SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Policy:	20-09
Subject:	MHSA Administration and Components
Authority:	Department of Health Care Services; California Code of Regulations, Title 9. Rehabilitative and Development Services, Division 1. Department of Mental Health, Chapter 14. Mental Health Services Act
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Supersedes:	N/A
Attachments:	MHSA Steering Committee Roles and Responsibilities

PURPOSE:

The purpose of this policy is to ensure that Mental Health Services Act (MHSA) programs are planned and implemented in accordance with State regulations. The policy outlines the minimum requirements and the implementation processes for each of the following MHSA administration activities:

1. Community Program Planning (CPP) Process
2. Capacity Assessment
3. Innovation (INN) Project Implementation
4. Funding Allocations

The policy also outlines the minimum requirements for each of the following MHSA Components:

5. Outreach and Engagement Component
6. Workforce Education and Training (WET) Programs Component
7. Capital Facilities and Technological Needs (CFTN) Component
8. Housing Component

SCOPE:

This Policy is for implementation of MHSA programs and administration only.

BACKGROUND:

In San Mateo County, MHSA supports a broad continuum of needs across personnel, prevention, early intervention and direct services, infrastructure, technology, training and other resources necessary to support planning, implementation, monitoring and evaluation of progress toward statewide goals for children, transition-age youth, adults, older adults and families.

MHSA legislation funds planning, evaluation and implementation of services in three primary

components Community Services and Supports (CSS), Prevention and Early Intervention (PEI) and Innovation (INN).

CSS is the largest component of MHSA; legislation requires 76% of funding be allocated to CSS to provide direct treatment and recovery services to individuals of all ages living with serious mental illness (SMI) or serious emotional disturbance (SED). Furthermore, the legislation requires that 51% of the CSS allocation fund Full Service Partnerships (FSP) services.

PEI accounts for 19% of the county's MHSA budget and targets individuals of all ages prior to the onset of mental illness, with the exception of early onset of psychotic disorders. 51% of the PEI allocation must fund programs for children and youth ages 0-25.

5% of funding is required to be allocated to INN funds to introduce new approaches or community-driven best practices that have not been proven to be effective.

DEFINITIONS

As per the California Code of Regulations, Title 9. Rehabilitative and Development Services, Division 1. Department of Mental Health, Chapter 14. Mental Health Services Act:

The "Mental Health Services Act (MHSA)" is the law that took effect on January 1, 2005 when Proposition 63 was approved by California voters and codified in the Welfare and Institutions Code.

"Community Program Planning" means the process to be used by the County to develop Three-Year Program and Expenditure Plans, and Annual Updates in partnership with stakeholders to: Identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act; Analyze the mental health needs in the community; Identify and re-evaluate priorities and strategies to meet those mental health needs.

"Stakeholders" means individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families.

"Client" means an individual of any age who is receiving or has received behavioral health services. The term "client" includes those who refer to themselves as clients, consumers, survivors, patients or ex-patients.

POLICY:

1. Community Program Planning (CPP) Process
    a. A Community Program Planning (CPP) process shall be implemented as the basis for developing the MHSA Three-Year Program and Expenditure Plans (Three-Year Plan) and Annual Updates.
    b. To ensure that the CPP process is adequately staffed, there shall be designated positions and/or units responsible for:
        i. Coordination and management of the CPP process.
        ii. Ensuring that stakeholders have the opportunity to participate in the CPP process.
        iii. Ensuring that stakeholder participation includes representatives of unserved and/or underserved populations and family members of unserved/underserved populations that reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity.
        iv. Outreach to clients with serious mental illness and/or serious emotional disturbance, and their family members, to ensure the opportunity to participate.
    c. The CPP process shall, at a minimum, include:
        i. Involvement of clients with serious mental illness and/or serious emotional disturbance and their family members in all aspects of the CPP process.
        ii. Participation of diverse stakeholders.
        iii. CPP training shall be provided to:
            a) staff designated responsible for any of the functions listed above that will enable staff to establish and sustain a CPP process.
            b) stakeholders, clients, and families, who are participating in the CPP process for each MHSA Three-Year Plan development process.

