EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Joaquin	Fiscal Year: 2006/07	Program Work Plan Name: 24/7/365 COMMUNITY RESPONSE TEAM
Program Work Plan #: SD-5		Estimated Start Date: July 1, 2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	Crisis Intervention Services (CIS) proposes to expand our current core behavioral health response services already coordinated with seven hospital emergency room programs and nine law enforcement agencies in our County. CIS is proposing a transformation of the current system to include: • Increased mobile community crisis response for assessment and intervention services 24/7/365. • Joint response of mental health staff with law enforcement to reduce incarcerations and inappropriate use of hospital emergency rooms. • Mental health response teams for intervention and prevention services to reduce use of law enforcement agencies for intervention in a crisis. • Coordination with the consumer-operated Wellness Center, developing peer support and assistance through the use of volunteer and/or employed consumer/family members, as included members of the multi-disciplinary crisis teams. • Focus on recovery and resiliency at all stages and levels of services. • Increase our ability to provide culturally sensitive response capabilities and expanded language capabilities. • Increase our response capability with the development of mobile, multidisciplinary response teams 24/7/365. • Develop an integrated career ladder allowing a path from volunteer to mental health specialist. • Increase hot and warm-line capabilities available 24/7/365. • Increase our ability for outreach and support and decrease consumers' isolation. • Increase support to consumers to enable them to manage their independence and community functioning. • Decrease frequent use of emergency medical care.	

	• Coordinate services and communications between warm/hot line and mobile Community Response Team.
Priority Population: *Describe the situational characteristics of the priority population*	The priority populations for Crisis Intervention Services (CIS) are adults and older adults with serious mental illness (SMI), children and youth with serious emotional disability (SED), and family and friends of SED and SMI consumers seeking information, education, assistance and support. Concurrently, we provide a walk-in mental health clinic offering assessments, referrals, information and education for individuals in the community seeking mental health assistance and support. Through integrated coordination between warm and hot-lines, the mobile Community Response Teams, core services of crisis intervention/stabilization and walk-in clinic, emphasis will be on increasing engagement with homeless populations, other traditionally underserved ethnic populations, and hard-to-reach rural populations. Increased outreach will be provided to agencies and associations, Board and Care Homes, and family members working and living with those with mental illness. Outreach will emphasize information and training to assist in early intervention and alternatives to emergency room services and involuntary hospitalizations and incarcerations. Special emphasis will be placed on providing culturally sensitive and linguistically appropriate response services.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Mobile Community Response Teams available 24/7/365, responsive to calls from consumers, family members of consumers, and community in addition to law enforcement agencies and hospitals. Emphasis will be on early intervention and education to decrease the necessity for emergency calls for police and emergency medical response.	☐	☒	☒	☒	☒	☒	☒
2) Integrated mental health and substance abuse assessment and services.	☐	☒	☒	☒	☒	☒	☒

3) Culturally appropriate services and outreach.	☐	☒	☒	☒	☒	☒	☒
4) Coordinated services in collaboration with primary health care providers.	☐	☒	☒	☒	☒	☒	☒
5) Peer support on mobile teams, in crisis stabilization, and on Warm-line services coordinated with the Clinical Hot-line services with emphasis on recovery and resiliency.	☐	☒	☒	☒	☒	☒	☒
6) Services located where needed- both through culturally sensitive mobile teams with diverse language capabilities, and at emergency rooms and law enforcement facilities where we can also provide in-service training and outreach to hospital and law enforcement staff.	☐	☒	☒	☒	☒	☒	☒
7) Cultural, gender, and age sensitive outreach at schools, primary care clinics, community agencies, faith based services and residential care facilities, with an anticipated outreach to 100 unserved persons.	☐	☒	☒	☒	☒	☒	☒
8) Increased outreach to enable consumers to manage independence and community functioning.	☐	☒	☒	☒	☒	☒	☒

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The primary focus of our program will be to change the status quo. At present, law enforcement agencies are the primary responders when families and residential providers have problems with persons with mental illness. Instead, through culturally sensitive 24/7/365 Community Response teams, we will provide a mental health response focused on offering intervention, support and stabilization. As safety allows, we will have the team respond without law enforcement involvement. We will have increased staff capability to accompany law enforcement to crisis situations and provide assistance and support to de-escalate potentially lethal situations.

