COUNTY OF SANTA CLARA
Behavioral Health Services

County of Santa Clara
Behavioral Health Services Department

Mental Health Services Act (MHSA) Fiscal Year 2024 Mid-Year Adjustment
&
Fiscal Year 2025 (July 1, 2024 – June 30, 2025) Annual Plan Update

WELLNESS • RECOVERY • RESILIENCE

DRAFT

Use this link to submit your comments during the public comment period: https://www.surveymonkey.com/r/ZD93MD7

30 Day Public Comment Period: February 9 - March 24, 2024

FY 2024 Mid-Year Adjustment & FY 2025 Annual Plan Update

February 9, 2024

Modifications made after the public comment period will appear in red.

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INTRODUCTION

The Santa Clara County Behavioral Health Services Department (BHSD) is pleased to present the following Mental Health Services Act (MHSA) *Annual Update for Fiscal Year (FY) 2025.*

The County's initial MHSA Plan was authorized by the Board of Supervisors on December 13, 2005 and approved by the California Department of Mental Health (DMH) on June 30, 2006. With over 17 years after the first three-year plan, the County of Santa Clara has demonstrated the ways in which MHSA funding has enabled local planning to make substantial improvements in the type, scope, and availability of behavioral health services, including expansions and modification of services for people with the most serious mental health needs. Recent regulation revisions in the MHSA have also given way to focused prevention and early intervention with special dedicated services to children, transition age youth and older adults. This plan represents over 51% of PEI revenue dedicated to ages 25 years and under as required by the Act. This plan also represents the innovative approaches to help support the wellness and recovery of all residents in County of Santa Clara.

Recognizing the importance of a transparent plan that clearly and specifically describes the services that will be provided, and which can easily align with MHSA funding categories, this plan breaks apart the larger initiatives into their discrete programs. Each program description is designed in a standardized format to easily display the target population, service components, program goals, anticipated numbers of consumers served and funding allocation. Discrete programs are organized by systems of care: Access & Unplanned Services, Children, Youth and Families (CYF), Adults/Older Adults (AOA), as well as by component for Innovation (INN), Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN). Within each system of care, programs are grouped by larger initiatives. As much as possible, we have provided descriptions to allow a reader to see how these programs relate to prior initiatives and how several services may be described under each initiative.

DIRECTOR'S MESSAGE

Dear Mental Health Services Act (MHSA) Stakeholders and Santa Clara County Community Members:

The Behavioral Health Services Department (Department) is pleased to present you with the County's Fiscal Year (FY) 2024 MHSA Mid-Year Adjustment Plan and the FY2025 MHSA Annual Plan (Draft Plans). In an unexpected year with the announcement of the MHSA modernization and the challenging fiscal situation, I appreciate the community's patience and support as the Department developed not only these draft plans but also started looking forward to the impacts of Proposition 1 on our MHSA-funded programs.

To help inform the development of the County's Draft Plan, the Department initiated a community-wide behavioral health needs survey, focusing on the needs of the clients and consumers of our services. The survey was reviewed and developed in collaboration with the MHSA Stakeholder Leadership Committee (SLC), which serves as the Department's primary advisory committee for MHSA activities and consists of representatives of various stakeholder groups, including clients/consumers, family members of clients/consumers, and underserved cultural communities.

The community survey was available online and accessible in the County's threshold languages and was administered from January to March 2023. Concurrently, consumer stakeholders were invited to participate in a series of 60-90 minute community conversations aimed at gathering consumer stakeholder feedback about areas of Department services that should stay the same or change, along with suggestions or recommendations for the Department's 5 strategic goals and priorities (listed below). A total of 29 community conversations were facilitated, either virtually or in person based on the community's preference.

- *Goal 1 (Timely Access): Ensure Medi-Cal Beneficiaries are Provided Timely Access to High-Quality Mental Health and Substance Use Treatment Services*
- *Goal 2 (Housing): Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter*
- *Goal 3 (Emerging Needs): Proactively Address Ongoing and Emerging Needs for Specific High Need Populations*
- *Goal 4 (Workforce Education & Training): Develop Innovative Solutions to Address Professional Workforce Shortages*
- *Goal 5 (Integrated System/Policy): Adapt to and Help Shape the Rapidly Shifting State Policy Landscape*

This plan document provides the Department's mid-year adjustment for FY 2024 and recommendations for FY 2025, based on the community's input, the overall Santa Clara County budget, and the continued feedback and input received from our committed stakeholder committee.

As we navigate changes at the local and state levels, the Department remains steadfast in its commitment to responding to the needs of our communities. Simultaneously, we are dedicated to practicing fiscal prudence by incorporating new fiscal information from the State each year, especially in relation to MHSA funding. This commitment ensures the development of an MHSA fiscal plan that not only supports wellness and recovery but also reflects sound financial management. Through the County's numerous comprehensive MHSA programs and services, we aim to meet the needs of consumers/clients and their families while maintaining a fiscally responsible approach.

Finally, I want to relay my appreciation and thank the many clients/consumers, family members, community members, stakeholders, community partners, agencies, and County staff who took part and helped guide the development of the County's Draft Plans as included in this document. The Department appreciates the comments and feedback from all our community participants, as we are committed to ensuring community involvement and stakeholder input in the County's MHSA planning process.

Sincerely,

Sherri Terao, Ed.D., IFECMH Specialist, RPFM
Director, Behavioral Health Services
County of Santa Clara

SANTA CLARA COUNTY OVERVIEW

COUNTY DEMOGRAPHICS

The County of Santa Clara's population of 1,870,945 is one of the largest in the state, following Los Angeles, San Diego, Orange, Riverside, and San Bernardino Counties, and the largest of the nine Bay Area counties[1]. Its population constitutes about one fourth of the Bay Area's total population. There are 15 cities ranging from Palo Alto in the north, to Gilroy in the south. San Jose is the largest city in the County, with a population of 971,233, and is the administrative site of County Government.[2] A significant portion of land area within the county is comprised of unincorporated ranch and farmland, and nearly 92% of the population lives in cities.[3] The County of Santa Clara has a culture rich in linguistic diversity (over 53.7% speak a language other than English at home).[4]

The County has one of the highest median family incomes in the country and is home to many extremely affluent areas, including San Jose, Palo Alto, Sunnyvale, Saratoga, and Mountain View. However, 7.4% of the population lives below the poverty level, of which disproportionate amounts identify as Black or African American, American Indian or Alaska Native, and some other race or two or more races.[5]

There are 15 cities in the County, spanning 50 miles from Palo Alto in the north to Gilroy in the south. South Santa Clara Valley is a census county division located in southern Santa Clara County. The area covers approximately 118 square miles and includes the cities of Morgan Hill, San Martin, and Gilroy. Approximately 102,978 residents reside in South County, of whom a large proportion (48%) are Hispanic/Latino.[6,7]

County of Santa Clara is home to approximately 43,777 veterans.[4] Veterans in Santa Clara County are eligible to receive services through the Veterans Affairs Northern California Health Care System. For this reason, few veterans show up in Mental Health Service Act (MHSA)-funded public mental health services.

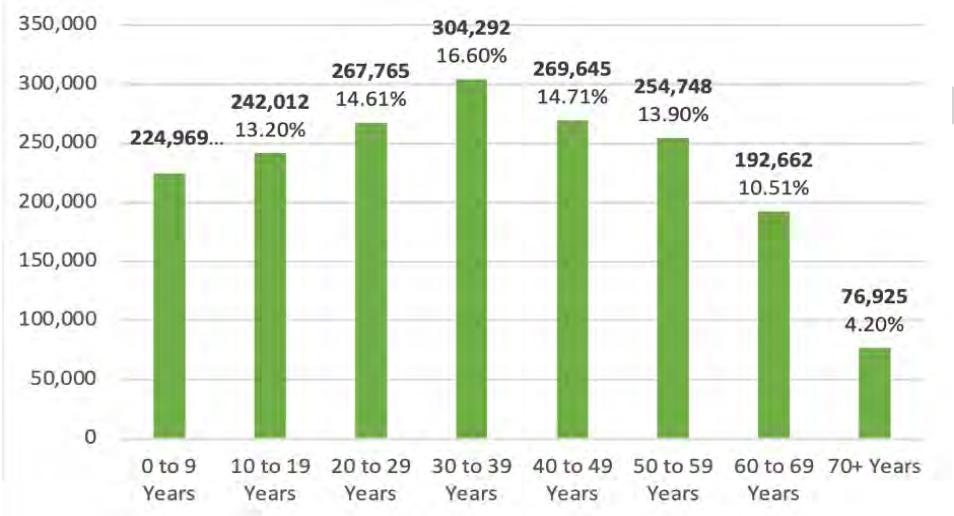
The BHSD is part of the Santa Clara Valley Health & Hospital System (SCVHHS). SCVHHS provides comprehensive care, services, and programs to the residents of County of Santa Clara. BHSD is currently set up as a "No Wrong Door" system of care intended to provide consumers

[1] Annual Estimates of the Resident Population for Counties in California: April 1, 2020 to July 1, 2022 (CO-EST2022-POP-06), U.S. Census Bureau, Population Division, Release Date: March 2023
[2] https://www.census.gov/quickfacts/fact/table/sanjosecitycalifornia/PST045222
[3] http://www.seecalifornia.com/counties/santa-clara.html#:~:text=A%20significant%20portion%20of%20the,sports%20venues%20and%20academic%20institutions
[4] https://www.census.gov/quickfacts/santaclaracountycalifornia
[5] https://data.census.gov/table/ACSST1Y2022.S1701?q=United%20States%20Income%20and%20Poverty&g=050XX00US06085
[6] https://www2.census.gov/geo/maps/dc10map/GUBlock/st06_ca/cousub/cs0608593175_south_santa_clara_valley/DC10BLK_CS0608593175_000.pdf
[7] https://www.census.gov/quickfacts/fact/table/gilroycitycalifornia,morganhillcitycalifornia,sanmartincdpcalifornia/BZA010220#qf-flag-X

with care regardless of where they go seeking mental health services. A No Wrong Door system of care is designed such that the appropriate level of care is easily accessible no matter where or how consumers present. In this access model, individuals should be able to be treated immediately and redirected to the appropriate level of care. 988 and the Behavioral Health Services Call Center is the entry point for access to all of the behavioral health services.

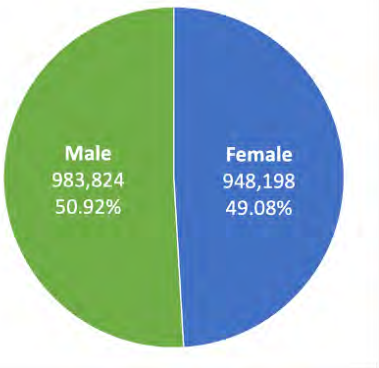
Below, information is provided on age, gender, and unique characteristics related to cultural diversity (number of threshold languages, race/ethnicity, and LGBTQ+ identities). As US Census and ACS data is unavailable for LGBTQ+ communities, local information on individuals who identify as LGBTQ+ are provided, when available.

Santa Clara County: Age



Note: Data are from the most recent US Census Bureau's 2022 population estimates from the American Community Survey.

Santa Clara County: Gender Identity



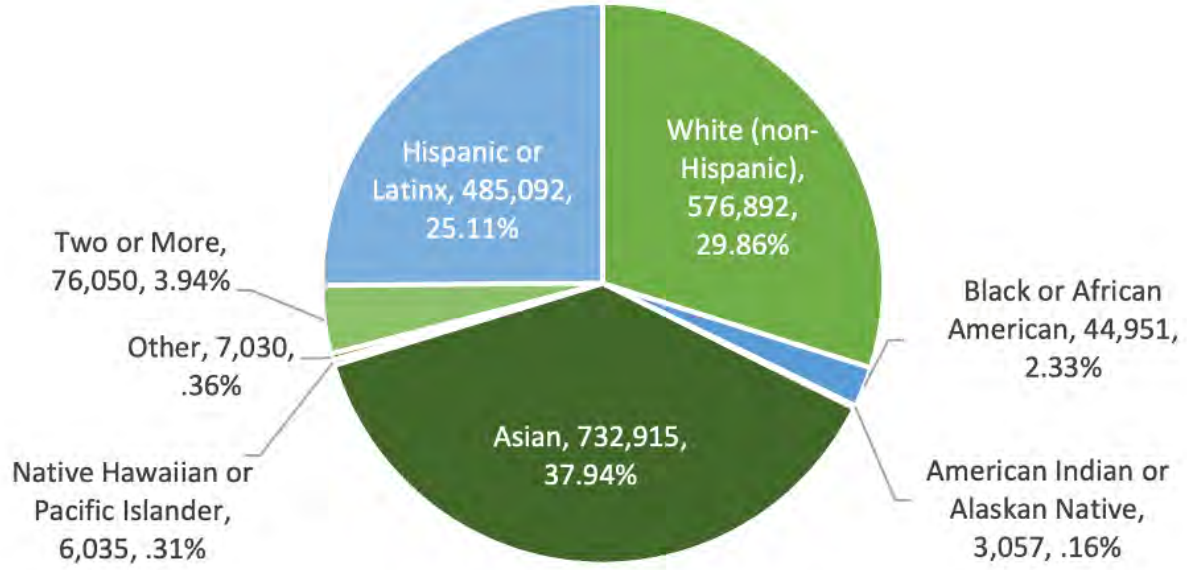
Note: Data are from the most recent US Census Bureau's 2022 population estimates from the American Community Survey. US Census data have limitations in lack of availability of transgender, gender non-binary, and intersex gender identity data. Local LGBTQ+ identity data are provided below in the "Unique Characteristics" section, when available.