2. Assessment of County Capacity to Implement MHSA Programs
   An assessment of the capacity to implement MHSA programs shall be conducted and include:
    a. The strengths and limitations of the County and service providers that impact their ability to meet the needs of racially and ethnically diverse populations. The

evaluation shall include an assessment of bilingual proficiency in threshold languages.

b. Percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to percentage of the total population needing services and the total population being served.
c. Identification of possible barriers to implementing the proposed programs/services and methods of addressing these barriers.

3. Innovation (INN) Project Implementation
    a. Innovation (INN) Projects shall be implemented to meet one of the following "primary purpose":
        i. Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.
        ii. Make a change to an existing practice in the field of mental health, including but not limited to, application to a different population.
        iii. Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.
    b. Approval requests to use INN Funds for a specific INN Project, shall be submitted to the Mental Health Services Oversight and Accountability Commission along with an INN Project Plan for each project.
    c. An INN Project Plan shall include the following:
        i. Name of the INN Project.
        ii. The total length of the INN Project and how this time period will allow sufficient time for the development, implementation, evaluation, decision-making, and communication of results, including new effective practices and lessons learned.
        iii. The selected "primary purpose" as described above in item 3.a., the reasons that this purpose is a priority, and how the INN Project will meet the purpose selected.
        iv. A description of how staff and stakeholders were involved in the planning process, were informed about and understood the purpose and requirements of the Mental Health Services Act INN Component
        v. A description of the County's plan to involve community stakeholders meaningfully in all phases of INN Projects, including evaluation of the INN Project and decision-making regarding whether to continue the INN Project, or elements of the Project, without INN Funds.
        vi. Key activities to achieve the intended outcomes of the INN Project that includes a timeline specifying key milestones for development and refinement of the approach; ongoing assessment and final evaluation of the INN Project; decision- making with meaningful involvement of

stakeholders; and communication of the results and lessons learned with a focus of dissemination of successful INN Projects.

vii. Description of the new or changed behavioral health approach, differentiation of the elements that are new or changed from existing practices, and how the INN Project is expected to contribute to the new or changed practice within the field of behavioral health.

viii. If applicable, the population to be served, including demographic information such as age, gender identity, race, ethnicity, sexual orientation, and language used.

ix. If applicable, the estimated number of clients expected to be served annually.

x. Examples of how the INN Project will reflect and be consistent with all relevant Mental Health Services Act standards.

xi. The methods the County will use to evaluate the effectiveness of the INN Project including:
    a) Intended outcomes, including at least one outcome relevant to the selected primary purpose, and how those outcomes will be measured, including specific indicators for each intended outcome.
    b) Methods the County will use to assess the project elements that contributed to the outcomes.
    c) How the evaluation will assess the effectiveness of the element(s) of the INN Project that are new or changed compared to existing practice in mental health.

xii. Continuation plan for after the INN Project term and funding ends, including:
    a) How the decision will be made to continue the INN Project, or elements of the project.
    b) How to provide continuity for individuals with serious mental illness who are receiving services.
    c) If applicable, how it will be funded.

xiii. A budget that includes the following:
    a) The total INN Funds requested for the INN Project
    b) Estimated total expenditures, including implementation and evaluation, for the entire duration of each INN Project by fiscal year and the following funding sources:
        (1) Innovation (INN) Funds
        (2) Medi-Cal Federal Financial Participation
        (3) 1991 Realignment
        (4) Behavioral Health Subaccount
        (5) Any other funding

c) A brief narrative to explain how the estimated total budget is consistent with the time-limited, evaluation focus of the project and includes sufficient funds to implement all key activities.

4. MHSA Funding Allocations
   a. The BHRS Fiscal Manager and fiscal staff will work closely with the MHSA Coordinator to ensure,
      i. funding allocations meet the required percent allocations across and within MHSA components, as summarized in the attached MHSA Program Funding Guidelines; and
      ii. consistent reporting of program names in the Annual Revenue and Expenditure Report (ARER) with the MHSA Three-Year Plan and subsequent Annual Updates.
   b. Prudent Reserve
      i. A Prudent Reserve will be established that does not exceed 33 percent of the average Community Services and Supports (CSS) revenue in the preceding five years.
      ii. The amount will be reassessed every five years, certified and submitted to the Department of Health Care Services (DHCS) as per Information Notice 19-017.
   c. Interest
      i. Each fiscal year, the interest accrued will be allocated to the component that earned the interest.