Concurrently, the teams would work on outreach and education throughout the community to help consumers and their family and friends learn how to identify early warning signs for intervention. Instead of having to wait until an illegal or dangerous situation occurs to call law enforcement, the family member or board and care operator could call the Community Response Team at the initial signs of difficulty. At the optimum, with an informed community and consumers not fearful of discussing their needs, the Team will assist in preventing confrontations with law enforcement, reduce hospitalizations and incarcerations, and also reduce frequent use of emergency rooms as mental health facilities.

We hope to renew the frequent contacts we had with each of the nine law enforcement agencies in our county and re-institute the liaison contacts. This allowed us to offer training for new officers at each department and participate in the annual training seminars for sworn officers. Having frequent contact and basic understanding of each other's programs and processes, we were able to avoid conflicts that grow from misunderstanding.

With the Warm and Hot line support and early intervention through the Community Response Team, we foresee that we will be able to intercede at earlier levels of a consumer's illness or decompensation and/or at lower levels of crisis intervention. We strongly feel this would not only reduce some of the impact of mental health issues on law enforcement but it would also allow us to work more closely with the officers, who are after all, a primary contact within the community as people search for mental health services.

Likewise, with the ability to offer safe, secure, stabilization services and medical care 24-hours a day, staff will be more available for street officers and consumers to consult with us about potential crisis issues. We will be able to offer alternatives to avoid incarcerations and/or hospitalizations.

Additional staff will be augmented with peer and family volunteers and employees. Emphasis will be upon expanding our cultural (age, gender, sexual orientation) and ethnic awareness needs within the teams and increasing our language capabilities so that we can fit in and be accepted wherever we are needed. Special focus will be

made to educate and train consumers and family members that will assist them to become integral active members of the team.

Concurrent with the above will be the development of the 24/7/365 Warm-line telephone response service staffed by peer and family member volunteers and employees. These positions provide experience and training for other positions on the 24/7/365 Hotline-Clinical phone response line, the Community Response Team, and other positions within Behavioral Health Services. The phone lines, through offering different levels of supportive services, would be closely coordinated to allow free exchange to either line so that the consumer/family member can easily obtain the services and support needed. All levels of service would promote and explore through modeling, the recovery model emphasizing capability and resiliency.

We can promote the development of early identification and intervention with decreasing stigma by educating the community in coordination with other agencies and Behavioral Health Services programs. Through the development of the fully functional Warm-line and Hot-line response capability, and the mobile team back-up, we can envision that there will be increased social supports that would allow full community functioning for consumers and increased ability to manage their independence.

With the increased use of peer and family member involvement, demonstrating the power of resiliency and recovery, we believe the goals of reduced hospitalization, reduced involuntary care, reduced incarceration, reduced isolation, reduced use of Emergency Room services, reduced out-of-home placement, and reduced institutionalization can be reached

3) Describe any housing or employment services to be provided.

A major component of the outreach emphasis of the Community Response Team would be providing information and referrals to the housing and employment resources. Referrals may be made to the pre-vocational and vocational groups in Adult Services.

Crisis would continue to assist with crisis housing needs. Housing vouchers may be provided for Transitional Care facilities, hotels and halfway houses, providing options to higher levels of care. Referrals would be made to other resources to assist with longer-term housing needs.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Crisis services will not be utilizing FSP's for this proposal. The major funds requested are system development, outreach, and education.

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

A major focus of this plan is to provide education and outreach to the community, especially to the law enforcement agencies, emergency room staffs, and to families and friends of those experiencing mental health emergencies, so that recovery will be maintained with fewer relapses as a result of early recognition, intervention, and implementation of culturally competent supportive services.