Unique Characteristics

The County of Santa Clara is unique and notable for the cultural diversity of its population. Ethnic/racial minority individuals, for example, constitute a majority of its residents, and the County includes 5 threshold languages. The largest proportion of its residents identify as Asian (37.94%), followed by non-Hispanic White (29.86%) and Hispanic or Latinx (25.11%). The Asian population in the County is comprised of high proportions of Indian, Chinese, Vietnamese, and Filipinx individuals. The County of Santa Clara is also home to a large population (39.7%) of foreign-born persons, with estimates of 775,222 or 41.43% of the total Santa Clara population born outside of the United States. Of the foreign-born population, approximately 64.4% are of Asian descent, and approximately 20.3% are of Latin American descent.[8]

In addition, TGI+ identifying individuals constitute a larger proportion of its residents as compared to the general population in the state of California, and the need for LGBTQ+ focused programming and training is evident in stakeholder feedback in the CPP data. Below are examples of such demographic data that demonstrate these unique aspects of cultural diversity within the County of Santa Clara.

Santa Clara County: Race / Ethnicity



Note: Data are from the most recent US Census Bureau's 2022 population estimates from the American Community Survey.

Threshold Languages

According to the California Department of Health Care Services (DHCS), threshold languages are defined as the following: "Per CCR, Title 9, section 1810.410, subdivision (a)(3), "Threshold Language" means a "language identified as the primary language, as indicated on the Medi-Cal

[8] https://data.census.gov/table/ACSST1Y2022.S0502?q=santa%20clara%20county

Eligibility Data System, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area"
(source: https://www.dhcs.ca.gov/Documents/BHIN-20-070-Threshold-Languages.pdf).
The following languages constitute the primary threshold languages for the County of Santa Clara County in 2022:

Santa Clara County: Five Threshold Languages

Consistent with the diverse culture and language representation within its County residents, the County of Santa Clara Behavioral Health Services Department is committed to providing its services to residents in its five threshold languages, to facilitate service access and mitigate any mental health service disparities in access. The County Board of Supervisors adopted the current Language Access Policy 3.58 on March 24, 2015 and amended most recently on June 6, 2023 (retrieved from https://saecommon.sccgov.org/countypolicy/Board-Policy-3.58-Language-Access.pdf)

LGBTQ+ Identity

Individuals who identify as Lesbian, Gay, Bisexual, Queer, Asexual, Pansexual, & Two-Spirit (LGBQAP2S+) and Transgender, Gender Non-Binary, & Intersex (TGI+) make up an important community in the County of Santa Clara. The need for LGBTQ+ focused programming and training is infused throughout BHSD services, as evident in stakeholder feedback in the CPP data.

Unfortunately, the US Census and American Community Survey Data have limitations in lack of availability of sexual orientation and gender identity data.[9] Local and statewide gender identity data, however, suggests that TGI+ communities represent a larger portion of Santa Clara County residents compared to the state of California. For example, according to AskCHIS California Health Interview Survey from the UCLA Center for Health Policy Research (an online data system that provides demographic information for counties in California)[10], TGI+ (including transgender and gender non-binary individuals, categorized with the term "transgender or gender non-conforming" in the Ask CHIS data) individuals constitute .89% of the general population in the state of California (5 year 2018-2022 estimates). In contrast, the TGI+ population in Santa Clara County is *larger* at 1.3% (4-year 2018, 2019, 2021, and 2022 data estimates, with 2020 data

[9] https://sanjosespotlight.com/census-data-survey-lgbtq-silicon-valley-san-jose/
[10] https://ask.chis.ucla.edu/

missing). In addition, 5-year averages from AskCHIS data in the years 2018-2022 show that 8.5% of Santa Clara County residents identify as LGBQ (Lesbian, Gay, Bisexual, Asexual, or other).

Underserved and Unserved Populations: County of Santa Clara Definitions

MHSA intends to serve individuals who are historically unserved or underserved by the public mental health care system.[11] By focusing resources on serving underserved and unserved individuals, MHSA endeavors to reduce historical disparities in access and quality of care that some populations have experienced. Additionally, individuals experiencing poverty or discrimination based on race, ethnicity, gender identity, or sexual orientation may be more likely to face mental health issues or difficulty navigating the system of care.

The County of Santa Clara recognizes these cultural disparities in mental health, substance use, and service access/utilization, and therefore prioritizes specialized attention in its services for communities of color, LGBTQ+, immigrant, refugee, and other culturally underserved communities. In conjunction with prioritizing these culturally diverse stakeholder needs, the County also includes the following California Code of Regulation groups within its definitions of unserved and underserved:

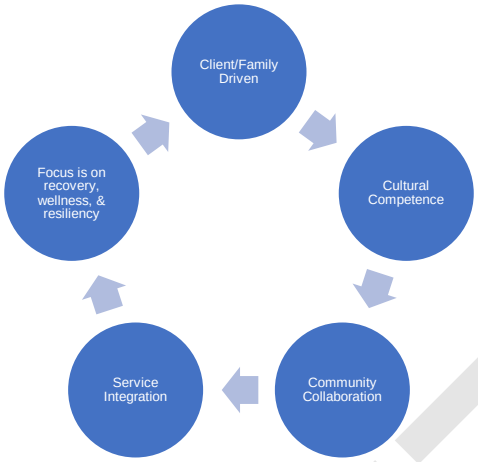
- Unserved. The California Code of Regulations defines "unserved" as "individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved."
- Underserved. Underserved individuals are defined as "individuals who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided the necessary or appropriate opportunities to support their recovery, wellness, and/or resilience."

MHSA OVERVIEW

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

[11] "Unserved" and "Underserved" are defined in California Code of Regulations, Title 9. Rehabilitative and Development Services, Division 1. Department of Mental Health, Chapter 14. Mental Health Services Act, Sections 3200.300 and 3200.310.

Figure 1: MHSA Values



MHSA is funded through a one percent tax on individual annual income exceeding one million dollars. California counties receive MHSA allocations from the state, which typically make up about 40-60% of a county's behavioral health budget depending on the population size of each county. Counties determine how to distribute these funds at the local level through a Community Program Planning (CPP) process which culminates in a Three-Year Plan or an Annual Plan Update.

MHSA funding is distributed across five funding categories to support all facets of the public mental health system throughout the lifespan (see Figure 2):

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Innovation (INN)
- Workforce Education and Training (WET)
- Capital Facilities and Technological Needs (CFTN)

Figure 2: MHSA Components

MHSA COMPONENTS

CSS: Community Services & Supports
Outreach and direct services for children, TAY, adults and older adults with SED/SMI. 51% of funds dedicated to Full Service Partnerships.

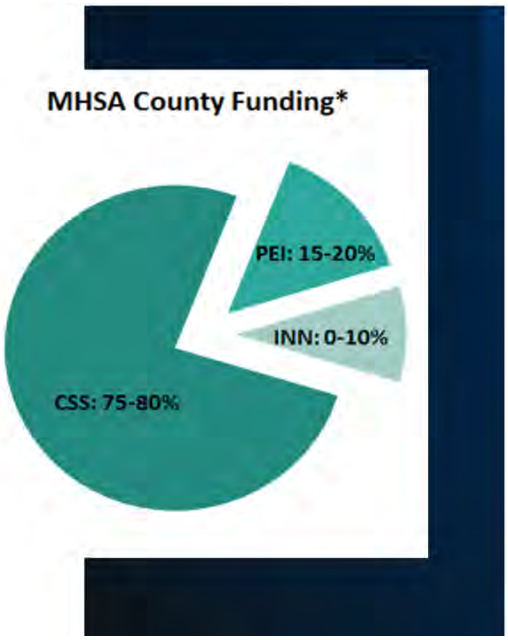
PEI: Prevention & Early Intervention
Prevention services to prevent the development of mental health problems Early intervention services to screen and intervene with early signs of mental health issues. 51% of funds dedicated for clients 25 years old and under.

CFTN: Capital Facilities & Technological Needs
Infrastructure to implement an electronic health record and support facilities where MHSA funded services will operate.

WET: Workforce Education & Training
Support to build, retain, and train a competent public mental health workforce.

INN: Innovation
Funding to test new approaches that may improve access, collaboration, and/or service outcomes for un-, under-, and inappropriately-served populations. Projects are short-term, for up to 5 years and the require additional approval by the Mental Health Services Oversight and Accountability Commission (MHSOAC).

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



MHSA defines four consumer age groups to reflect the different mental health needs associated with a person's age, and counties are directed to provide age-appropriate services for each:

- Children: 0-15 years
- Transition Age Youth (TAY): 16-25 years
- Adults: 26-59 years
- Older Adults: 60 years and older

County of Santa Clara initially projected a reduction in funding as a result of the COVID-19 pandemic and the potential effects the economy would have on high income earners, those with incomes above $1M. As Figure 10 indicates, the estimated MHSA Revenues fluctuate year to year and the volatility of these funds cannot be more pronounced than during the pandemic. Figure 11 demonstrates the increasing investments to programs and services as a response to emerging and immediate needs. As the revenue source for MHSA is highly volatile, much budgetary prudence is required in order to maintain needed services and provide sustainability for years to come.

Figure 10. County of Santa Clara MHSA Apportionments

County of Santa Clara MHSA Apportionments

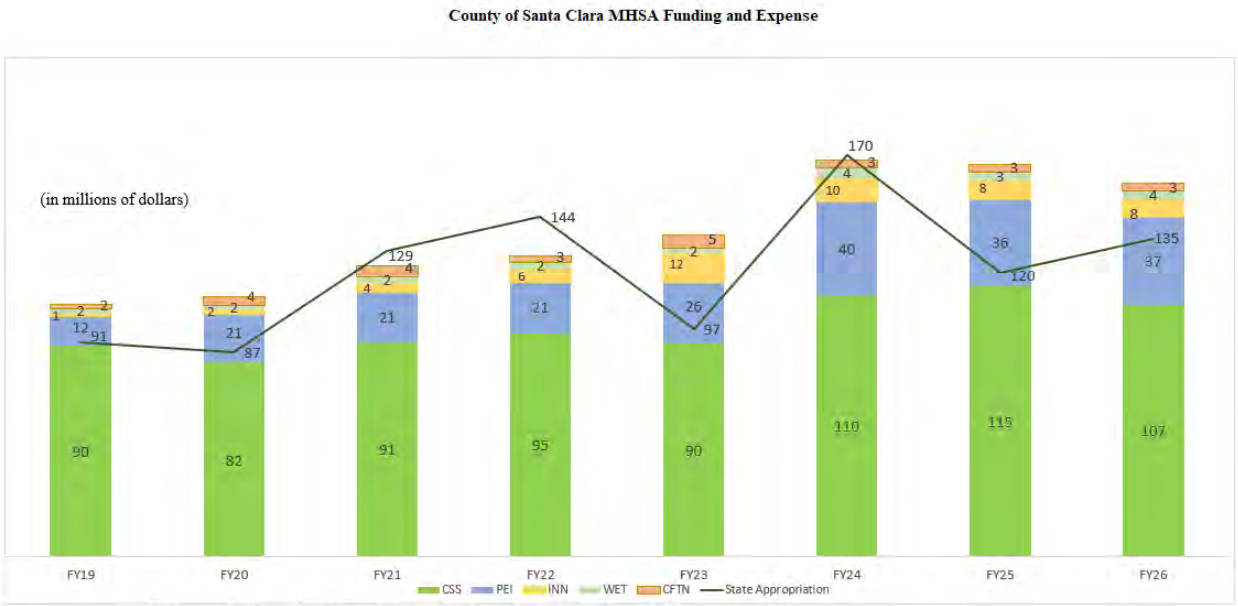
(in millions of dollars)

	FY19	FY20	FY21	FY22	FY23	FY24 Estimate	FY25 Estimate	FY26 Estimate
CSS	$ 69.3	$ 65.3	$ 98.0	$ 109.3	$ 72.5	$ 129.2	$ 91.2	$ 102.3
PEI	$ 17.1	$ 16.5	$ 24.6	$ 27.4	$ 18.6	$ 32.3	$ 22.8	$ 25.6
INN	$ 4.5	$ 4.8	$ 6.7	$ 7.3	$ 5.4	$ 8.5	$ 6.0	$ 6.7
Total[1]	$ 90.9	$ 86.6	$ 129.3	$ 144.0	$ 96.5	$ 170.0	$ 120.0	$ 134.6
% Change		-5%	49%	11%	-33%	76%	-29%	12%
% Share of State	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%

Total funding distribution is to be allocated as follow (WIC § 5892(a)(3)&(a)(6)):
76% to CSS
19% to PEI
5% to INN

[1] https://www.sco.ca.gov/ard_payments_mentalhealthservicefund.html

Figure 11. County of Santa Clara MHSA Funding and Expense



	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26
Total Expenses	107	110	123	127	136	168	166	158

THE COUNTY OF SANTA CLARA'S MHSA PLAN

The current County of Santa Clara FY 2025 MHSA Annual Update Plan describe the County of Santa Clara Behavioral Health Services Department's (BHSD) Community Planning Process (CPP), which constituted a community collaborative and engaged process for identifying and prioritizing diverse stakeholder input. The plans propose modified services and expenditures and new programs to support a robust behavioral health system based on cultural responsivity, wellness, and recovery.

