EXHIBIT A

INNOVATION WORKPLAN
COUNTY CERTIFICATION

County Name:	**San Joaquin**

County Mental Health Director	Project Lead
Name: Victor Singh Telephone Number: (209) 468-8750 Email: vsingh@sjcbhs.org	Name: Lynn Tarrant Telephone Number: (209) 468-2392 Email: ltarrant@sjcbhs.org
Mailing address: 1212 N. California St. Stockton, CA 95202	Mailing address: 1212 N. California St. Stockton, CA 95202

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.

_____ _____ _____

Signature (Local Mental Health Director/Designee) Date Title

Exhibit B

INNOVATION WORK PLAN

Description of Community Program Planning and Local Review Processes

County Name: San Joaquin

Work Plan Name: Adapting Functional Family Therapy

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

1. Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)

The San Joaquin County Behavioral Health Services (BHS) Innovation Work Plan was developed through a vibrant Community Program Planning Process that engaged parents, adolescent consumers, community partners, BHS staff and former staff, and a dedicated Children and Youth Services (CYS) Planning Team.

The Community Program Planning Process grew organically out of the development of the BHS Annual Plan in early 2012. The comprehensive internal review of programs and practices undertaken at that time led – not unexpectedly -- to uncertain agreement about the importance and high priority of a systematic redesign of children and youth services, with the primary goal being the reduction of youth crisis episodes and hospitalizations. This data-driven and community-informed process led to the formation of the CYS Planning Team, and the Innovation Work Plan maps a pathway toward its ultimate goal. At the end of the planning process, formal presentations were made to the MHSA Planning Stakeholder Steering Committee and the San Joaquin County Mental Health Board to solicit final suggestions.

Both the annual planning and Innovation planning efforts have been led by Vic Singh, Director of Behavioral Health Services, Lynn Tarrant, Deputy Director of Behavioral Health Services, and Rane Community Development, a consulting firm with Mental Health planning expertise. A commitment from the outset to consumers, parent, caregiver and community input was fulfilled through far-reaching outreach efforts. The many voices that were heard as a result contributed to an innovation project design and one that was quite truly shaped by many hands and hearts.

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:

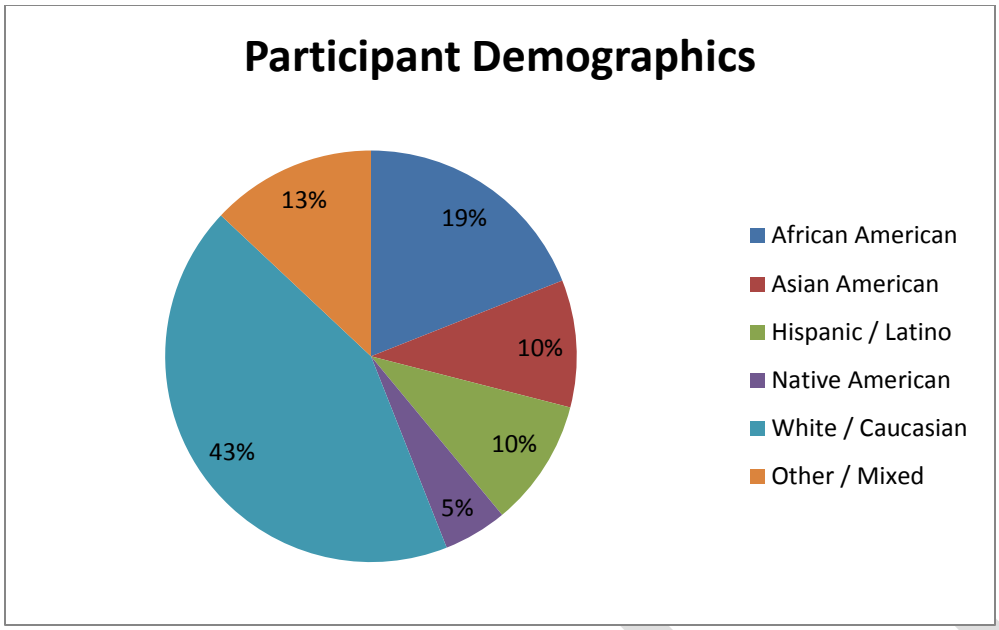
May 2012	BHS Annual Action Planning, including Community Focus Groups
	Establishment of CYS Planning Team
June 2012	CYS Planning Team Retreat
July 2012	CYS Data Analysis and Review by CYS Planning Team
August 2012	Focus Group with CYS Staff Focus Group with Community Partners Focus Group with Parents of CYS consumers who have experienced a crisis episode Interviews with Former CYS Staff Interviews with Community Partners Interviews with CYS consumers who have experienced a crisis episode
September 2012	Interviews with Parents of CYS consumers
	Community Input Meeting
	Refinement of Innovation Work Plan by CYS Planning Team and BHS Leadership

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.