As we add early intervention, the mobile response teams, and peer and family team members – the core values of recovery and resiliency will be the outcome of each contact.

Additionally, with continuous, uninterrupted availability of the Warm-line as an integral part of clinical services to provide consistent support and response to those calling, management of independence and positive community functioning will be reinforced at all levels of service.

Through the focus on peer support and employment, increased numbers of consumers/family members will be employed, thereby expanding the diversity and awareness of staff to consumer/ family member culture with a resulting heightened awareness of consumer needs. Additionally, staff will continue to make use of video and teleconference training opportunities and the sharing of best practices.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

San Joaquin County Behavioral Health Services (BHS) has a "Mobile Evaluation Team" in Older Adult Services, providing limited (weekday) response to callers seeking assessment and intervention for consumers primarily residing in residential care facilities. With the creation of Community Mobile Response Teams, we will be able to respond to callers and assist them by providing information and assistance so that hospitalizations and/or incarcerations can be avoided. This will also reduce the use of hospital emergency rooms and jail facilities as de facto mental health facilities.

We currently have one staff member in the Crisis department dedicated each day (8 AM to 11 PM) to respond to calls from any of nine law enforcement agencies and/or seven hospitals. If more than one call is received, or if the call comes after 11 PM, response is delayed as the additional responder is only available on an "on-call" basis. With the new program we will have additional clinical services available at all times.

Currently, Crisis Services does not have any self-identified peers, friends, or family members as volunteers or employees working in the clinic. We want to change this with support and guidance in the provision of services that is available from peer support, and the participation of consumers and/or family members in team activities.

The current program lacks the consistent provision of a Warm-line, and has Hot-line capacity with available staffing in Crisis (7 am- 1 am) or Psychiatric Health Facility (PHF- 1 am- 7 am). We rely on the family providing transportation and/or calling law enforcement for intervention, when in crisis. With the expanded program, we propose that the supportive services will be consistently available 24 hours a day, seven days a week, 365 days a year.

Very limited outreach or information/education is provided in the community and we have limited contact with primary care providers. Outreach and education programs for law enforcement and emergency room staffs was started but is not regularly scheduled due to decreased funding for staffing. Conjointly with the Wellness Center, we will be able to offer awareness, early intervention, and intervention training to law enforcement and hospital staff. Concurrently, we hope to offer outreach to family and friends of those with mental illness, enabling them to assist with early recognition of warning signs and medication side effects so that interventions can happen quickly and easily. These same services will be made available to those offering supportive housing and to Board and Care operators so that again, early intervention can be sought out and obtained, thereby protecting placements and reducing homelessness.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

It is proposed that consumers and/or family members will provide major support for the Warm-line, possibly in coordination with the proposed SJCBHS MHSA-funded Wellness Center. The Wellness Center will be a consumer-operated support service center, providing wellness training, independent living skills, and education, in close coordination with Crisis services, Community Response Team and the Hot/Warm-lines. As consumers gain education, skills and experience through the Wellness Center, we anticipate that those interested could work on the Warm-line and/or become members of the Community Response Team.

Participation by employed peers, family members, and volunteers will be a critical part of the mobile community response teams. Cross-training staff will enable us to have a diverse pool of paraprofessional staff to augment and expand the response capabilities of the clinical specialists. Based upon particular needs at the time, we anticipate being able to draw from this group to provide language, ethnic and consumer culture expertise for the team, enabling the team to quickly establish rapport, trust and acceptance when responding to crisis situations. This would

include utilizing culturally, ethnically and linguistically competent resources of community-based organizations in addition to existing agency staffing, in particular peer consumers or family members hired as recovery coaches or outreach workers.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Consumers, Family Members, and National Alliance on Mental Illness (NAMI): As stated in the proposal for the SJCBHS MHSA-funded Community Consortium, we do not want to lose the partnerships and trust developed with consumers and community-based organizations as we jointly worked through the MHSA process. The Crisis Department has also established close ties with NAMI, consumers, and staff preparing the proposal for the Wellness Center. Crisis Services and the Wellness Center will be closely allied through cross training of staffs, coordination of services, and formulation and building of the Warm and Hot lines. Individuals and organizations will experience a seamless transition in the provision of services. Concurrently, with increased communications, services will improve and become more responsive as we build and grow in response to feedback and recommendations of the community, consumers, and community-based organizations.