The FY 2025 Annual Update Plan includes the following sections:

- Overview of the Community Planning Process, including Community Conversations, Client/Consumer Survey, SLC / Stakeholder Review of Data and Recommendations, and Public Review which took place in the County from January through March 2023. BHSD's CPP was predicated on involvement and partnership with mental health consumers and family member stakeholders.

- An executive summary of Santa Clara County's MHSA program descriptions by system of care and component type, including a brief description of each program and information on the expected number of unduplicated clients to be served, the cost per person served, and each program's annual budget.

- Details about plans for program continuation, changes, and targeted enhancements to the existing and new programming in mental health services funded by MHSA in FY 2025, along with their linkages to the stakeholder data recommendations from the CPP.

- FY 2024 Mid-year adjustments for all Santa Clara County MHSA programs.

- FY 2025 Annual program updates for all Santa Clara County MHSA programs.

This Draft Plan reflects the deep commitment of BHSD leadership and staff, providers, consumers, family members, and other stakeholders to the meaningful participation of the community as a whole in designing MHSA programs that are wellness and recovery focused, client and family driven, culturally competent, integrated, and collaborative.

DEVELOPMENT OF THE FY 2025 ANNUAL UPDATE PLAN

STAKEHOLDER LEADERSHIP COMMITTEE

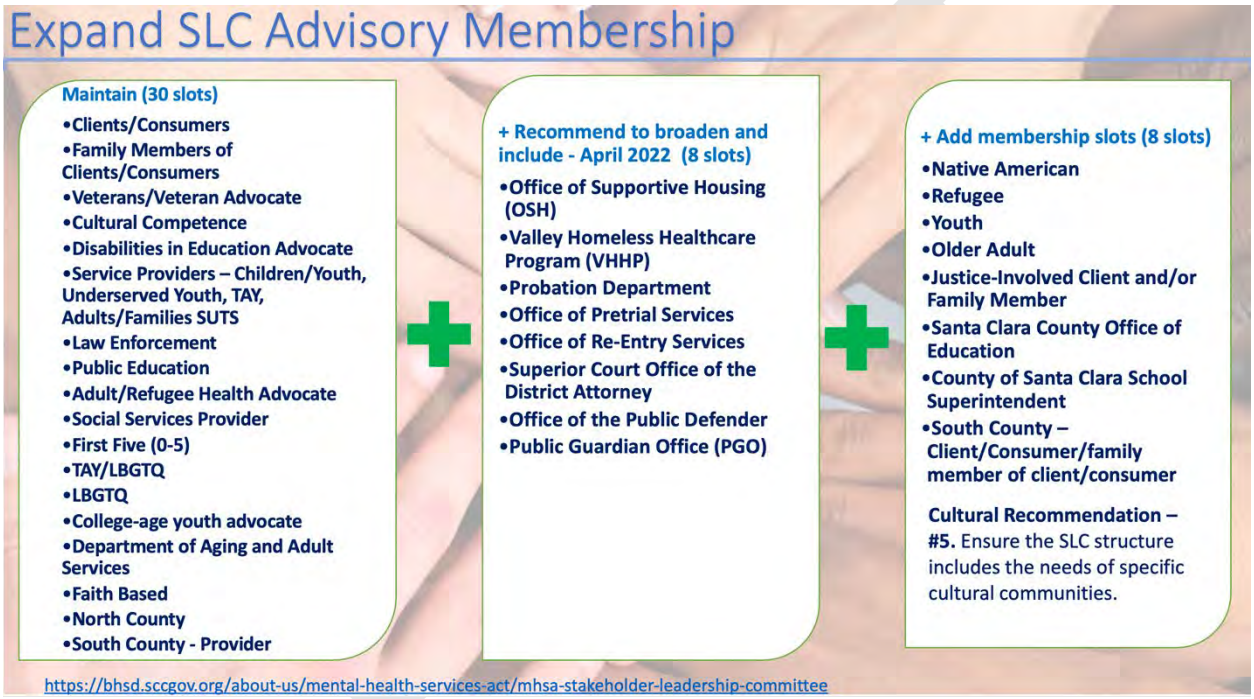
With its core commitment and prioritization of community collaboration and consumer and family member partnership, Santa Clara County's BHSD hosts a Stakeholder Leadership Committee (existing since 2005) whose mission is to serve as the vehicle "to provide input and to advise the County Behavioral Health Services Department (BHSD) in its MHSA planning and implementation activities"[12]. The Santa Clara County SLC provides input that drives major decisions on mental health policy, program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations for each MHSA three-year plan, annual updates, and mid-year adjustments. Essentially, the SLC serves as the BHSD's primary advisory committee for MHSA activities.

The MHSA SLC consists of representatives of various stakeholder groups, including consumers, family members and underserved cultural communities. The MHSA SLC members review, comment and provide input on MHSA plans and annual updates. MHSA SLC meetings serve as a forum to assure wide-ranging representation in the MHSA community planning process. All MHSA SLC meetings are open to the public and allow for public comment. Throughout the year, the BHSD holds MHSA SLC meetings to discuss MHSA-related business and programs. More detailed information about its roles and responsibilities can be found here: https://bhsd.sccgov.org/sites/g/files/exjcpb711/files/documents/mhsa-slc-roles-responsibilities-07-27-22.pdf

Given the unique characteristics of the diverse demographic makeup in the County of Santa Clara with cultural diversity representing the majority of the population, BHSD takes a deliberate approach to defining representative seats on the SLC to ensure that the voices and needs of the County's diverse community members are embodied on the committee.

[12] https://bhsd.sccgov.org/about-us/mental-health-services-act/mhsa-stakeholder-leadership-committee

The 2023 SLC membership includes expanded membership that resulted from an effort to include specific cultural communities within the SLC structure as recommended by community data and input from the 2022 MHSA community planning process. In August 2022, the BHSD increased the number of SLC seats by eight to add several new seats to represent the needs of youth, Native Americans, refugees, older adults, justice-involved clients or family members, South County residents, the Santa Clara Office of Education, and the County of Santa Clara School Superintendent. BHSD also acted on a recommendation to broaden its membership to include 8 key stakeholder areas. These changes and current seats and representation on the SLC are specified below:



With these changes, BHSD aims to enhance its efforts to partner with a committee that is able to represent the voices and needs of the diverse communities within the County.

COMMUNITY PLANNING PROCESS

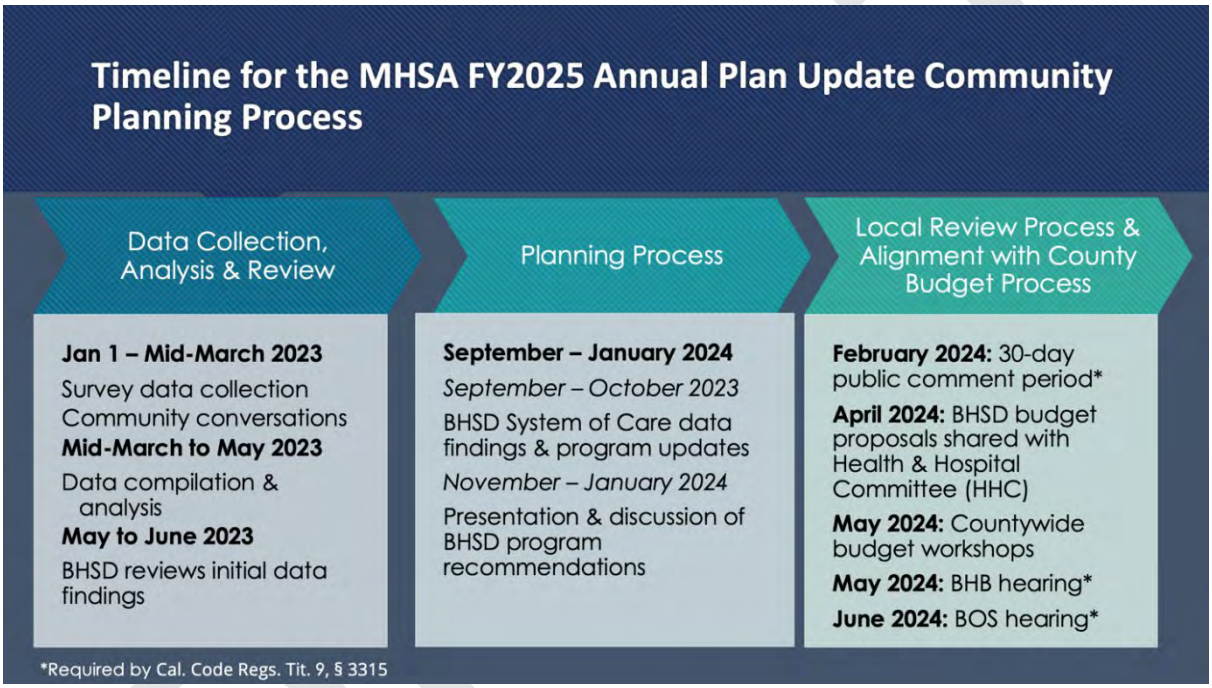
In January of 2023, the County of Santa Clara County Behavioral Health Services Department (BHSD) initiated a Community Planning Process to inform the next Mental Health Services Act (MHSA) FY 2025 Annual Update Plan. This process was led by the following team members: Sherri Terao, Director of the Behavioral Health Department; Jeanne Moral, Behavioral Health Division Director; Roshni Shah, MHSA Manager/Coordinator Program Manager III; Juan Miguel Munoz-Morris, MHSA Innovation Program Manager, Jeannette Ferris, WET Coordinator/Manager; Jamina Hackett, Program Manager for TRUST; Rebeca Lopez, MHSA Program Manager II; Pooja Singh, MHSA graduate intern; and Siobhan Burgos, MHSA peer support intern.

