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<td>● Prepare and disseminate findings</td>
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**Project Measurement**

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment. (suggested length – one page)

The following logic model outlines the proposed indicators for the project. The proposed research plan is summarized below.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Strategy</th>
<th>Activity</th>
<th>Hypothesized Outcome</th>
<th>Measurable Indicator</th>
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</table>
| **Goal 1: Increase the quality of services, including better outcomes** | Augment and adapt FFT to include parent partners and youth mentors. | Hire, train, and supervise parent partners and peer mentors to work with youth and families referred to FFT. | More youth and families agree to try FFT and more are retained to completion. | • 70% of those referred are engaged in FFT  
• 70% of those engaged in FFT complete the treatment |
|  | Overall, youth and families report better functioning following the intervention and improvements are sustained over time. |  | • 70% of those completing FFT show marked improvement on the CANS compared to entry into FFT.  
• 70% of those completing FFT demonstrate sustained improvements 6-months post intervention. |

| Goal 2: Promote interagency collaboration | Create a multi-agency FFT training cohort to implement FFT county-wide. | Convene multiple agency partners in weekly supervision meetings, bi-monthly project meetings and annual learning communities. | Project leads and staff will become more familiar with partner agencies’ services and protocols. | • All partners will remain committed and satisfied with project outcomes, as demonstrated through learning communities and confidential interviews.  
• New protocols and operating agreements will be developed to guide communication and coordination, including expanded contracts or MOUS. |
|  |  |  | Natural opportunities will arise to improve and strengthen coordination and collaboration both within and beyond the FFT project. | |
The project will be reviewed and assessed using a combination of quantitative and qualitative measures in which to analyze whether outcomes have been achieved as indicated and to determine whether overall the project was effective from the perspectives of parents, youth, partner agencies, and other stakeholders. The following research activities are proposed, though modifications to the research plan may be developed following project implementation.

**Establish a comparison group**

Parent partners and youth mentors will be offered to all families referred to FFT who are receiving services from the Stockton or the Tracy/Manteca Clinics and families of youth assessed at Probation intake not currently linked to mental health services.

BHS will seek to develop a data sharing relationship with an out-of-county community that is also using FFT to serve as a comparison group of those receiving FFT as usual.

**Quantitative research activities**

**Analyze referral and retention data.** Using an excel spreadsheet, program staff will track all individuals referred into the program. The spreadsheet will track date referred to the program, date in which FFT services initiated, number of sessions completed, and date FFT services are concluded. The spreadsheet will also track which families have a parent partner and/or youth mentor assigned.

- Measure proportion of families referred by the number of families for which FFT services initiate.
- Measure proportion of those engaged by the number which complete FFT intervention.
- Compare outcomes between experimental group receiving adapted version of FFT and those receiving FFT as usual.
- Analysis will be conducted annually.

**Analyze participant and family outcomes.** FFT fidelity model will be strictly adhered too, including all required data reporting and outcome monitoring. In addition, the Child Adolescent Needs Survey (CANS) will be used to identify families that would benefit from FFT and measure progress made during the course of treatment. The CANS assessment will be conducted at baseline on all participants. The CANS will also be used to establish an exit benchmark of progress and will be re-administered after six-months to determine if outcomes are sustained over time. Analysis will be conducted two years and four years following project initiation and will include a comparison between the experimental group and the comparison group receiving FFT as usual.

The FFT fidelity model includes several pre and post outcomes questionnaires for to determine participant satisfaction with the intervention as well as to track behavioral changes over time. The following instruments will be used to help assess outcomes.

- Youth Outcome Questionnaire (YOQ) pre and post
- Youth Outcome Questionnaire Self Report (YOQSR) pre and post
• Outcome Questionnaire (OQ45) pre and post
• Counseling Process Questionnaire (CPQ) every session
• Client Outcome Measure (COM) post intervention
• Therapist Outcome Measure (TOM) post intervention

Qualitative research activities

FFT fidelity measures and outcomes data will be analyzed and interpreted in the context of findings from the following:

Annual learning communities. Once annually, all project team members and executive stakeholders will meet to discuss project strengths and challenges and to develop shared recommendations and expectations for ongoing improvements. Consumers and family members who have received FFT will be encouraged to participate in this process with the intent that their feedback will continue the cultural shift of the inclusion of family voice in both service delivery and program development. BHS will work with California Institute of Mental Health (CIMH) staff, who will be conducting the FFT training and fidelity monitoring, to identify other regional partners who may wish to participate in a regional learning communities to discuss what has worked for other regions implementing FFT.