Law Enforcement: Effective, efficient, responsive mental health services are a mandatory necessity for law enforcement. Likewise, educated, knowledgeable officers, with specific training to support pro-active response in mental health emergencies are integral for the operation of Crisis Services. We have long worked together to establish and maintain these goals through specific training from Mental Health staff for officers, and officers offering ride-along training for clinical staff. However of late, due to decreased resources and staffing, we have been unable to maintain consistent training schedules and inter-departmental liaison meetings.

We hope to renew the contacts we had with each of the nine law enforcement agencies in our county and reinstitute liaison contacts. With Warm and Hot line support and early intervention through the Community Response Team, we anticipate that we will be able to intercede at earlier levels of decompensation and lower levels of crisis intervention, thus reducing some of the impact of mental health issues on law enforcement.

Valley Mountain Regional Services (VMRC): We meet monthly with representatives from VMRC and actively work to coordinate our services. We will continue this close cooperation and have discussed options about how we can coordinate our crisis response services to allow joint response when needed and/or communicate information so that we do not replicate and waste resources available.

Hospitals: As with law enforcement agencies, we have had cooperative agreements with the hospitals in our county for many years. Of late, we have not been able to

maintain regular liaison meetings and tend to communicate only when problems arise. We want to use our Community Response Team to regain close coordination with the hospitals. With the Warm and Hot-lines working with the Community Response Team to intercede more proactively in potential mental health crisis situations, we anticipate a reduction in the flow of crisis cases to the emergency rooms.

Health Care Providers: Coordination of services has long been a goal of Crisis Services. We have been dependent upon consumers to inform their physicians and/or dependent upon the physician to make contact with Mental Health if they had concerns or questions. With the addition of Mental Health Specialists and Clerical staff we foresee a program of increased communication and coordination with primary care physicians and community health clinics. In the past we offered the National Depression Screening program to clinics and would like to do so again, along with offering the other screening programs. Through mobile services, we see an opportunity to reach out and support health clinics by bringing more information and evaluation services to them and getting more information and feedback from them.

Tribal Organizations: The Three Rivers Lodge (Native Directions Incorporated), which is located in Manteca, participated in the MHSA planning process. Crisis anticipates maintaining the link as a resource for persons in crisis, both through referrals to and from this tribal organization. A liaison Crisis staff will be assigned with an identified tribal community-based organization.

Schools, Colleges, and Universities:

The Crisis department has long been one of the training sites for intern and student nurses, psychiatric technicians, medical students, and undergraduate and graduate level students of social work, psychology and related fields. These opportunities for mutual learning will continue.

Additionally, Crisis receives referrals from school law enforcement agencies of all levels, and from school nurses, health clinics, counselors and administrators. It is anticipated that increased collaboration with these community partners will result in appropriate linkage for services.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

All staff will continue to attend mandatory cultural competency training. In addition, the Physician Lecture Series, which provides in-service training for clinical and medical staff, will continue to offer programs focused on specific cultural and ethnic considerations in clinical and medical practice.

Results of the analysis of Part II, Section II indicated the following ethnic disparities:

A. Lack of service penetration in the Hispanic Communities.

Special efforts will be made to add Hispanic staff (volunteers, employees, peer support, family and friends) to our Community Response Team, Warm and Hot lines, and core services. Positions will be identified that will require bilingual fluency in Spanish. Additionally, through coordination with organizational providers and with the proposed "La Familia: Servicios Psico-Sociales" Behavioral Health Services clinic, we will continue and expand our outreach efforts by participating at health fairs and in clinics established to serve the indigent, migrant, working poor, refugees, and homeless. We will increase our coordination with Channel Medical Clinic, Woodbridge Medical Clinic, Tracy Medical Clinic and Cesar Chavez Clinic at San Joaquin County General Hospital and work more closely with migrant worker programs through migrant housing groups and the school programs.