The Community Planning Process was guided by community based participatory principles with the goal of garnering community feedback as a primary guide for MHSA three-year plan priorities. The process took place from January 2023 through early February 2024, and included 5 parts:

5 Parts of the Community Planning Process

Part 1. Partnership with Stakeholders: Stakeholder Leadership Committee (SLC)
Part 2. Community-Wide Survey
Part 3. Community Conversation Groups
Part 4. SLC / Community Review and Revision of Data and Recommendations
Part 5. Public Review of Plan and Approval Process

An overview of the 2023 CPP timeline is depicted in the figure below:

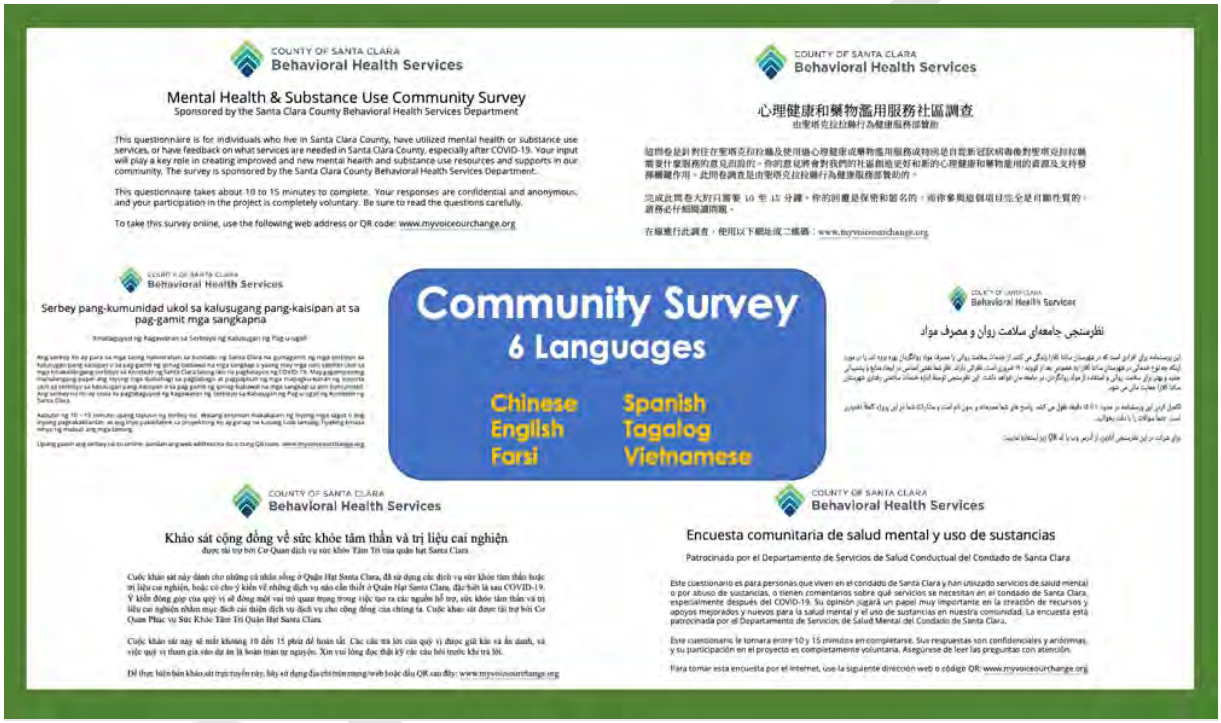


Part 1. Partnership with Stakeholders: Stakeholder Leadership Committee (SLC)

In its roles of partnering with BHSD in decisions related to mental health policy, program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations, the SCC MHSA Stakeholder Leadership Committee (via a SLC subcommittee) took the lead in reviewing and modifying previous versions of a community survey (originally created in 2018 and updated in 2020 and 2022). The purpose of the revised community survey was to understand the mental health and substance use service needs of residents in Santa Clara County, and to obtain feedback about community member and consumers' experiences of BHSD MH / SU services. The survey was reviewed by the BHSD executive team and the Community Connections Psychological Associates, Inc. independent evaluation team, and vetted by the larger Stakeholder Leadership Committee. Survey modifications addressed such areas as community-wide mental health and substance use needs, COVID-19 pandemic concerns, and telehealth services.

Part 2. Community-Wide Survey

The community survey created by the SLC assessed six primary categories: 1) Access to Care; 2) Quality of Care; 3) Cultural Considerations; 4) Recovery Orientation; 5) Family Inclusion; and 6) Telehealth. Community surveys were available in the 6 most common threshold languages within SCC: English, Spanish, Vietnamese, Mandarin, Tagalog, and Farsi. All survey responses were collected from January 1, 2023 through the middle of March 2023.



Outreach for the 2023 consumer stakeholder survey utilized a multi-method approach, with the goal of reaching a diverse representation of County consumers and family stakeholders. First, electronic outreach was utilized to reach individuals via online means. Examples of these online outreach efforts included social media ads, email mailers, and newsletters issued by Behavioral Health Services Department (BHSD) to consistently remind members in the community to complete the survey throughout the months of January through March 2023. The survey was available to complete online or on paper to reach as many community members as possible in Santa Clara County.

Multi-Method Survey Outreach
to Recruit a Diverse Sample of County Consumers & Family Members

Second, to ensure adequate representation of BHSD consumers and family members as respondents to the community survey, BHSD enlisted the assistance of community partners and clinical providers. BHSD community-serving partners took an active role in spreading the word about the survey through their newsletters and distribution lists in English and other threshold languages. Postcards, posters, fliers, and paper copies of the survey were handed out throughout County Clinics, County offices, and Self-help centers, and providers encouraged current consumers of County services to participate in the survey. Copies were also provided to County partners and shared in their centers and networks.

Finally, a concerted effort was made to market the community survey to culturally diverse communities in the County. Announcements were made at Community Conversations targeted at different LGBTQ+, immigrant, refugee, non-English speaking, and ethnic minority communities, and BHSD also engaged community peers to outreach about the survey at places/organizations of community gathering, such as community centers and places of worship, among others.

Data Analysis for the Survey

Survey analyses were divided into several main parts. First, qualitative comments from the survey were combined with comments from the community conversations to yield a unified set of qualitative data. Second, descriptive statistics (i.e., means and standard deviations) were calculated for the 6 major domains that are consistent with MHSA principles, and compared with scores from last year's CPP survey, to track any variations over time. Third, data from the survey's access to care, WET, and strengths and barriers questions were analyzed to inform recommendations.

Part 3. Community Conversation Groups

In order to hear directly from community stakeholders, the BHSD partnered with County programs and Community-based partner organizations to host online and in-person 60-to-90-minute community listening events ("Community Conversations"). A total of 435 community stakeholders participated across 29 community conversations. Community partner organizations who hosted the conversations included the following: Allcove, Asian Americans for Community Involvement, Behavioral Health Contractors Association, Bill Wilson Center, Community Solutions, County Behavioral Health Services Department Teams (Access / Unplanned Services, Administrative Services, Children Youth & Families, Finance; and Adult/Older Adult), Cultural Communities Wellness Program, East San Jose Public Library, Gardner Health Services, Ethnic Wellness Center, Gilroy Senior Center, Momentum for Health, Mothers against Murder, National Alliance

on Mental Illness-Santa Clara County The Office of LGBTQ+ Affairs, Office of the Public Defender, Project Safety Net, Q Corner, Re-entry Services, San Jose State University, Santa Clara County Office of Education, County of Santa Clara Probation Department – Juvenile Hall, Silicon Valley Gurdwara, Stanford University School of Medicine, Vietnamese American Service Center (VASC), Young Men's Christian Association (YMCA) of Silicon Valley, and the LGBTQ Youth Space of Caminar.

The conversations were open to the public and attended by consumers/clients, family members, service providers, and numerous other stakeholders. Community conversation groups targeted a diverse representation of community stakeholders across the SCC community and BHSD systems of care. English-speaking sessions were led and facilitated by members of the CCPA independent evaluation team; non-English speaking sessions were facilitated by a representative from the host organization or County BHSD team. Each conversation included a brief overview of MHSA, followed by three primary discussion prompts:

3 Community Conversation Discussion Prompts

1. In thinking about mental health and substance use services in Santa Clara County, what should stay the same?
2. In thinking about mental health and substance use services in Santa Clara County, what should be added or changed?
3. Suggestions or recommendations for the 5 Behavioral Health Department's Priorities? *(Note: 5 BHSD goals are listed below)*

Community stakeholders participated in each conversation through open verbal conversation or written chat comments (for online sessions). Each conversation was recorded solely for the purpose of facilitating accuracy of data capture and transcription by the independent evaluation team. At the beginning of each community conversation, participants were informed that the session would be recorded, and had the option of opting out of participation. Participants were informed that the recordings and transcripts would only be used for data analysis by the independent/external evaluation team. For in-person community conversations, only audio was recorded, and for online community conversations, names or faces were not be recorded or linked with their comments (thus maintaining anonymity). All verbal and written (chat) comments served as qualitative data for thematic analysis of each individual stakeholder comment.

Data Analysis for Community Conversations

Each community conversation was transcribed, and then coded for individual community comments about the areas of need relevant to BHSD services (strengths were coded and reported separately, above). The data were then coded using a grounded theory approach to identify an overarching set of areas of need (called "primary themes or codes"), listed in order of frequency mentioned. Each primary theme / area of need was also organized into subthemes ("secondary" themes) to clarify community feedback and organize recommendations. These subthemes provide descriptions and definitions of stakeholders' comments within each overarching area of need (primary theme).

Given that community conversation stakeholders were prompted to comment on any feedback or recommendations for BHSD's five (5) main goals (listed above), each of the areas of need (at the secondary or subtheme level) were compared against the Department goals to identify any overlap and correspondence with the Department's 5 main goals. Goals that corresponded with primary or secondary themes are indicated in all data tables and analyses; this analysis allows for BHSD to consider stakeholder feedback in their decisions and plans as they focus on the 5 department goals. Results for these qualitative analyses are presented in each of the Department, System of Care, and Other Areas of Focus sub reports in this overarching program evaluation report.

See below for a list of each community conversation, along with the number of participants and language in which the conversation was conducted. The Appendix includes data tables for the themes and sub-themes of each Community Conversation.

Community Conversation Groups (Total n = 435)

Region

1. North County Community (32, *English*)
2. South County Older Adults (3, *English*)
3. South County Spanish & English speaking, some unhoused *(42, English & Spanish)*

Children, Youth, Families

4. Youth Group 1 (7, *English*)
5. Youth Group 2, LGBTQ+ (3, *English*)
6. Youth Group 3 (14, *English*)
7. Youth Group 4, University students (12, *English*)
8. Youth who are Unhoused (6, *English*)
9. Family Members, General (10, *English*)
10. Providers: Children, Youth, & Family Services (32, *English*)
11. Young Men Involved in Juvenile Justice *(9, English)*
12. Young Women Involved in Juvenile Justice *(2, English)*

Justice-Involved

14. Diversion Community (65, *English*)
15. Reentry Community (18, *English*)

    Young Men Involved in Juvenile Justice *(9, English)*

    Young Women Involved in Juvenile Justice *(2, English)*

Unhoused

16. Unhoused (1, *English*)
17. Adults in Residential/Transitional Housing (Unhoused) *(4, English)*
18. Providers: Supportive Housing (13, *English*)

    South County Spanish & English speaking, some unhoused *(42, English & Spanish)*

    Youth who are Unhoused (6, *English*)

General / Other

19. Providers: Adult & Older Adult (24, *English*)
20. Consumers/Clients, General (4, *English*)

Cultural Communities	Older Adults
13. TGI+ (9, *English*) 14. LGBQPA2S+ (7, *English*) Youth Group 2, LGBTQ+ *(3, English)* 15. Spanish Speaking LGBTQ+ Adults (19, *Spanish*) 16. Spanish Speaking Adults (6, *Spanish*) South County Spanish & English speaking, some unhoused *(42, English & Spanish)* 17. African Immigrant Community *(15, English)* 18. South Asian (Punjabi) Community (27, *Punjabi*) 19. African American (3, *English*) 20. Vietnamese Community (27, *Vietnamese*) 21. Middle Eastern Community (7, *English*) 22. Providers: Refugee Services (14, *English*)	South County Older Adults (3, *English*)

Note: Parentheses include the number of participants in each community conversation, followed by the language in which the conversation was conducted.
Note: Occasionally, multiple individuals attended a Community Conversation from the same device (e.g., couples, families, client-provider dyads using the same laptop). Efforts were made to count all individuals who were present, but these participant counts may under-represent the total number of individuals who participated on Zoom.
Note: Community partner organizations who hosted the conversations included the following: Allcove, Asian Americans for Community Involvement, Behavioral Health Contractors Association, Bill Wilson Center, Community Solutions, County Behavioral Health Services Department Teams (Access / Unplanned Services, Administrative Services, Children Youth & Families, Finance; and Adult/Older Adult), Cultural Communities Wellness Program, East San Jose Public Library, Gardner Health Services, Ethnic Wellness Center, Gilroy Senior Center, Momentum for Health, Mothers against Murder, National Alliance on Mental Illness-Santa Clara County The Office of LGBTQ+ Affairs, Office of the Public Defender, Project Safety Net, Q Corner, Re-entry Services, San Jose State University, Santa Clara County Office of Education, County of Santa Clara Probation Department – Juvenile Hall, Silicon Valley Gurdwara, Stanford University School of Medicine, Vietnamese American Service Center (VASC), Young Men's Christian Association (YMCA) of Silicon Valley, The LGBTQ Youth Space of Caminar

In the first three weeks of June 2023, BHSD leadership and program teams were provided with a preliminary presentation of the CPP data findings and recommendations. These presentations allowed BHSD system of care leaders to create their preliminary recommendations based on community stakeholder (i.e., community member, consumer, and family member) qualitative and quantitative feedback.