Literature review. Following the four year FFT project period, the project director and research assistant will review the project and outcome data to determine if there are any significant advantages to the adapted FFT model compared to FFT as usual. The research team will also review existing literature documenting outcomes to determine if the outcomes experienced by those receiving FFT as usual are similar to those found in previous studies. If the outcomes of the comparison group are similar to those in previously published research and if the outcomes of those receiving the adapted FFT model are significantly improved, further research into the peer adaptation will be strongly recommended.

Disseminate findings

Findings will be disseminated to all stakeholders and partners in a final project report (anticipated completion December 2017). If outcomes appear significant, as described above, further efforts will be made to work with CIMH and the Mental Health Services Oversight and Accountability Commission (MHSOAC) to help disseminate the findings through either published reports or conference presentations.
Leveraging Resources (if applicable)

Provide a list of resources to be leveraged, if applicable.

- Medi-Cal / Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Revenue

Primary additional funding sources will be Medi-Cal and/or EPSDT revenue related to the delivery of Mental Health Services and Case management Services delivered by team members of this project. With the exception of the Outreach Worker Trainee and the Deputy Probation Officer I, all other staff identified in the budget will deliver medically necessary mental health services billed to Medi-Cal.
Exhibit D

Innovation Work Plan Description
(For Posting on DMH Website)

County Name: San Joaquin
Work Plan Name: Adapting Functional Family Therapy

Annual Number of Clients to be served (if applicable):

Population to Be Served (if applicable):

The target population includes youth, aged 11-18, at risk for and/or presenting with delinquency, violence, substance use, conduct disorder, oppositional defiant disorder, or disruptive behavior disorder and their families.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

San Joaquin County Behavioral Health Services, in partnership with San Joaquin County Probation Department and two community based organizations, will adapt the functional family therapy model to include the use of parent partners and peer mentors for both pre-engagement and post discharge interventions to be more inclusive of peer contributions and to improve outcomes associated with retention and long-term benefits to the families. Additionally, this project will help promote interagency collaboration through the development of interagency operating procedures for referral, case management, and the coordination of additional resources amongst partner providers.
Insert Exhibit E: Innovation Funding Request
Insert Exhibit F: Innovation Projected Revenues and Expenditures
Exhibit G

Innovation Component
Request for Funding for Community Program Planning

Date: April 2013

County: San Joaquin

Total Amount Requested: $2,701,393

Funding Purposes
Please briefly describe the purpose and amount for which the requested funding will be used.

Funding will be used to hire, train, and monitor staff implementing an adaptation of the functional family therapy model. Additionally, some funding will be used to purchase equipment, office supplies, travel for trainings, program evaluation, and administrative overhead.

Certification
I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said County and the following statements are true. I have not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements listed above represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures. The proposed activities are consistent with the Mental Health Services Act, the Department’s regulations governing the MHSA, and draft proposed guidelines for the Innovation component of the Three-Year Program and Expenditure Plan; and to the best of my knowledge and belief this request in all respects is true, correct, and in accordance with the law.

Signature (Director/Designee, County Mental Health Department)
San Joaquin County Behavioral Health Services

2013 MHSA Innovation Component Proposal: Adapting Functional Family Therapy

Budget Narrative and Detail

The following budget narrative is based on a one year planning period (FY 12/13) and a four year project period (FY 13/14 – FY 16/17). The project is intended to end on June 30, 2017. All figures are rounded to the nearest whole number.

I. Expenditures: $4,863,830

A. Personnel

$1,627,506: Total personnel costs.

Personnel costs include the part time salary costs associated with one chief mental health clinician (0.5) and one mental health clinician III from the crisis follow-up team (0.5) who were the principal staff involved in the innovation outreach and engagement and implementation plan for BHS during the planning year period.