B. Services to the African-American community, though the penetration rate slightly exceeds that of the percentage of African-Americans in the county, are felt to be inappropriate, due to over utilization of Crisis and Inpatient services. With stronger outreach, especially through faith-based organizations, and increased availability of the Community Response Team, services will be identified and provided prior to the need for crisis intervention and hospitalization and/or incarceration.

C. Gay, Lesbian, Bisexual, and Transgender (GLBT) individuals have been hesitant to self-identify due to potential discrimination and stigma. Specialized outreach efforts will be necessary via organizational providers who have established trust and can provide entrance to the hard to reach rural populations throughout the county. The San Joaquin AIDS Foundation has been participating in our focus groups and has committed to continue to provide outreach and engagement services to the GLBT community.

D. Data in Part II Section II of the plan refers to Asian/Pacific Islander groups. San Joaquin County has large population groups of Southeast Asians who came to the United States as refugees. These include persons from Laos (including the Hmong cultures), Cambodia and Vietnam. Cambodian is, in fact, a threshold language in this county. Crisis currently coordinates with the Transcultural Clinic (TCC) for referrals to existing programs and frequently requests the use of interpreters to assist us to serve persons being seen in Crisis Intervention.

It is anticipated that with increased use of consumer peers and/or family members as recovery coaches, our cultural and linguistic competence will increase. With the added ability to work in collaboration with both the TCC and identified Community Based Organizations (CBOs) serving the Lao, Hmong, Vietnamese and Cambodian communities, two-way communications will be established and maintained with each group to insure that the mental health needs of all will be recognized and served.

E. The Native American communities were included in surveys with outreach by Native Directions/Three Rivers Lodge. The surveys indicated the importance of building trust, understanding Native American cultures, and providing more

accessible (mobile) services. Establishing a liaison from Crisis Intervention will assist in learning more about the Native American community and linkage to necessary services.

F. A focus group and surveys were conducted through the Community Partnership for Families with particular outreach to the Muslim/Pakistani communities in San Joaquin County. This information indicates that awareness of mental illness and mental health services and more outreach to the community are needed. Crisis staff, through the 24-hour hotline, mobile community response and consumer and family member involvement, plan to link with the community to increase mutual understanding of cultures and mental health. Crisis also will link with existing services at the outlying specialty mental health clinics.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Considerations for Gay, Lesbian, Bisexual and Transgender (GLBT) consumers are no different than other cultural considerations. Diversity is accepted and expected as a strength of the community at large. It is the individual's needs and strengths that are the focus of treatment, and treatment teams will reflect in their membership the diversity and strengths of the community. Crisis Intervention Services is both the entry point for planned mental health services and the linkage point for referral to services that are appropriate to a consumer's expressed needs. This might include referral or linkage to a CBO or mental health program that is particularly sensitive to gender or sexual orientation issues. A staff liaison will be assigned with the AIDS Foundation to assist with referrals to Crisis Intervention.

Crisis Intervention Services uses the Women's Center as a resource for referrals for persons (women and men) living with domestic violence. It is anticipated that this resource would be more fully further developed, with in-service training provided for the respective staffs of both agencies. Other private providers or agencies that provide anger management or domestic violence prevention are also used as resources for referral in the community.

Information, training and support will be requested from the CBOs to assist us to gain greater insight, sensitivity, and response capability to the differing psychological needs of men and women, boys and girls.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

SJCBHS currently has contracted providers in all of the contiguous counties and has developed supportive working relationships with mental health services within those

counties. In addition, we have providers that we have worked with and can contact, located in more than half of the counties in California. Through the 24-hour, toll-free access line, beneficiaries can contact us for information and support at any time. We feel we have the capacity to be able to assist wherever the beneficiary is located, whether in need of a Treatment Acknowledgement Notification, to communicate with hospitals about pending admissions, or simply to look for supportive services.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable.