Part 4. SLC / Community Review and Revision of Data and Recommendations

From September 13, 2023 through February 5, 2024, a series of 9 meetings were conducted to facilitate SLC and community review of data and recommendations for the County's FY 2025

annual plan update. Each retreat was open to public participation. These 9 meetings had four main goals, listed below:

Four Main Goals / Parts of the SLC / Community Retreats

1) Presentation of the CPP data and recommendations by the independent evaluation team, Community Connections Psychological Associates.

2) Presentation of proposed program continuation, change, and targeted enhancement items for the MHSA FY2025 annual update plan (grounded in the CPP data and recommendations from item 1) by the major BHSD systems of care and/or component team leaders (i.e., Workforce Education and Training team and the Adult/Older Adult, Children Youth and Family, and Access and Unplanned Services systems of care).

3) Collection of additional feedback from SLC and community stakeholders about the CPP data and proposed MHSA FY 2025 annual plan update recommendations (from items 1 and 2). Several avenues for this feedback were provided, to create several options that fit the diverse preferences for participation from consumers and family members: a) anonymous in-person written feedback forms; d) an anonymous online survey; e) email comments to a BHSD MHSA team email address; and f) facilitated in-person breakout focus groups at 2 of the 9 meetings, for stakeholders to openly discuss their comments.

4) Further revision (along with presentation of these revisions) of proposed items for the MHSA FY 2025 annual plan update, in response to community, consumer, and family member feedback from item 3 above.

This four-part process allowed for an iterative process of community stakeholder partnership and collaboration in collaboratively creating the Santa Clara County's MHSA FY 2025 annual plan update. Discussions around upcoming legislation, such as SB 326, were incorporated at multiple stakeholder meetings to gather input and feedback, and to foster a collaborative and open discussion around potential changes. The below table lists each of these 9 CPP meetings conducted from September 13, 2023 through February 5, 2024, along with the number of attendees at each meeting.

Attendees at these Community Planning Process retreats included a diverse range of community stakeholders. These stakeholders included members of the Santa Clara County Stakeholder Leadership Committee (SLC; described in the "Stakeholder Leadership Committee" section of this report), BHSD staff and providers, BHSD collaborators (e.g., from partner organizations such as the Santa Clara County Office of Education, Community-based organizations and clinics, schools, and non-profit programs), and general community members (e.g., transitional-aged youth community members, adult consumers, family members, and advocates).

Table: Eight Public/Stakeholder Retreats / Activities: County of Santa Clara MHSA FY 2025 Annual Plan Update

Date	Meeting	Number of Attendees
September 13, 2023 9AM - 12PM	Kick-Off Retreat • Planning Process Timeline • Finance and MHSA Update • Department-level Data Findings	60
October 4, 2023 1-4PM	Data for the Access & Unplanned Services System of Care and Workforce, Education, and Training	31
October 11, 2023 1-4PM	Data for the Children, Youth, and Families System of Care	21
October 18, 2023 1-4PM	Data for Housing and the Adult and Older Adult System of Care	29
November 1, 2023 1-3PM	Round 1 Program Recommendations: Housing and the Adult and Older Adult System of Care	26
November 16, 2023 1-3:30PM	Round 1 Program Recommendations: Access & Unplanned Services System of Care, Workforce, Education, and Training, Children, Youth, and Families System of Care	33
December 15, 2023 10AM- 12PM	Program Recommendations to Address Impacts of BHSA	50
January 9, 2024 1:00 – 2:30PM	BHSA prioritization Working Session	24
February 5, 2024 9:00- 10:00 AM	Innovation and Recommendation Updates	67

Part 5. Public Review of Plan and Approval Process

The 30-day public comment period opens February 09, 2024 and closes on March 24, 2024. The County announces and disseminates the Draft Plan to the Board of Supervisors, Behavioral Health Advisory Board, County staff, service providers, consumers, family members, and those

whose email addresses are associated with the stakeholder email list compiled throughout this planning process. A public notice is posted on the County's MHSA website. The draft Plan is posted to the County's website and can be downloaded electronically along with public comment forms with instructions on how to submit stakeholder input. Paper copies can be made available at the BHSD offices in San Jose. Any interested party could request a copy of the draft Plan by submitting a written or verbal request to the MHSA Coordinator at mhsa@hhs.sccgov.org.

FY 2024 Mid-Year Adjustment and FY 2025 Annual Plan Update 30-day Public Comment Period Stakeholder Comment Form:

https://www.surveymonkey.com/r/ZD93MD7

The Behavioral Health Board will host a public hearing in the Spring of 2024 (date TBD), during which stakeholders will be engaged to provide feedback about the Draft Plan.

-place holder for notes from the Public Hearing-

EXECUTIVE SUMMARY OF MHSA FUNDED PROGRAMS

The following summary tables provide a snapshot of annual FY 2025 budget allocations and status (i.e., whether the program is new, continuing, modified, sunsetting, etc.) for each program in the three major BHSD systems of care (Children Youth and Family, Adult and Older Adult, and Access and Unplanned Services). A brief description of each program is also provided in these executive summary tables.

SNAPSHOT: COMMUNITY SERVICES AND SUPPORTS

Program	Description	Status & Costs
Full Service Partnership (FSP) Programs		
Child Full Service Partnership (Continuum)	Continuation of the FSP model from previously approved plans, including maintenance FSP services for those who may still need services (e.g. housing support) to remain successful in the community and intensive FSP services for individuals with serious mental illness.	***Status:*** Continuing ***# to be served***: 310 ***Cost per person***: $30,844 ***FY 2025 budget***: $9,561,488
Transitional Age Youth FSP	Continuation of the FSP model from previously approved plans, including maintenance FSP services for those who may still need services (e.g. housing support) to remain successful in the community and intensive FSP services for individuals with serious mental illness.	***Status:*** Continuing ***# to be served***: 483 ***Cost per person***: $20,160 ***FY 2025 budget***: $9,737,171
Adult Full Service Partnership	This includes the following programs: 1.Adult Full Service Partnership 2.Intensive Full Service Partnership Continuation of the FSP model from previously approved plans. This FSP level provides needed, ongoing services for consumers with SMI addressing needs that include housing support and other clinical services.	***Status:*** Continuing ***# to be served***: 1,357 ***Cost per person***: $7,966 ***FY 2025 budget***: $10,810,218
Criminal Justice FSP	Continuation of the FSP model from previously approved plans. This tier of service will ensure that justice-involved individuals receive the appropriate level of care to meet their clinical needs and housing support, to remain successful in the community.	***Status:*** Continuing ***# to be served***: 700 ***Cost per person***: $10,664 ***FY 2025 budget***: $7,464,763
Forensic Assertive Community Treatment	FACT's structure is similar to ACT for justice-involved consumers' needs Assertive Community Treatment (ACT) is an evidence-based behavioral health program for people with serious mental illness who are at risk of or would otherwise be served in institutional	***Status:*** Continuing ***# to be served***: 172 ***Cost per person***: $35,766 ***FY 2025 budget***: $6,151,745

	settings (e.g. hospitals, jails/prisons) or experience homelessness.	
Older Adult Full Service Partnership	Intensive wraparound services to Older Adult's with severe mental illness in a low staff to consumer ratio (1:10) through a "whatever it takes" approach	***Status:*** Continuing ***# to be served***: 43 ***Cost per person***: $64,061 ***FY 2025 budget*:** $2,754,618
Assertive Community Treatment	Assertive Community Treatment (ACT) is an evidence-based behavioral health program for people with serious mental illness who are at risk of or would otherwise be served in institutional settings (e.g. hospitals, jails/prisons) or experience homelessness. The ACT model is a comprehensive community-based model of treatment, support, and rehabilitation for individuals with serious mental illness who are unwilling or unable to engage in mental health services and who are experiencing frequent and repetitive hospitalizations and/or incarcerations, likely to be homeless, and may suffer from a co-occurring disorder.	***Status:*** Continuing ***# to be served***: 251 ***Cost per person***: $33,858 ***FY 2025 budget***: $8,498,432
Permanent Supportive Housing	This includes the following programs: 1.Permanent Supportive Housing Program 2.Abode HEAT (Homeless Engagement and Access Team) Consists of County-operated services designed to meet the housing and service needs of chronically homeless individuals with severe mental health needs. Adding the Homeless Engagement and Access Team (HEAT) as an effort to improve behavioral health access and outcomes for homeless individuals with mental illness.	***Status:*** Continuing ***# to be served***: 875 ***Cost per person***: $5,470 ***FY 2025 budget***: $4,786,268
Combined FSP and Non-FSP Programs		
Crisis Stabilization Unit and Crisis Residential Treatment	This includes the following programs: 1.Crisis Stabilization Unit 2.Crisis Residential Treatment Crisis support, counseling, and linkage services up to 24-hour stabilization unit and CRT	***Status:*** Continuing ***# to be served***: 1,628 ***Cost per person***: $13,393 ***Total FY 2025 budget***: $21,803,892 FY 2025 FSP budget: $6,312,820 FY 2025 Non-FSP budget: $15,491,072
Criminal Justice Residential and Outpatient Treatment Programs	The Criminal Justice Services (CJS) Evan's Lane Outpatient and Residential program provides comprehensive behavioral health services for clients that combine components of	***Status:*** Continuing ***# to be served***: 142 ***Cost per person***: $51,180

	recovery-oriented, evidence-based practices, promising practice, and trauma-informed practices.	***Total FY 2025 budget***: $7,267,518 FY 2025 FSP budget: $3,633,752 FY 2025 Non-FSP budget: $3,633,766
Non-Full Service Partnership (Non-FSP) Programs		
Children & Family Behavioral Health Outpatient/IOP Services	This includes the following programs: 1.Family & Children Behavioral Health Outpatient / Intensive Outpatient: Counseling, case management, and medication management services for children who meet medical necessity. Long-term counseling, case management, and medication management services provided at a greater frequency and intensity for intensive outpatient treatment. 2.Family & Children Ethnic Outpatient Services: Counseling, case management, and medication management services for children who meet medical necessity. Long-term counseling, case management, and medication management services provided at a greater frequency and intensity for intensive outpatient treatment. 3.Family & Children Behavioral Health Integrated Outpatient Services: Outpatient integrated behavioral health services to children and youth with co-occurring mental health and substance abuse needs	***Status:*** Continuing ***# to be served***: 5,490 ***Cost per person***: $7,242 ***FY 2025 budget***: $39,760,050
Specialty Services - Integrated MH/SUD	Specialty Services – Eating Disorders Specialty clinical services such as counseling and case management for children, youth and adults with eating disorders	***Status:*** Continuing ***# to be served***: 45 ***Cost per person***: $18,884 ***FY 2025 budget***: $849,767
Services for Juvenile Justice Involved Youth	Juvenile Justice Development (JJD) funds positions that focus on the wellness and recovery of youth returning to their communities through transition planning in a strength-based, client-centered, and healing oriented manner. JJD works alongside families to support youth in developing life skills that allow them to thrive, engage in school or vocational settings as well as meaningful daily activities. Note: The Youth Therapeutic Integrated Program (YTIP) was a standalone program providing support to address mental health and substance needs for youth (ages12-14) who are involved with juvenile justice system and receiving treatment services.	**Status:** Continuing **# to be served:** 665 **Cost per person:** $5,640 **FY 2025 budget:** $3,750,455