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 Cassettari	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)
Mike Tarrango	BHS Mental Health Clinician III (Crisis Supervisor)
Romy Mann	Clinician, ASPIRAnet
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	ASPIRAnet
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

Raul Sanchez	Juvenile Justice Commission, Family Member
Robina Asghar	Community Partnership for Families
Stephanie McCoy	Child Abuse Prevention Council of San Joaquin County
T. Klingenberg	Family Member
Tosh Saruwatari	San Joaquin NAMI, Mental Health and Substance Abuse Board member
Vanessa Felder	Parent Partner
Lynn Tarrant	BHS Deputy Director, Children and Youth Services
Jim Garrett	BHS Deputy Director, 24 Hour Services

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: DRAFT TEXT Final version to be completed 2/28/13.

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:

To be inserted by February 28, 2013.

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 TO UNDERSERVED GROUPS

☒ INCREASE THE 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. 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 the 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. Parent partners and peer mentors will be assigned to approximately one-half of the families served, establishing an internal comparison group for evaluation.

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.

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.

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.

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.

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.

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.

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.

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. 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.

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

Major Tasks and Activities	2013	2014	2015	2016	2017
	Project Period 7/13 – 6/17				
• Refine Innovation Plan • Approved by Mental Health Services Oversight and Accountability Commission and the San Joaquin County Board of Supervisors • Develop staff training, tools, and protocols • Revisit and revise protocols					
• MOUs with Interagency partners • Begin hiring process • Conduct staff trainings on the use of CANS and FFT					
Goal 1: Implement FFT Adaptation ○ Begin FFT sessions ○ Develop and begin use of protocols that routinely incorporate parent partners and peer mentors into FFT engagement retention and follow-up. ○ Begin universal CANS assessment process ○ Convene annual learning communities to assess operational successes and challenges					
Goal 2: Improve interagency collaboration ○ Identify and prioritize challenges to be addressed ○ Develop interagency protocols on the use of FFT, including early identification and referral protocols ○ Refine operations and county-wide approaches to early identification and intervention for at-risk youth and families					
• Investigate Learning Questions • Prepare and disseminate findings					

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 full research plan is summarized below.

Goal	Strategy	Activity	Hypothesized Outcome	Measurable Indicator
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.
			Natural opportunities will arise to improve and strengthen coordination and collaboration both within and beyond the FFT project.	• New protocols and operating agreements will be developed to guide communication and coordination, including expanded contracts or MOUS.

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 randomly assigned 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 further comparison group.

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 initiate, 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 proportion for which FFT services initiate.
- Measure proportion of those engaged by proportion 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

The core 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. 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

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

200

Work Plan Name:

Adapting Functional Family Therapy

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.

EXHIBIT E

Mental Health Services Act
Innovation Funding Request

County: San Joaquin Date: 15-Jan-13

	Innovation Work Plans		FY 09/10 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1							
2		Adapting Functional Family Therapy		$ 2,942,445			
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23							
24							
25							
26	Subtotal: Work Plans		$0	$2,942,445	$0	$0	$0
27	Plus County Administration						
28	Plus Optional 10% Operating Reserve						
29	Total MHSA Funds Required for Innovation		$0	$2,942,445			

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: San Joaquin Fiscal Year: 2012/13

Work Plan #: 2

Work Plan Name: Adapting Functional Family Therapy

New Work Plan ☑

Expansion ☐

Months of Operation: 07/13 - 06/17

MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	984,917	487,646	941,000	$2,413,563
2. Operating Expenditures	664,130			$664,130
3. Non-recurring expenditures	92,000			$92,000
4. Training Consultant Contracts	134,250			$134,250
5. Work Plan Management	506,120	24,382	45,800	$576,302
Expenditures	**$2,381,417**	**$512,028**	**$986,800**	**$3,880,245**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. Medi-Cal/E.P.S.D.T.	468,900		468,900	$937,800
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$468,900**	**$0**	**$468,900**	**$937,800**
4. Total Revenues	**$468,900**	**$0**	**$468,900**	**$937,800**
C. Total Funding Requirements	**$1,912,517**	**$512,028**	**$517,900**	**$2,942,445**

Prepared by: Beth A. Way Date: 1/15/2013

Telephone Number: (209) 468-8778

Exhibit G

Innovation Component
Request for Funding for Community Program Planning

Date: March 2013

County: San Joaquin

Total Amount Requested:

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)