13) Please provide a timeline for this work plan, including all critical implementation dates.

Month 1 & 2:

- Begin Staff Recruitment and Interview
- Attend CBO/MH Consortium Meetings
- Begin Collaborative Meetings with CBO Staff
- Begin Development of New or Revised Program Policies and Procedures
- Begin Integrated Staff Meetings and Orientation Process with New Staff
- Crisis Area Reconfigured to Accommodate Changes

Month 3 & 4:

- Program Policies and Procedures Completed
- Program Fully staffed – Continue Orientation

14) Exhibit 5: Budget and Staffing Detail Worksheets

Exhibits 5a and 5b for each fiscal year are presented on the following pages.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): San Joaquin | Fiscal Year: 2005-06

Program Workplan #: SD-5 | Date: 3/6/06

Program Workplan Name: Community Response Team | Page 1 of 1

Type of Funding: 2. System Development | Months of Operation: 1

Proposed Total Client Capacity of Program/Service: 0 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Beth A. Way

Client Capacity of Program/Service Expanded through MHSA: 0 | Telephone Number: (209)468-8778

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0	$0	$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$0			$0
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$0**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$0	$0	$0	$0
3. Total Revenues	$0	$0	$0	$0
C. One-Time CSS Funding Expenditures	**$454,250**			**$454,250**
D. Total Funding Requirements	**$454,250**	**$0**	**$0**	**$454,250**
E. Percent of Total Funding Requirements for Full Service Partnerships				**0.0%**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): San Joaquin | Fiscal Year: 2005-06

Program Workplan #: SD-5 | Date: 3/6/06

Program Workplan Name: Community Response Team |

Type of Funding: 2. System Development | Months of Operation: 1

Proposed Total Client Capacity of Program/Service: 0 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Beth A. Way

Client Capacity of Program/Service Expanded through MHSA: 0 | Telephone Number: (209)468-8778

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	0.00	0.00		$0
C. Total Program Positions		0.00	0.00		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): San Joaquin | Fiscal Year: 2006-07

Program Workplan #: SD-5 | Date: 6/6/06

Program Workplan Name: Community Response Team | Page 1 of 1

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 500 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 200 | Prepared by: Beth A. Way

Client Capacity of Program/Service Expanded through MHSA: 300 | Telephone Number: (209)468-8778

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)	$191,642			$191,642
b. New Additional Personnel Expenditures (from Staffing Detail)	$473,749			$473,749
c. Employee Benefits	$296,433			$296,433
d. Total Personnel Expenditures	$961,824	$0	$0	$961,824
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation	$2,000			$2,000
d. General Office Expenditures	$2,000			$2,000
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)	$3,780			$3,780
h. Total Operating Expenditures	$7,780	$0	$0	$7,780
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$0			$0
6. Total Proposed Program Budget	**$969,604**	**$0**	**$0**	**$969,604**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)	$84,515			$84,515
b. Medicare/Patient Fees/Patient Insurance	$11,269			$11,269
c. Realignment	$185,930			$185,930
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$281,714	$0	$0	$281,714
2. New Revenues				
a. Medi-Cal (FFP only)	$137,578			$137,578
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$137,578	$0	$0	$137,578
3. Total Revenues	$419,292	$0	$0	$419,292
C. One-Time CSS Funding Expenditures	**$0**			**$0**
D. Total Funding Requirements	**$550,312**	**$0**	**$0**	**$550,312**
E. Percent of Total Funding Requirements for Full Service Partnerships				

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): San Joaquin | Fiscal Year: 2006-07

Program Workplan #: SD-5 | Date: 3/6/06

Program Workplan Name: Community Response Team |

Type of Funding: 2. System Development | Months of Operation: 1

Proposed Total Client Capacity of Program/Service: 500 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 200 | Prepared by: Beth A. Way

Client Capacity of Program/Service Expanded through MHSA: 300 | Telephone Number: (209)468-8778