	The YTIP program sunsetted and the County is now operating the program as part of the Juvenile Justice Clinics. The youth served is included in the Juvenile Justice Development report	
Commercially Sexually Exploited Children (CSEC) Program	Services and mental health support to children and young people ages 10-21 who have experienced commercial sexual exploitation to help them recover from emotional, physical, and sexual trauma. *Note: Foster Care Development program ended in FY21, and program funds merged with CSEC.	***Status:*** Continuing ***# to be served***: 30 ***Cost per person***: $57,223 ***Total FY 2025 Budget:*** $1,716,701 *FY 2025 budget CSEC: $491,944* *FY 2025 budget Foster Care Development: $1,224,757*
Mobile Crisis Stabilization Services (MRSS)	This includes the following programs: 1.Mobile Response and Stabilization Services: Mobile Response and Stabilization Services (MRSS) program services are available 24/7 and include stabilization and support services to children, youth, and families in the community who are depressed, suicidal, or having acute psychological crisis. 2.Post-Crisis Stabilization Services: The Post-Crisis Stabilization Program (PCSS) program offers intensive community-based services to provide stabilization and support to youth in Santa Clara County who may be at risk of hospitalization. From FY25 and onwards, PCSS will be reported as a separate program and fiscal item from MRSS Onsite rapid-response crisis assessment and intervention for children who are depressed, suicidal, or having acute psychological crisis	***Status:*** Continuing ***# to be served***: 1,143 ***Cost per person***: $1,705 ***FY 2025 budget***: $1,948,908
Independent Living Program (ILP)		***Status:*** Not Continuing, program was sunsetted at the end of FY 2024 ***# to be served***: N/A ***Cost per person***: N/A ***FY 2025 budget***: N/A
TAY Outpatient Services	This includes the following programs: 1.TAY Outpatient Program: Outpatient programs for TAY ages 16-24 aim to prevent chronic mental illness while improving quality of life for youth. Programs are focused on preventing or improving symptoms that may lead to chronic	***Status:*** Continuing ***# to be served***:710 ***Cost per person***: $4,048 ***Total FY 2025 Budget:*** *$2,873,721*

	mental illness while keeping TAY on track developmentally. 2.TAY LGBTQ: Supports individuals ages 16-24 and aims to prevent chronic mental illness while improving quality of life for youth and young adults who identify as part of the LGBTQ+ community or are questioning.	*FY 2025 budget TAY Outpatient: $1,804,207* *FY 2025 budget IOP: $1,069,514*
Intensive Outpatient Program (IOP)	Intensive outpatient programs for TAY ages 16-24. TAY Outpatient and Intensive Outpatient are reported together.	
TAY Crisis and Drop In Center	Safe, welcoming, and inclusive spaces for youth to receive access to behavioral health resources and overnight respite	***Status:*** Continuing ***# to be served***: 135 ***Cost per person***: $6,033 ***FY 2025 budget***: $814,503
TAY Interdisciplinary Service Teams	The TAY interdisciplinary Service Team (IST) provides a spectrum of resources to youth and young adults, including those who are homeless, that support their behavioral health and help launch them into adulthood.	***Status:*** Continuing ***# to be served***: 173 ***Cost per person***: $9,278 ***FY 2025 budget***: $1,605,016
Adult Residential Treatment	This program was designed with a plan to purchase potential facilities that would provide a full range of clinical and support services for consumers needing Adult Resident Treatment. The BHSD continues to work with the County's Office of Supportive Housing and Fleet and Facilities in this effort.	***Status:*** Continuing ***# to be served***: 164 ***Cost per person***: $56,782 ***FY 2025 budget***: $9,312,243
Assisted Outpatient Treatment (AOT)	AOT implementation is guided by AB 1421 "Laura's Law" which refers to a legal process by which a judge may compel an individual to comply with a treatment plan on an outpatient basis. AOT is a less restrictive form of civil commitment for individuals with severe mental illness who are unable or unwilling to receive or adhere to community mental health services voluntarily.	***Status:*** Continuing ***# to be served***: 81 ***Cost per person***: $139,468 ***FY 2025 budget***: $11,296,904
Specialty Outpatient Services	This includes the following programs: 1.Ethnic Specific Outpatient Continuum: Designed to provide culturally relevant intensive mental, emotional, and behavioral services and counseling to adults who have mental health disorders. 2.Gender Affirming Care Clinic (GACC): Provides specialty gender affirming outpatient Behavioral Health Services to transgender and gender diverse community members ages 5 and older. This clinic exists because of the significant	***Status:*** Continuing ***# to be served***:348 ***Cost per person***: $10,835 ***FY 2025 budget***: $3,770,773

	mental health disparities faced by the TGD community and ongoing difficulty accessing quality, gender affirming care	
Outpatient Services for Adults	Outpatient Services for Adults (18-59 years old) include counseling, case management, and medication management, and crisis services for adults and older adults who meet medical necessity to improve quality of life, address unique mental health needs, and prevent higher intensity care by allowing clients to receive services in the community. This includes 26 unduplicated served in the Hard of Hearing program.	***Status:*** Continuing ***# to be served***: 6,020 ***Cost per person***: $3,333 ***Total FY 2025 Budget:*** $20,063,743 FY 2025 budget Outpatient Services for Adults: $16,860,670 FY 2025 budget Outpatient Services for Older Adults: $3,203,073
Outpatient Services for Older Adults	Outpatient Services for Older Adult (60 and over) include counseling, case management, and medication management, and crisis services for adults and older adults who meet medical necessity to improve quality of life, address unique mental health needs, and prevent higher intensity care by allowing clients to receive services in the community. Due to organizational changes, Adult Outpatient and Older Adult Outpatient services are presented as a combined report on the subsequent pages.	
Hope Services: Integrated Mental Health and Autism Services	Counseling, case management, and psychiatric services to children, adolescents, young adults, adults, and senior citizens with a qualifying mental health diagnosis and a developmental disability.	***Status:*** Continuing ***# to be served***: 1,367 ***Cost per person***: $1,926 ***FY 2025 budget***: $2,633,115
CalWORKs Community Health Alliance	Behavioral health services to adult clients enrolled in the Welfare-to-Work (WTW) Program who experience mental health and substance abuse issues	***Status:*** Continuing ***# to be served***: 411 ***Cost per person***: $6,253 ***FY 2025 budget***: $2,570,123
Individualized Supported Services (Employment)	Using the consumer-driven Individual Placement and Support (IPS) evidence-based practice, this project integrates employment as a wellness goal for clients/consumers and provides an array of individual supports to help clients and consumers achieve their goals.	***Status:*** Continuing ***# to be served***:163 ***Cost per person***: $10,308 ***FY 2025 budget***: $1,680,148
County Clinics	An array of mental health supports including basic mental health services and medication support. The County's clinics expand access to mental health services in the community serving diverse, ethnic communities. This includes: Downtown Mental Health Center Service Teams (DTMH): Assists individuals within the context of a mutual partnership effort to achieve higher	***Status:*** Continuing ***# to be served***: 2,277 ***Cost per person***: $4,483 ***FY 2025 budget***: $10,209,470

	levels of functioning, develop community/family support systems wherever possible, promote self-reliance and self-sufficiency, and encourage individuals to work or to return to work whenever possible. Central Wellness Benefits Center (CWBC): Assists clients in accessing health benefits while managing their medication needs. If qualified for coverage, CWBC links clients to more extensive behavioral health outpatient services within County of Santa Clara. The Vietnamese American Service Center – Behavioral Health (VASCBH): A culturally proficient outpatient behavioral health site to provide behavioral health services primarily to children, youth, adult and older adult Vietnamese and Latino populations of Santa Clara County who have severe mental illness.	
Mental Health Urgent Care	Screening, assessment, brief medication management, and referral to other community resources at walk-in outpatient clinic for County residents who are experiencing behavioral health crises. Formerly known as Mental Health Urgent Care	***Status:*** Continuing ***# to be served***: 2,640 ***Cost per person***: $1,953 ***FY 2025 budget***: $5,156,209
Community Placement Team Services and IMD Alternative Program	Case management, housing, and linkage support by a 24-hour case management unit that provides services to consumers returning to the community from other settings. Comprehensive treatment services in a supportive, structured environment as an alternative to a locked setting serving up to 45 consumers for approximately 6-months	***Status:*** Continuing ***# to be served***: 298 ***Cost per person***: $4,529 ***FY 2025 budget***: $1,349,614
Criminal Justice Outpatient Services	*This includes the following programs:* *1.CJS Aftercare* *2.CJS Intensive Outpatient*	***Status:*** *Continuing* ***# to be served:*** *243* ***Cost per person:*** *$11,707* ***FY 2025 budget:*** *$2,844,891*
In-Home Outreach Teams	Targeted outreach and engagement teams to identify and connect consumers with mental health needs to services (based on RISE model from Ventura County and IHOT model from Alameda County)	***Status:*** Continuing ***# to be served***: 373 ***Cost per person***: $5,541 ***FY 2025 budget***: $2,066,729
Connections Program	Case management and linkage services for older adults who are at risk of abuse as part of a collaboration with Adult Protective Services	***Status:*** Continuing ***# to be served***: 98 ***Cost per person***: $4,472 ***FY 2025 budget***: $438,281

SNAPSHOT: PREVENTION & EARLY INTERVENTION

Program	Description	Costs and Number of Participants
Prevention		
Violence Prevention Program & Intimate Partner Violence Prevention	In partnership with communities and County Departments, redirecting attention to a growing community need regarding intimate partner violence.	**Status:** Not Continuing, program was sunsetted at the end of FY24
Support for Parents	An array of support initiatives that are intended to prevent or intervene early in the development of emotional and behavioral problems in young children by providing the parents with outcome-based parenting strategies, support services, and classes	***Status:*** Continuing ***# to be served***: 13,838 ***Cost per person***: $62 ***FY 2025 budget***: $861,903
Promotores	Culturally and linguistically targeted outreach within communities and neighborhoods to create enhanced linkages/referrals from and to nearby clinics to community services provided by Peer Health Educators	***Status:*** Continuing ***# to be served***: ***3,058*** ***Cost per person***: $225 ***FY 2025 budget***: $688,015
Older Adult PEI Services	Program designed to enhance older adult quality of life, address their specific mental health needs, and help them remain in their homes whenever possible rather than needing more intensive care	***Status: Continuing*** ***# to be served***: 65 ***Cost per person***: $6,596 ***FY 2025 budget***: $428,730
Early Intervention		
Raising Early Awareness Creating Hope (REACH)	An array of early detection, prevention and intervention services to youth experiencing signs and symptoms related to the early onset of psychosis and schizophrenia	***Status:*** Continuing ***# to be served***: 129 ***Cost per person***: $17,689 ***FY 2025 budget***: $2,281,929
Integrated Prevention Services for Cultural Communities (IPSCC)	People with mental and substance abuse disorders may die decades earlier than the average person — mostly from untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by poor health habits such as inadequate physical activity, poor nutrition, smoking, and substance abuse. Barriers to primary care — coupled with challenges in navigating complex healthcare systems — have been a major obstacle to care.	***Status:*** Continuing ***# to be served***: 754 ***Cost per person***: $2,385 ***FY 2025 budget***: $1,798,211
Elder's Storytelling Program	The new Elders' Storytelling Program will serve culturally isolated older adults with mild to moderate depression using the culturally proficient technique of life review and storytelling (reminiscence) and incorporate innovative service components to help reduce the elder client's depressive symptoms and	***Status:*** Continuing ***# to be served***:112 ***Cost per person***: $4,095 ***FY 2025 budget***: $458,676

	restore their position of social connectedness with their family, friends, caregivers and community.	
School Linked Services (SLS) Initiative	Screening, identification, referral, and counseling services for school age children/youth in school-based settings	***Status:*** Continuing ***# to be served***: 9,479 ***Cost per person***: $2,360 ***FY 2025 budget***: $22,368,656
allcove	allcove is an integrated behavioral health center for adolescents and young adults focusing on prevention and early intervention. All services are free or low cost which include behavioral health, peer support, substance use, psychiatry, medical services, employment, and education services to youth experiencing mild to moderate symptoms.	***Status:*** Continuing ***# to be served***: 245 ***Cost per person***: $17,478 ***FY 2025 budget***: $4,282,012
Outreach for Increasing Recognition of Early Signs of Mental Illness		
Older Adult In-Home Peer Respite Program	Free supportive counseling, visitation, and respite services provides caregivers of older adults a break from caregiving while simultaneously providing older adult consumers with companionship and social support	***Status:*** Continuing ***# to be served***: 47 ***Cost per person***: $9,759 ***FY 2025 budget***: $458,676
Law Enforcement Training and Mobile De-Escalation Response	Trainings and collaboration through the Law Enforcement Liaison Team Program (LEL) that utilizes Interactive Video Stimulation Training (IVST) for increased recognition of mental health and de-escalation skill-building. Trauma-Informed Policing Trainings to increase understanding and awareness of the impact of trauma and develop trauma-informed responses	***Status:*** Continuing ***# to be served***: 1167 ***Cost per person***: $219 ***FY 2025 budget***: $256,000
Stigma and Discrimination Reduction		
New Refugees Program	An array of outreach, engagement, and prevention activities treatment for new refugees	***Status:*** Continuing ***# to be served***: 213 ***Cost per person***: $3,661 ***FY 2025 budget***: $779,783
Cultural Communities Wellness Program (CCWP)	Peer support, outreach, engagement and educational services to underserved and unserved communities to reduce stigma and discrimination and increase access to mental health services	***Status:*** Continuing ***# to be served***: 6,288 ***Cost per person***: $381 ***FY 2025 budget***: $2,397,540
Access and Linkage to Treatment		
Services for Children 0-5	Array of services to promote early identification of early signs of mental health and developmental delays; provide access and linkage to treatment for children 0-5 and their families	***Status:*** Continuing ***# to be served***: 1,359 ***Cost per person***: $1203 ***FY 2025 budget***: $1,635,369