5. Outreach and Engagement Component
   a. Outreach and engagement programs and activities shall be developed for the purpose of identifying unserved children and adolescents with serious emotional disturbance and adults and older adults with serious mental illness or at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder; in order to engage them, and when appropriate their families, in the mental health system so that they receive the appropriate services.
   b. Outreach and Engagement activities may include:
      i. Strategies to reduce ethnic/racial disparities.
      i. Food, clothing, and shelter, but only when the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system.
      ii. Outreach to entities such as community-based organizations, schools, tribal communities, primary care providers, faith-based organizations.
      iii. Outreach to individuals such as community leaders, homeless or individuals incarcerated in county facilities.

6. Workforce Education and Training (WET) Component
    a. A WET Coordinator shall be designated to coordinate WET programs and activities and act as a liaison to statewide WET activities.
    b. WET programs and activities shall address workforce shortages and deficits identified through a Workforce Needs Assessment, conducted at least once every five years, and includes:
        i. A list of BHRS occupations within the following categories and the number of individuals in each occupation.
            a) Licensed mental health staff who provide services to clients.
            b) Mental health staff, not required to be licensed, who provide services to clients.
            c) Other health care professionals who provide services to clients, such as physicians, rehabilitation therapists and traditional cultural healers.
            d) Managerial and supervisory positions, if more than 50% of the individual's time is spent managing or supervising others.
            e) Personnel who provide support to staff providing services to clients.
        ii. For each occupation above:
            a) An estimate of the number of additional positions needed and the number of positions determined to be hard-to-fill or for which it is hard to retain staff including in certain geographical areas
            b) The number of positions, including job title and/or job description, for which recruitment priority is given to clients and/or family members of clients.
            c) An estimate of the number of personnel by racial/ethnic group.
        iii. The estimated number of clients and family members of clients by racial/ethnic group served.
        iv. A list of the languages in which staff proficiency is required to ensure access to and quality of services for individuals whose primary language is not English. For each language listed:
            a) The number of staff who are proficient in that language.
            b) The estimated number of additional staff necessary to meet the need.
        v. The number of employees and volunteers in each of the following categories:
            a) Employees, volunteers and/or individuals under contract who are directly supervised by County staff.
            b) Employees, volunteers and/or individuals under contract who are directly supervised by contract agency staff.
        vi. Any additional workforce needs identified.

7. Capital Facilities and Technological Needs (CFTN) Component

a. CFTN projects shall support BHRS and/or contract providers to enable the provision of MHSA administration, services, and supports, including:
    i. Acquire and build upon land that will be County-owned
    ii. Acquire buildings that will be County-owned
    iii. Construct buildings that will be County-owned
    iv. Renovate buildings that are County-owned
    v. Establish a capitalized repair/replacement reserve for buildings acquired or constructed with Capital Facilities funds and/or personnel cost directly associated with a Capital Facilities Project, i.e., a project manager.
b. CFTN component projects shall not include housing projects.
c. CFTN buildings shall serve clients in less restrictive settings. If a CFTN project, whether acquisition, construction, or renovation, is a restrictive setting, BHRS shall demonstrate the need for a building with a restrictive setting by including specific facts and justifications in a CFTN plan as follows:
    i. There is an unmet need for a restrictive facility in order to adequately serve clients with serious mental illness and/or emotional disorder.
    ii. These needs cannot be adequately served in a less-restrictive setting. Specific reasons to substantiate the inability to meet the needs in a less-restrictive setting shall be included in the CFTN plan.
    iii. It is not feasible to build the required facility using non-MHSA funds. Specific reasons for non-feasibility shall be included in the CFTN plan
    iv. BHRS has pursued, and been unable to obtain, other sources of funding.
    v. The proposal for a restrictive facility was developed through a Community Program Planning process and local Mental Health and Substance Abuse Recovery Commission review and adoption by the Board of Supervisors.
d. Non-county privately owned building may be renovated under this CFTN component if the building is dedicated and used to provide MHSA services and shall include the following descriptions in a CFTN plan:
    i. For treatment facilities, how the renovation will benefit the clients served in the facility i.e., will result in an expansion of the capacity/access to existing services or the provision of new services
    ii. For administrative offices, how the administrative offices augment/support to BHRS' ability to provide MHSA programs/services
    iii. How the costs of renovation are reasonable and consistent with what a prudent buyer would incur. The prudent buyer refuses to pay more than the going price for an item/service and seeks to economize by minimizing costs.
    iv. Demonstrate a method for protecting its capital interest in the renovation. Examples of methods counties might use to protect their capital interest in renovated facilities shall include, but are not limited to:

a) Instituting a deed restriction on property use in exchange for the resources invested.
b) Amending loan agreements to reflect all improvements are considered property of the County which allows the County the option of removing the improvements if specified conditions are not met.
c) Acquiring an interest in the property as evidenced by a grant deed.

e. CFTN shall only cover those portions of land and buildings where MHSA programs, services and administrative supports are provided.
f. Land acquired and built upon or construction/renovation of buildings shall be for a minimum of twenty years.
g. All buildings under this CFTN component shall comply with federal, state and local laws and regulations including zoning and building codes and requirements; licensing requirements, where applicable; fire safety requirements; environmental reporting and requirements; hazardous materials requirements; the Americans with Disabilities Act (ADA), California Government Code Section 11135 and other applicable requirements.
h. CFTN may establish a capitalized repair/replacement reserve for buildings acquired or constructed through CFTN. The reserve will be controlled, managed, and disbursed by BHRS.
i. BHRS shall ensure that the property is updated to comply with applicable requirements, and maintained as necessary, and that appropriate fire, disaster, and liability insurance coverage is maintained.
j. For "lease (rent) to own" a building under CFTN component BHRS shall provide justification why "lease (rent) to own" is preferable to the outright purchase of the building and why the purchase of such property, with MHSA CFTN funds is not feasible.
k. For purchase of land with no MHSA funds budgeted for construction of a building or purchase of a building (i.e., modular, etc.), BHRS shall explain its choice and provide a timeline with expected sources of income for the planned construction or purchase of building upon this land and how this serves to increase BHRS infrastructure.

8. <u>Housing Component</u>
   a. The Housing component shall include housing assistance services as follows:
      i. Rental assistance or capitalized operating subsidies.
      ii. Security deposits, utility deposits, or other move-in cost assistance.
      iii. Utility payments.
      iv. Moving cost assistance.
      v. Build or rehabilitate housing for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless.

b. The Housing component may include housing across the continuum for individuals with mental illness including,
    i. temporary, transitional, halfway, residential care and permanent single or scattered-site supportive housing; and
    ii. the acquisition, rehabilitation or construction of permanent supportive housing and operating subsidies.
c. The Housing shall not include involuntary, restrictive facilities and long-term hospital and/or long-term institutional care.
d. Housing shall be made available to for individuals with serious mental illness who are homeless, or at risk of homelessness and who meet the MHSA target population as follows:
    i. Adults or older adults with serious mental illness
    ii. Children and youth with severe emotional disorders
    iii. In addition to meeting either (i) or (ii) above, the individual shall be one of the following:
        a) Homeless, meaning living on the streets or lacking a fixed and regular night-time residence. This includes living in a shelter, motel or other temporary living situation in which the individual has no tenant rights.
        b) At risk of being homeless due to one of the following situations:
            (1) Transition age youth exiting the child welfare or juvenile justice systems.
            (2) Discharge from crisis and transitional residential settings; a hospital, including acute psychiatric hospitals; psychiatric health facilities; skilled nursing facilities with a certified special treatment program for the mentally disordered; and mental health rehabilitation centers.
            (3) Release from city or county jails.
            (4) Temporarily placed in a residential care facility upon discharge from (2) or (3) above.