Personnel costs for the four year project period include the continued involvement of both these staff members as well as several new positions, including two youth mentors, three parent partners, and 1 parent partner/case manager. An office worker I position is also included in the budget to provide clerical and administrative support the functional family therapy team. A 2% annual cost of living adjustment is built into the budget assumptions.

The salaries of the other BHS clinicians participating on the FFT team will be leveraged from ongoing funding sources.

Personnel costs are fully loaded to include all negotiated benefits.

B. Operating Expenses

$226,130: Total Operating Costs

Office Supplies: $6,500.

$1,500 is allocated annually for office supplies and materials for clinicians and staff working within the FFT unit ($6,000 for the four year project period). $500 was allocated during the planning year.
Travel Cost / Motor Pool: $20,000.
$5,000 is allocated annually for travel costs associated with the use of county vehicles from the motor pool. County vehicles are used in all transports of clients to services. County vehicles are also used for home visits. County vehicles may only be used by a specially trained and licensed county employee. No motor pool costs are allocated during the planning year.

Trainings: $35,000
$10,000 is allocated annually for first two years and $5,000 is allocated annually for the last two years of the four year project period for staff training activities including mental health first aid trainings, cultural competency trainings and other trainings designed to improve the competencies of the parent and youth mentors engaged in the adapted functional family therapy model. These trainings are intended to augment the new employee orientation and other standardized trainings to give peer employees a better grounding in mental health practices. $5,000 was allocated during the training period. These funds were used by staff members, including existing parent partners to audit and review various models considered during the planning period.

Mileage: $3,500
$750 is allocated annually for the four year project period and $500 was allocated during the planning year for personal car use for travel to trainings and meetings.

Communications: $9,180
$2,160 is allocated annually for the four year project period for the operation of new phone lines to the newly hired team members. An additional $540 was budgeted during the planning year for communication costs incurred by the planning team.

Rane Community Development: $96,000
$15,000 is allocated annually for implementation technical assistance from Rane Community Development. Additionally, $36,000 was allocated to Rane community Development to facilitate the outreach and engagement portion of the planning process, develop and refine the strategies, assure commitments from stakeholders and key partners, and to prepare a written plan for submission.

Program Supplies and Manuals: $21,000
$5,000 is allocated annually for program supplies and manuals, including parent and family member program information guides. An additional $1,000 was expended during the planning year to order various program manuals and information guides necessary to audit and review potential program models.
Rents and Utilities: $34,350
$8,300 is allocated annually for rent and utility costs based on the facility requirements for supporting team members. An additional $1,150 was budgeted during the planning year for the associated rent and utility costs of the planning team members.

License and Permits: $600
$150 is allocated annually for any updated license or permitting costs necessary during the project period.

C. Non-recurring Expenses
$147,000: Total non-recurring costs.

Furniture: $72,000
$72,000 is budgeted during the planning year for the purchase of furniture, cubical dividers, and other fixed assets to accommodate the anticipated increase in staff and the movement and re-arrangement of the current office configurations to accommodate clinicians and staff into the proposed project team area.

Computers: $20,000
$20,000 is budgeted during the planning year for the purchase of computer equipment including desktop monitors, laptops, printers, copiers, telephone handsets, and associated memory and wireless access devices, and power cables for workspaces.

Software: $55,000
$55,000 is budgeted during the first two years of the project period to purchase and to modify the CANS software package to meet the requirements of BHS and the adapted functional family therapy team.

D. Training Consultants and Contractors
$1,999,124: Total Training Consultants and Contractors

San Joaquin County Probation Department: $489,635
$118,797 is provided in the first year of operations to cover the salary and benefit costs associated with one probation officer. Salary and benefit costs are budgeted to increase by 2% annually to account for cost of living salary increases.

Respite Bed Contract: $225,000
$50,000 is budgeted annually during the project period for referrals for respite beds for children and youth who may need a safe place to stabilize prior to or during the FFT intervention in order to begin or resume treatment interventions. An additional
$25,000 is allocated during the planning year to help develop the selected contractor(s) create the required facility enhancements, develop policies and referrals associated with desired outcomes, and develop and implement training programs with staff to orient them to program goals and objectives, including expectations for documentation, communication, and coordination.