Office of Consumer Affairs	Three programs focused on connecting consumers to support from peers who have a shared lived experience of navigating the mental health system and are uniquely qualified to offer support, encouragement, and hope to consumers	***Status:*** Continuing ***# to be served***: 582 ***Cost per person***: $665 ***FY 2025 budget***: *$969,221*
Office of Family Affairs	Education support and resources to assist families in navigating the behavioral health system through offering direct support, information, and education, with the goal of providing recovery and hope	***Status:*** Continuing ***# to be served***: 4037 ***Cost per person***: $104 ***FY 2025 budget***: *$421,525*
Re-Entry Services Team	This is a multi-disciplinary team housed at the Re-Entry Resource Center that provides custodial and non-custodial individuals with referral and wrap around services. The program offers linkage to mental health outpatient services; alcohol and drug treatment and care; resources to the faith communities; peer mentoring; housing; general assistance benefits; health referrals; transitional case management; and a clothes closet. This overall assessment and wraparound services including custody health, mental health, probation, DADS, SSA, housing, and peer mentors	***Status:*** Continuing ***# to be served***: 287 ***Cost per person***: $1,843 ***FY 2025 budget***: *$529,047*
LGBTQ+ Access and Linkage	A variety of healing services, community engagement activities, and health education occurs specifically designed and implemented for specific communities	***Status:*** Continuing ***# to be served***: 20,285 ***Cost per person***: $78 ***FY 2025 budget***: $1,586,653
Behavioral Health Navigator Program	The peer run BH Navigator program will help connect individuals and families to County and community resources, and guide them through the behavioral health system, ensuring that all community members have access to accurate and relevant information, linkage to services, and partnership navigating various support opportunities. Peer Navigators will offer personalized assistance to get help for behavioral health need, peer guidance about options for wellness services and support, knowledgeable information and resources for mental health, substance use, suicide prevention, support groups, and more, connection to County and community-based resources, and support from Peers with an understanding of local services.	***Status:*** Continuing ***# to be served***: 7,750 ***Cost per person***: $129 ***FY 2025 budget***: $998,434
Psychiatric Emergency Response Team (PERT)	Expand on the established PERT model by offering post-crisis peer-driven linkage services	***Status:*** Continuing ***# to be served***: 477 ***Cost per person***: $3,559 ***FY 2025 budget***: $1,697,546

Suicide Prevention		
Suicide Prevention Strategic Plan	An array of programs and services for targeted high-risk populations, and a community education and information campaign to increase public awareness of suicide and suicide prevention	***Status:*** Continuing ***# to be served***: *1,248,043* ***Cost per person***: $3 ***FY 2025 budget***: $3,997,368
Improve Timely Access to Services for Underserved Populations		
Culture-Specific Wellness Centers	A variety of healing services, community engagement activities, and health education occurs specifically designed and implemented for specific cultural communities	***Status:*** Continuing ***# to be served***: 57,565 ***Cost per person***: $25 ***FY 2025 budget***: $1,454,769

SNAPSHOT: INNOVATIONS PROGRAMS

Program	Description	Status & Costs
Innovation		
INN 15: Trusted Response Urgent Support Team (TRUST)	The TRUST program provides community-based mobile crisis response that does not involve law enforcement, and offers a safe and welcoming environment to reduce the stigma associated with seeking mental health services by the intended consumers	***Status:*** Ongoing ***# to be served***: 5000 ***Cost per person***: $1,167 ***FY 2025 budget***: $5,837,075
INN 16: Addressing Stigma and Trauma among Vietnamese and African American/Ancestry Communities	This project aims to increase knowledge of and access to mental health services among the Vietnamese and African American/African Ancestry communities by destigmatizing mental health services in the context of their culture. The project will focus on culturally responsive prevention, community outreach and education services for children, adults, and families	***Status:*** Ends 06/2025 ***# to be served***: 1,000 ***Cost per person***: $584 ***FY 2025 budget***: $584,380

SNAPSHOT: WORKFORCE, EDUCATION AND TRAINING PROGRAMS

Program	Description	Costs and Number of Participants
WET Workplan (W1) – Administrative	Workforce Education and Training Coordination - Positions budgeted for Workforce, Education and Training infrastructure and are charged entirely to this budget. The infrastructure is to support the education and training efforts for underrepresented populations to enter the Behavioral Health Workforce and advance within the system as desired.	***Status:*** *Continuing* ***# to be served***: NA ***Cost per person***: NA ***FY 2025 budget***: $323,513
WET Workplan (W2) - Training	Promising Practice-Based Training in Adult Recovery Principles & Child, Adolescent & Family Service Models - This WET Workplan expands training for Behavioral Health Services Department (BHSD) and County Contract Providers (CCP) workforce that includes, direct service providers, administrative and management staff, consumers, clients and family members and other key stakeholders. The training workplan will promote and encourage the integration of wellness and recovery methods and the value of providing peer support and the use of staff with "lived experience" via a continuous learning model.	***Status:*** Continuing ***# to be served***: 5000 ***Cost per person***: $164 ***FY 2025 budget***: $822,165
WET Workplan (W2) - Training	Improved Services & Outreach to Unserved and Underserved Populations – This WET Workplan will expand specialized cultural humility/competency training to all staff to improve services to ethnic and cultural populations. Ethnic and cultural populations are broadly defined to include marginalized populations such as Black, Indigenous, and People of Color (BIPOC), the Elderly, Youth, People with Disabilities, LGBTQ+ individuals, Immigrant and Refugee populations.	
WET Workplan (W2) - Training	Welcoming Consumers and Family Members - This action will develop and implement training, workshops and consultations that promotes an environment that welcomes consumers, clients, and family members as contributing members of the public behavioral health system. Trainings will focus on advancing the educational, employment, and leadership opportunities for consumers, clients, and family members public mental health.	
WET Workplan (W2) - Training	WET Collaboration with Key System Partners - This action will build on the collaboration between the Behavioral Health Services Department and key system partners to develop and share training and education programs so that consumers and family members receive more effective integrated services.	
WET Workplan (W3): MH Career Pathways & Stipends and Financial	Comprehensive Mental Health Career Pathway Model - Position and overhead budgeted to support the development of the model. The model supports BHSD commitment to	***Status:*** Continuing ***# to be served***: 69 ***Cost per person***: $31,937

Incentives to Support Mental Health Career Pathway	developing a workforce that can meet the needs of its diverse population and is trained in the principles of recovery and strength-based approaches and culturally appropriate interventions. The needed "cultural change" in the transformation process is expected to occur as the workforce's composition changes to include more individuals who have "lived experiences" as consumers and family partners, and who come from the diverse cultural, ethnic, and linguistic underserved and unserved communities that BHSD seeks to serve.	***FY 2025 budget***: $2,203,638
WET Workplan (W3): MH Career Pathways & Stipends and Financial Incentives to Support Mental Health Career Pathway	Stipends and Incentives to Support Mental Health Career Pathway - This action is intended to provide financial support through stipends and other financial incentives to attract and enable consumers, family members, and college students to enroll in a full range of educational programs that are prerequisites to employment and advancement in the public behavioral health system. One-time reduction in FY 2025 for CCP student interns from 48 to 23 student interns. This is due to low number of CCP students participating in the WET stipend program.	
WET Administration		$131,713
Total Budget		**$3,481,029**

SNAPSHOT: CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS PROGRAMS

Program	Description	Status & Costs
CFTN Support Staff	Ongoing support for EHR FTE (staff)/Technology Services and Solutions (TSS)	***Status: Continuing*** ***Cost***: $1,950,000
EHR Project	Ongoing support for CCPs (County Contracted Agencies) in EHR implementation	***Status: Continuing*** ***Cost***: $1,353,178
Total Budget		**$3,303,178**

PROPOSED CHANGES FOR FY 2024 MID-YEAR ADJUSTMENT

The following table details proposed FY 2024 mid-year adjustments for each program, listed by system of care (Access and Unplanned Services, Children Youth and Families, and Adult and Older Adult). Note that program components that remain the same without proposed changes for FY 2024 mid-year adjustment are not listed in the tables below; they are described in the annual plan updates portion of the report.

The recommendations listed below were originally proposed and adopted in the MHSA FY24-26 three-year plan, but are now proposed to pause or not move forward as part of the FY 2024 mid-year adjustment. Fiscal Impact table on subsequent page/s.

BHSD SYSTEM OF CARE	MHSA COMPONENT	PROGRAM NAME	PREVIOUSLY APPROVED RECOMMENDATIONS IN THE FY24-26 3-YEAR PLAN THAT ARE PAUSED/NOT MOVING FORWARD	FREQUENCY
Access & Unplanned Services	PEI	BH Navigator	Add 1.0 FTE - LPHA will provide direct, dedicated support to Peer Staff when clinically complex or urgent cases present.	On-Going
Access & Unplanned Services	PEI	LEL's	Adding funds to complete the remaining 10 Interactive Video Simulation Training (IVST) videos using a professional talent agency/actors will allow for the LEL's to continue to present IVST to law enforcement and community agencies and groups using new and more relevant examples of the work law enforcement and staff encounter via the use of videos.	One-Time
Access & Unplanned Services	PEI	Suicide Prevention	Dedicated Management Analyst to enhance data collection, analysis and reporting capabilities, helping to inform effective outreach efforts and education campaigns; enhancing the program's ability to develop and validate culturally-tailored strategies for Suicide Prevention. Update for FY24 is a reduction in MHSA funds due to change in staff code from Management Analyst to Associate Management Analyst from proposed FY 24-26 three-year plan	On-Going

BHSD SYSTEM OF CARE	MHSA COMPONENT	PROGRAM NAME	PREVIOUSLY APPROVED RECOMMENDATIONS IN THE FY24-26 3-YEAR PLAN THAT ARE PAUSED/NOT MOVING FORWARD	FREQUENCY
Adult/Older Adult	CSS	24 HR care unit-since program is re-strucutring	Add 1.0 FTE Rehabilitation Counselor to the community placement team to assist with care coordination efforts in order to transition clients from long term psychiatric facilities.	On-Going
Adult/Older Adult	CSS	BH Urgent Care	To support the implementation of the Peer Navigation program an additional 1.0 FTE added to cover the gaps in coverage. This will increase capacity for Same Day Access.	On-Going
Adult/Older Adult	CSS	CSI	AOT Master Lease Housing Expansion – to serve additional fifty (50) clients	On-Going
Adult/Older Adult	CSS	Assisted Outpatient Treatment (AOT)	Proposed PSW II rehabilitation counselor in FY 24-26 three-year plan. Update for FY24 is a reduction in MHSA funds due to change in AOT staffing	On-Going
Adult/Older Adult	CSS	Supportive Services	Supportive Services for No Place Like Home (NPLH) Supportive Housing units Note: This program was proposed to utilize MHSA starting FY24, but the program continued utilizing a different funding source	On-Going
Adult/Older Adult	PEI	Cultural Communities Wellness	Add 1.0 FTE for the Cultural Communities Wellness Program to increase support for the Latino Community	On-Going

BHSD SYSTEM OF CARE	MHSA COMPONENT	PROGRAM NAME	PREVIOUSLY APPROVED RECOMMENDATIONS IN THE FY24-26 3-YEAR PLAN THAT ARE PAUSED/NOT MOVING FORWARD	FREQUENCY
BHSD	WET	System Initiatives, Planning and Communication	Develop a new peer mentoring program for High School (HS) and Community College (CC) Students. This new program was to introduce students to the benefits and rewards of entering the BH system of care's workforce.	On-Going
BHSD	WET	System Initiatives, Planning and Communication	Develop a new training team to provide internal trainer for the Learning Partnership that supports both County and CCP workforce. Proposing adding the following FTE's: 2.0 FTE Program Manager II and 2.0 FTE Training and Staff Development Specialists	On-Going
Children, Youth, & Families	CSS	F&C SVCS	Increase F&C Outpatient continuum services focused on LGBTQ community that is age specific	Ongoing Will be revisited in FY 26
Children, Youth, & Families	CSS	F&C SVCS	Sunset the integrated services program as Co-Occurring capabilities are being built into outpatient programs	Sunset Will be revisited in FY 26
BHSD	CSS	CSS Admin	Addition of staff to support the growth of MHSA activities: stakeholder planning activities, evaluation, outreach, required outcomes reporting, program review, coordination, and technical assistance. Update for FY24 is a reduction of 2.0 FTE due to structural deficit.	On-Going

The recommendations listed below are new or updated proposals as part of the FY 2024 mid-year adjustment. Fiscal Impact table on subsequent page/s.