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
Psychiatric Technicians			2.00	$38,231	$76,462
Mental Health Clinician II			1.00	$115,180	$115,180
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	3.00		$191,642
B. New Additional Positions					
					$0
Mental Health Clinician II			3.00	$54,060	$162,180
Psychiatric Technicians			3.00	$38,231	$114,693
Senior Office Assistant			1.00	$30,556	$30,556
Outreach Worker		5.00	5.00	$33,264	$166,320
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	5.00	12.00		$473,749
C. Total Program Positions		5.00	15.00		$665,391

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5c—Mental Health Services Act Community Services and Support Budget Narrative
Community Response Team System Development Work Plan

County:	**San Joaquin**	**Fiscal Year:**	**2006-07**
Workplan #	**SD-5**	**Date:**	**3/10/06**

1. Expenditures		
a. Client, Family Member and Caregiver Support Expenditures		
i. Travel and Transportation		
ii. Housing		
iii. Employment and Education Supports		
iv. Other Support Expenditures		
v. **Total Support Expenditures**		$ 0
b. Personnel Expenditures		
i. Current Existing Personnel Expenditures		
1. Psychiatric Technician-(2 FTE @ $38,231)	$76,462	
2. Mental Health Clinician II- (1 FTE @ $115,180)	$115,180	$191,642
ii. New Additional Personnel Expenditures		
1. Mental Health Clinician II-(3 FTE @ $54,060)	$162,180	
2. Psychiatric Technician-(3 FTE @ $38,231)	114,693	
3. Senior Office Assistant-(1FTE @ $30,556)	30,556	
4. Outreach Worker-(5FTE @ $33,264)	166,320	$473,749
iii. Employee Benefits		
1. Benefits calculated at 47% for Regular employees and 15% for Temporary employees		$296,433
iv. Total Personnel Expenditures		**$961,824**
c. Operating Expenditures		
i. Travel and Transportation		
1. Staff mileage reimbursements and county motor pool costs based on past history		$ 2,000
ii. General Office Expenditures		
1. Office supplies, printing, small equipment		$ 2,000
iii. Rent, Utilities and Equipment		
iv. Medication and Medical Supports		
v. Other operating Expenses		
1. Communication and data line charges		$ 3,780
vi. Total Operating Expenditures		$ 7,780
d. Estimated Total Expenditures when service provider is not known		
i. Community Based Organization Contracts based on staffing		**$ 0**
e. Total Proposed Program Budget		**$969,604**

2. Revenues		
a. Existing Revenues		
i. Medi-Cal (FFP only)	$ 84,515	
ii. Medicare/Patient Fees/ Patient Insurance	11,269	

iii. Realignment	185,930	$281,714
b. Total Existing Revenue		
c. New Revenues		
i. Medi-Cal (FFP only)		$137,578
d. Total New Revenue		**$137,578**
e. Total Existing and New Revenue		**$419,292**
3. One-Time CSS Funding Expenditures		
4. Total Funding Requirements		**$550,312**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): San Joaquin | Fiscal Year: 2007-08

Program Workplan #: SD-5 | Date: 3/6/06

Program Workplan Name: Community Response Team | Page 1 of 1

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 500 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 200 | Prepared by: Beth A. Way

Client Capacity of Program/Service Expanded through MHSA: 300 | Telephone Number: (209)468-8778

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)	$201,224			$201,224
b. New Additional Personnel Expenditures (from Staffing Detail)	$497,437			$497,437
c. Employee Benefits	$306,017			$306,017
d. Total Personnel Expenditures	$1,004,678	$0	$0	$1,004,678
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation	$2,000			$2,000
d. General Office Expenditures	$3,700			$3,700
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)	$4,280			$4,280
h. Total Operating Expenditures	$9,980	$0	$0	$9,980
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known	$0			$0
6. Total Proposed Program Budget	**$1,014,658**	**$0**	**$0**	**$1,014,658**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)	$88,740			$88,740
b. Medicare/Patient Fees/Patient Insurance	$11,832			$11,832
c. Realignment	$195,227			$195,227
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$295,799	$0	$0	$295,799
2. New Revenues				
a. Medi-Cal (FFP only)	$143,772			$143,772
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$143,772	$0	$0	$143,772
3. Total Revenues	$439,571	$0	$0	$439,571
C. One-Time CSS Funding Expenditures	**$0**			**$0**
D. Total Funding Requirements	**$575,087**	**$0**	**$0**	**$575,087**
E. Percent of Total Funding Requirements for Full Service Partnerships				