PROCEDURE/ RESPONSIBILITY

1. The MHSA Coordinator has oversight responsibilities of all MHSA Administration activities outlined in this policy and works collaboratively with:
    a. the Office of Diversity and Equity and the Office of Family and Consumer Affairs to support meaningful outreach, participation of unserved/underserved communities, clients and family members of clients;
    b. BHRS managers responsible for monitoring and oversight of the MHSA Components to ensure that activities and programs are carried out in accordance with State requirements; and

c. the BHRS Fiscal Manager and fiscal staff to ensure consistent reporting of program names in the Annual Revenue and Expenditure Report (ARER) with the MHSA Three-Year Plan and subsequent Annual Updates.
    i. Training will be provided to any new MHSA program and/or fiscal staff that support the development of the MHSA Three-Year Plan, Annual Update, and the ARER to sustain the consistency in program names.

2. The MHSA Coordinator shall be responsible for carrying out a Community Program Planning (CPP) process for every MHSA Three-Year Plan and Annual Updates. The CPP process for the MHSA Three-Year Plan shall include the following:
    a. Facilitate an MHSA Steering Committee, to guide and inform and prioritize outcomes of the CPP process. The MHSA Steering Committee makes recommendations to the planning and services development process and assures that MHSA planning reflects local diverse needs and priorities, contains the appropriate balance of services within available resources and meets the criteria and goals established.
        i. An MHSA Steering Committee Member Application shall be posted on the MHSA website and circulated broadly to ensure culturally diverse stakeholders, clients, family members of clients and vulnerable communities are represented on the committee.
        ii. The MHSA Steering Committee Roles and Responsibilities document, attached, includes the purpose, composition requirements, expectations and meeting frequency. Any updates to the document shall be developed, vetted, and approved by the MHSA Steering Committee members.
    b. Conduct stakeholder input through a CPP framework that includes the following:
        i. A Needs Assessment phase shall include, but not limited to:
            a) A review of local plans, reports/evaluations, and/or assessments across service sectors that interface with behavioral health clients (justice system, housing, health equity, substance use, etc.)
            b) A county-wide survey to support the prioritization of needs.
        ii. A Strategy Development phase shall include, but not limited to:
            a) County-wide input sessions and key interviews targeting culturally, age-based and geographically diverse stakeholders will recommend strategies that address:
                (1) the needs identified during the Needs Assessment phase;

(2) the requirements for developing programs under both MHSA components, Community Services and Supports (CSS) and Prevention and Early Intervention (PEI); and
(3) the requirements to maintain the percentage of funding allocation at 51% of CSS to Full Service Partnerships and 51% of PEI for ages 0-25 population.

b) Prioritization of the strategies identified through the input sessions and key interviews, by the MHSA Steering Committee.

iii. The MHSA Three-Year Plan Development phase shall include, but not limited to:

a) A draft MHSA Three-Year Plan shall be prepared by the MHSA Coordinator that is reflective of the data collected and prioritization from stakeholders and the MHSA Steering Committee throughout the CPP process and includes number of children, traditional-aged youth (TAY), adult, and older adults by gender, race/ethnicity, and primary language, cost per person and documentation of achievement in performance outcomes for CSS, PEI, and INN programs and other requirements as per California Code, Welfare and Institutions Code - WIC § 5848.
b) Opening of a 30-day public comment process for review of the MHSA Three-Year Plan, followed by a public hearing by the Mental Health and Substance Abuse Recovery Commission (MHSARC).
c) Adoption of the MHSA Three-Year Plan by the Board of Supervisors.
d) Submission of the MHSA Three-Year Plan to the Mental Health Services Oversight Commission (MHSOAC) and the Department of Health Care Services (DHCS), within 30 days of adoption by the Board of Supervisors, and by June 30th of each fiscal year.

c. The MHSA Coordinator shall ensure the following input support activities:

i. Training (pre-session orientations) for stakeholders, clients and family members of clients to support meaningful participation in all CPP activities.
ii. Conducting all analysis, documentation and presentation of data collected throughout the CPP process and posting these on the MHSA website for the public to access.

iii. Review all public comment information and respond to substantive questions or comments in writing and present to the MHSARC for review. Substantive comments are defined as feedback that would impact or require a programmatic or fiscal change in the MHSA Three-Year Plan.