Valley Community Counseling Center: $318,776
$79,694 is budgeted annually over the four year project period for the salary and benefits of a clinician who will be conducting FFT.

Victor Community Treatment and Supports: $455,024
$113,756 is budgeted annually over the four year project period for the salary and benefits of a clinician who will be conducting FFT.

California Institute for Mental Health: $106,750
Funds are allocated for each of the four year project period according to required training and fidelity monitoring protocols.

San Joaquin Data Co-op: $160,000
$40,000 is allocated annually over the four year project period for an outside evaluation firm to determine if the adapted FFT model shows improved outcomes compared to FFT as usual.

Resource Development Associates: $67,017
$16,260 is allocated for each of the first three years of the project and $17,255 is allocated in the last year of the evaluation to conduct interviews and collect stories of project participants to develop biographic sketches of participants and on the impact of the adapted FFT model for publication.

IS Support: $176,922
$60,000 is allocated during the planning year and $56,922 is allocated in the first year for information systems technical support to help get all computers networked and operating and linked into the new CANS system. This will require significant reconfiguration of BHS and contractor operating systems to ensure that the new assessment tool is appropriately linked to billing and clinician management systems as well as conform to the technical specifications of BHS, Probation, and contractor information systems. An additional $20,000 is allocated in each of the ongoing project years for ongoing IS support services, including server, network, database, and hardware management.
E. Work Plan Management

$864,070: Total Work Plan Narrative

Administrative Overhead: $658,950
Administrative overhead is calculated as 15% of total personnel and operating costs. Administrative overhead includes costs associated with program management and review including auditing, financial management, and director level support.

Indirect Costs: $205,120
Indirect costs are calculated as proportion of the management analyst time required to operate a program of this scope. Management analysts are responsible for all contract management, including receipt and verification of invoices and ensuring contractors meet program obligations.

II. Revenues: $2,162,437

A. Previous MHSA funding received for INN: $1,224,637
Innovation funding in the amount of $401,937 will be utilized in FY 12/13 from prior fiscal years Innovation funds received. Innovation funding in the amount of $822,700 for FY 13/14 will be utilized from prior fiscal years Innovation funding received.

B. Medi-Cal / EPSDT Revenue: $937,800
The project is anticipated to generate a total of $937,800 in revenue which will partially offset the cost of operating this program. The revenue projections take into account a start-up period which will include training and client engagement prior to beginning billable operations. Years two, three, and four are projected to meet the full revenue projections for the project of $267,950, annually. In the first year of the project revenues are anticipated at $133,950, approximately half of those expected in later years.

III. Requested Allocation: $2,701,393

- Expenditures: $4,863,830
- Revenues (includes funding previously received) $2,162,437
- Funding Request: $2,701,393
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<th>staff FY 15/16</th>
<th>staff FY 16/17</th>
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San Joaquin County Behavioral Health Services: Innovation Plan, April 22, 2013.
Page 31
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<td>IS support</td>
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<td>Work Plan Management</td>
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<tr>
<td>Administrative Overhead @ 15%</td>
<td>$38,353.00</td>
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<td>Indirect</td>
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<td>Total Expenditures</td>
<td>$401,937.00</td>
<td>$1,173,289</td>
<td>$1,107,157</td>
<td>$1,084,200</td>
<td>$1,097,248</td>
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<tr>
<td>B. Revenue:</td>
<td>$937,800</td>
<td>FY 12/13</td>
<td>FY 13/14</td>
<td>FY 14/15</td>
<td>FY 15/16</td>
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<td>----------</td>
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<tr>
<td>INN Funding Received</td>
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<tr>
<td>Medi-Cal Revenue/E.P.S.D.T.</td>
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<td>$133,950</td>
<td>$267,950</td>
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<tr>
<td>Total Revenues</td>
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| Total Project Budget | $        | $216,639 | $839,207 | $816,250 | $829,298 |

<table>
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<th>Total Project Costs (FY 12/13 - 16/17):</th>
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