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): San Joaquin | Fiscal Year: 2007-08

Program Workplan #: SD-5 | Date: 3/6/06

Program Workplan Name: Community Response Team |

Type of Funding: 2. System Development | Months of Operation: 1

Proposed Total Client Capacity of Program/Service: 500 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 200 | Prepared by: Beth A. Way

Client Capacity of Program/Service Expanded through MHSA: 300 | Telephone Number: (209)468-8778

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
Psychiatric Technicians			2.00	$40,143	$80,285
Mental Health Clinician II			1.00	$120,939	$120,939
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	3.00		$201,224
B. New Additional Positions					
					$0
Mental Health Clinician II			3.00	$56,763	$170,289
Psychiatric Technicians			3.00	$40,143	$120,428
Senior Office Assistant			1.00	$32,084	$32,084
Outreach Worker		5.00	5.00	$34,927	$174,636
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	5.00	12.00		$497,437
C. Total Program Positions		5.00	15.00		$698,661

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5c—Mental Health Services Act Community Services and Support Budget Narrative
Community Response Team System Development Work Plan

County:	**San Joaquin**	**Fiscal Year:**	**2007-08**
Workplan #	**SD-5**	**Date:**	**3/10/06**

1. Expenditures			
a. Client, Family Member and Caregiver Support Expenditures			
i. Travel and Transportation			
ii. Housing			
iii. Employment and Education Supports			
iv. Other Support Expenditures			
v. **Total Support Expenditures**			$ 0
b. Personnel Expenditures			
i. Current Existing Personnel Expenditures (Includes a 5% COLA)			
1. Psychiatric Technician-(2 FTE @ $40,143)	$80,285		
2. Mental Health Clinician II- (1 FTE @ $120,939)	$120,939		$201,224
ii. New Additional Personnel Expenditures (Includes a 5% COLA)			
1. Mental Health Clinician II-(3 FTE @ $56,763)	$170,289		
2. Psychiatric Technician-(3 FTE @ $40,143)	120,428		
3. Senior Office Assistant-(1FTE @ $32,084)	32,084		
4. Outreach Worker-(5FTE @ $34,927)	174,636		$497,437
iii. Employee Benefits			
1. Benefits calculated at 47% for employees			$306,017
iv. Total Personnel Expenditures			**$1,004,678**
c. Operating Expenditures			
i. Travel and Transportation			
1. Staff mileage reimbursements and county motor pool costs Based on past history			$ 2,000
ii. General Office Expenditures			
1. Office supplies, printing, small equipment			$ 3,700
iii. Rent, Utilities and Equipment			
iv. Medication and Medical Supports			
v. Other operating Expenses			
1. Communication and data line charges			$ 4,280
vi. Total Operating Expenditures			$ 9,980
d. Estimated Total Expenditures when service provider is not known			
i. Community Based Organization Contracts based on staffing			**$ 0**
e. Total Proposed Program Budget			**$1,014,658**
2. Revenues			
a. Existing Revenues			
i. Medi-Cal (FFP only)	$ 88,740		
ii. Medicare/Patient Fees/ Patient Insurance	11,832		
iii. Realignment	195,227		$295,799

b. Total Existing Revenue	**$295,799**
c. New Revenues	
i. Medi-Cal (FFP only)	$143,772
d. Total New Revenue	**$143,772**
c. Total Existing and New Revenue	**$439,571**
3. One-Time CSS Funding Expenditures	
4. Total Funding Requirements	**$575,087**