d. The MHSA Coordinator shall ensure that various means are used to circulate information about the CPP process, the MHSA Three-Year Plan draft, and the 30-day public comment period including, but not limited to:
   i. Announcements at internal and external community meetings.
   ii. Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.).
   iii. E-mail communication to the MHSA distribution list of subscribers from the MHSA website and the Office of Diversity and Equity distribution list of subscribers.
   iv. Postings on physical bulletin board at BHRS clinics, wellness/drop-in centers, community-based organizations, and other public spaces.
   v. Posting on the MHSA webpage, the BHRS Blog, and the BHRS Wellness Matters Newsletter.

3. The MHSA Coordinator shall be responsible for facilitating stakeholder input for any updates to the MHSA Three-Year Plan including, necessary changes and new program planning during the MHSA Three-Year Plan implementation period. Activities to support updates to the MHSA Three-Year Plan shall include, but not limited:
   a. Facilitation of work groups, taskforces, subcommittees, and/or ad-hoc groups of subject matter experts, stakeholders and clients and family members of clients to guide and support the process.
   b. Inclusion of the changes and/or new program planning in the MHSA Annual Update, number of children, traditional-aged youth (TAY), adult, and older adults by gender, race/ethnicity, and primary language, cost per person and documentation of achievement in performance outcomes for CSS, PEI, and INN programs and other requirements as per California Code, Welfare and Institutions Code - WIC § 5848. The MHSA Annual Update also requires a 30-day public comment period and public hearing by the MHSARC, Board of Supervisor adoption and submission to the state MHSOAC and DHCS by June 30th of each fiscal year.
4. The MHSA Coordinator shall be responsible for carrying out a process for Innovation (INN) Project planning. The process for planning for INN Projects shall be and extension

of the MHSA Three-Year Plan development process described above in items 2-3 and include the following:

a. A broad solicitation of INN Project ideas shall include information about INN requirements and an INN Idea Form to capture all the necessary requirements for INN funding. The solicitation shall be circulated through various means including flyers, announcements, email distributions, posting on the MHSA website and BHRS Wellness Matters and the BHRS Blog
b. INN project ideas shall address one of the priority needs identified directly by the community during the MHSA Three-Year Plan development process.
c. MHSA INN project brainstorming sessions held with groups as requested
d. Pre-screened of submitted against the INN requirements, by the MHSA Coordinator
e. An MHSA INN Selection Committee made up of MHSA Steering Committee clients, family members, community service providers and BHRS staff, facilitated by the MHSA Coordinator to select and prioritize the INN Projects that shall move forward to develop into full INN Project proposals.
f. The MHSA Steering Committee will review any INN Project ideas selected, provide input regarding the design, implementation and other details of the project prior to developing a full proposal.
g. Once the full INN Project are drafted, a 30-day public comment period and public hearing by the MHSARC is required followed by Board of Supervisor adoption and submission to the state MHSOAC and DHCS.

5. The Workforce Education and Training (WET) Coordinator shall be responsible for coordinating WET programs and activities including, but not limited to:
    a. Educating and training the BHRS workforce on incorporating Mental Health Services Act standards into its work.
    b. Increasing the number of clients and family members of clients employed through activities such recruitment, supported employment services, and creating and implementing promotional opportunities.
    c. Creating and implementing policies that promote job retention.
    d. Focused outreach and recruitment to provide equal employment opportunities for individuals who share the racial/ethnic, cultural and/or linguistic characteristics of clients, family members of clients and others in the community who have serious mental illness and/or serious emotional disturbance.
    e. Recruiting, employing and supporting the employment of individuals who are culturally and linguistically competent or, at a minimum, are educated and trained in cultural competence and linguistic competence.
    f. Providing financial incentives to recruit or retain BHRS employees.

g. Incorporating the input of diverse racial/ethnic populations and clients and family members of clients and, whenever possible, utilize them as trainers and consultants in WET programs and activities.
h. Including all BHRS employees and volunteers, whether paid or not, in WET programs and/or activities.

Approved: *Signature on File*
Dr. Jei Africa, PsyD
BHRS Director