BHSD SYSTEM OF CARE	MHSA COMPONENT	PROGRAM NAME	NEW RECOMMENDATIONS BEING CONSIDERED	FREQUENCY
BHSD	CSS	QA/UR Reorg	Release MHSA funding for 31 positions due to BHSD reorganization starting in FY24. Positions will utilize a different funding source. No impact on service delivery	On-Going
BHSD	CFTN	QA/UR Reorg		On-Going
BHSD	WET	QA/UR Reorg		On-Going
BHSD	CSS	QA/UR Reorg	Release MHSA funding for positions recognized for QA/UR Reorg	On-Going
BHSD	CFTN	QA/UR Reorg		On-Going
BHSD	WET	QA/UR Reorg		On-Going
CYF	PEI	School Linked Services	MHSA funds were TBD for CYF Wellness in FY24-26 three-year planning process. $5M of PEI funds to be used to support the implementation of wellness centers	One-time
Access & Unplanned Services	PEI	Psychiatrict Emergency Response Team (PERT)	INN12 - PERT Program transition to MHSA PEI in addition, 3.0 FTE new MHSA PEI positions	On-Going
Access & Unplanned Services	PEI	Psychiatrict Emergency Response Team (PERT)	Shift funding for one (1) Psychiatric Social Worker II from MHSA PEI PERT program to MOU with Campbell from FY 2024 onwards	On-Going
Adult/Older Adult	CSS	Adult Residential Treatment	Continue funds to ART program located at 431 N. White Road, San Jose, CA due to current increase in admissions and utilization for FY23. This is a 24- hour program that provide services for the SMI population 365 days a year. The goal of the program is to decompress the Emergency Psychiatric (EPS) and other inpatient psychiatric settings.	One-Time

BHSD SYSTEM OF CARE	MHSA COMPONENT	PROGRAM NAME	NEW RECOMMENDATIONS BEING CONSIDERED	FREQUENCY
Adult/Older Adult	CSS	Adult Residential Treatment	The goal is to set aside funding to support the ART program at 650 Bascom: • development (financing, construction, rehab, acquisition) of new temp shelter, temp treatment and permanent housing • support efforts around increasing all the new program/work plan/set aside for the Purchase & renovation of Properties • to increase Residential Care Facilities (RCF), Temporary Shelters, Adult Residential Treatment (ART), Crisis Residential program and Master lease shared housing options in a phased approach since these projects require on going funding.	One-Time
Adult/Older Adult	CSS	Adult / Older Adult - FSP	Reallocation $3.9M ongoing in FY24 Mid-Year and total $7.3 ($3.4M+$3.9M from FY24 Mid-Year) ongoing in FY25 from FSP contracts Flex/Housing to support PSH initiative	On-Going
Adult/Older Adult	CSS	Adult / Older Adult - FSP	Reallocation $3.9M ongoing in FY24 Mid-Year and total $7.3 ($3.4M+$3.9M from FY24 Mid-Year) ongoing in FY25 from FSP contracts Flex/Housing to support PSH initiative	On-Going

Fiscal Impact as a Result of Recommended 3-Year Plan Modifications for FY 2024 Annual

The recommendations listed below were originally proposed and adopted in the MHSA FY24-26 three-year plan, but are now proposed to pause or not move forward as part of the FY 2024 mid-year adjustment.

SYSTEM OF CARE	COMPONENT	PROGRAM	PREVIOUSLY APPROVED RECOMMENDATIONS IN THE FY24-26 3-YEAR PLAN THAT ARE PAUSED/NOT MOVING FORWARD	FREQUENCY	FY24 Annual Adjustment
Access & Unplanned Services	PEI	BH Navigator	Add 1.0 FTE - LPHA will provide direct, dedicated support to Peer Staff when clinically complex or urgent cases present.	On-Going	$ (165,464.00)
Access & Unplanned Services	PEI	LEL's	Adding funds to complete the remaining 10 Interactive Video Simulation Training (IVST) videos using a professional talent agency/actors will allow for the LEL's to continue to present IVST to law enforcement and community agencies and groups using new and more relevant examples of the work law enforcement and staff encounter via the use of videos.	One-Time	$ (35,000.00)
Access & Unplanned Services	PEI	Suicide Prevention	Dedicated Management Analyst to enhance data collection, analysis and reporting capabilities, helping to inform effective outreach efforts and education campaigns; enhancing the program's ability to develop and validate culturally-tailored strategies for Suicide Prevention	On-Going	$ (36,428.00)
AOA	CSS	24 HR care unit-since program is re-structuring	Add 1.0 FTE Rehabilitation Counselor to the community placement team to assist with care coordination efforts in order to transition clients from long term psychiatric facilities.	On-Going	$ (147,113.00)
AOA	CSS	BH Urgent Care	To support the implementation of the Peer Navigation program an additional 2.0 FTE's added to cover the gaps in coverage. This will increase capacity for Same Day Access.	On-Going	$ (177,527.00)
AOA	CSS	CSI	AOT Master Lease Housing Expansion- to serve additional fifty (50) clients	On-Going	$ (669,010.00)
AOA	CSS	Assisted Outpatient Treatment (AOT)	AOT - PSW II for a rehab Counselor	On-Going	$ (38,264.00)
AOA	CSS	Supportive Services	Supportive Services for No Place Like Home (NPLH) Supportive Housing units	On-Going	$ (2,893,000.00)
AOA	PEI	Cultural Communities Wellness	Add 1.0 FTE for the Cultural Communities Wellness Program to increase support for the Latino Community	On-Going	$ (104,901.00)
BHSD	WET	System Initiatives, Planning and Communication	Develop a new peer mentoring program for High School (HS) and Community College (CC) Students by introducing students to the benefits and rewards of entering the BH system of care.	On-Going	$ (127,203.00)
BHSD	WET	System Initiatives, Planning and Communication	Develop a new training team to provide internal trainers for the Learning Partnership that supports both County and CCP workforce.	On-Going	$ (763,288.00)
CYF	CSS	F&C SVCS	Increase F&C Outpatient continuum services focused on LGBTQ community that is age specific.	On-Going	$ (1,111,826.00)
CYF	CSS	F&C SVCS	Sunset the integrated services program as Co-Occurring capabilities are being built into outpatient programs.	On-Going	$ 1,111,826.00
BHSD	CSS	CSS Admin	Addition of 2.0 FTE to support MHSA team	On-Going	$ (311,359.00)

Fiscal Impact as a Result of Recommended 3-Year Plan Modifications for FY 2024 Annual

The recommendations listed below are new or updated proposals as part of the FY 2024 mid-year adjustment.

SYSTEM OF CARE	COMPONENT	PROGRAM	NEW RECOMMENDATIONS BEING CONSIDERED	FREQUENCY	FY24 Annual Adjustment
BHSD	CSS	QA/UR Reorg	Release MHSA funding for 31 positions due to reorg-CSS	On-Going	$ (2,494,489.00)
BHSD	CFTN	QA/UR Reorg	Release MHSA funding for 31 positions due to reorg-CFTN	On-Going	$ (420,212.00)
BHSD	WET	QA/UR Reorg	Release MHSA funding for 31 positions due to reorg-WET	On-Going	$ (105,053.00)
BHSD	CSS	QA/UR Reorg	Release MHSA funding for positions recognized for QA/UR Reorg	On-Going	$ (2,441,717.00)
BHSD	CFTN	QA/UR Reorg	Release MHSA funding for positions recognized for QA/UR Reorg	On-Going	$ (866,610.00)
BHSD	WET	QA/UR Reorg	Release MHSA funding for positions recognized for QA/UR Reorg	On-Going	$ (227,611.00)
BHSD	CSS	FY24 County Reduction	FY24 County Reduction	On-Going	$ (2,448,207.00)
BHSD	PEI	FY24 County Reduction	FY24 County Reduction	On-Going	$ (1,405,625.00)
BHSD	INN	FY24 County Reduction	FY24 County Reduction (INN12 - PERT Program transition to MHSA PEI)	On-Going	$ (703,863.00)
CYF	PEI	School Linked Services	CYF Wellness	One-time	$ 5,000,000.00
Access & Unplanned Services	PEI	Psychiatrict Emergency Response Team (PERT)	INN12 - PERT Program transition to MHSA PEI in addition, 3.0 FTE new MHSA PEI positions	On-Going	$ 1,644,001.00
Access & Unplanned Services	PEI	Psychiatrict Emergency Response Team (PERT)	Reallocation of funding source for PERT Program 1.0 FTE to City of Campbell	On-Going	$ (186,385.00)
AOA	CSS	Adult Residential Treatment	Continue funds to ART program located at 431 N. White Road, San Jose, CA due to current increase in admissions and utilization for FY23.	One-Time	$ 709,415.00

AOA	CSS	Adult Residential Treatment	Continue funds to ART program located at 650 Bascom, San Jose, CA due to current increase in admissions and utilization for FY23.	One-Time	$ 2,163,968.00
AOA	CSS	Adult / Older Adult - FSP	Reallocation $3.9M ongoing in FY24 Mid-Year and total $7.3 ($3.4M+$3.9M from Fy24 Mid-Year) ongoing in FY25 from FSP contracts Flex/Housing to support PSH initiative - SB43 Reserve	On-Going	$ 3,888,310.00
AOA	CSS	Adult / Older Adult - FSP	Reallocation $3.9M ongoing in FY24 Mid-Year and total $7.3 ($3.4M+$3.9M from Fy24 Mid-Year) ongoing in FY25 from FSP contracts Flex/Housing to support PSH initiative - SB43 Reserve	On-Going	$ (3,888,310.00)

PROPOSED CHANGES FOR FY 2025 ANNUAL PLAN UPDATE

The following are tables detailing proposed FY 2025 annual plan update changes for each program listed by system of care. Note that ongoing changes listed in the above section on FY 2024 modifications are presumed to continue in FY 2025 and are not duplicated in the tables below. Also note that program components that remain the same without proposed changes for FY 2025 are not listed in the tables below; they are described in the annual plan updates portion of the report.

The recommendations listed below were originally proposed and adopted in the MHSA FY24-26 three-year plan, but are now proposed to pause or not move forward as part of the FY 2025 annual plan update. Fiscal Impact table on subsequent page/s.

BHSD SYSTEM OF CARE	MHSA COMPONENT	PROGRAM NAME	PREVIOUSLY APPROVED RECOMMENDATIONS IN THE FY24-26 3-YEAR PLAN THAT ARE PAUSED/NOT MOVING FORWARD	FREQUENCY
Access & Unplanned Services	PEI	LGBTQIA + Wellness	Add 7.0 FTE to align program staffing to meet urgent County need for LGBTQIA+ Wellness Services	On-Going
Adult/Older Adult	CSS	Cross Systems Initiative (CSI)	AOT Master Lease Housing Expansion – to serve additional fifty (50) clients	On-Going
BHSD	WET	System Initiatives, Planning and Communication	Develop a new peer mentoring program for High School (HS) and Community College (CC) Students. This new program was to introduce students to the benefits and rewards of entering the BH system of care's workforce.	On-Going
Children, Youth, & Families	CSS	Family & Childrens (F&C) Services	Redesign and expand Ethnic programming to support a range in services from Wellness through Intensive	On-Going
Children, Youth, & Families	CSS	Full Service Partnership (FSP)	Redesign and expand TAY and Child FSP programming to provide the range of FSP and IFSP services	On-Going
Children, Youth, & Families	CSS	Transitional Age Youth (TAY) Services	Redesign and expand TAY OP programming to support a range in services from Wellness through Intensive	On-Going
Children, Youth, & Families	PEI	School Linked Services	Re-design PEI Universal Supports and Services to increase outreach, prevention supports and services, and access to Santa Clara County school districts	On-Going
Children, Youth, & Families	PEI	School Linked Services	Re-design SLS BH OP/IOP programming to increases access to intensive services and allows for flexibility to serve your continuously based on need	On-Going
BHSD	CSS	CSS Admin	Addition of funds for evaluation services for the BHSD - MHSA team to support the growth of MHSA activities: stakeholder planning activities, evaluation, outreach, required outcomes reporting, program review, coordination, and technical assistance.	On-Going

The recommendations listed below are new or updated proposals as part of the FY 2025 annual plan update. Fiscal Impact table on subsequent page/s.

BHSD SYSTEM OF CARE	MHSA COMPONENT	PROGRAM NAME	NEW RECOMMENDATIONS BEING CONSIDERED	FREQUENCY
Access & Unplanned Services	PEI	Psychiatrict Emergency Response Team (PERT)	INN12 - PERT Program transition to MHSA PEI in addition, 3.0 FTE new MHSA PEI positions	On-Going
Adult/Older Adult	CSS	Adult Residential Treatment	Continue and expand ART services at 431 N White Rd and 650 S Bascom. Includes reallocation of funds to make ART program fully MHSA funded.	On-Going
Adult/Older Adult	CSS	Adult Residential Treatment		On-Going
Adult/Older Adult	CSS	Adult Residential Treatment		On-Going
Adult/Older Adult	CSS	Adult/Older Adult - FSP	Reallocation $3.9M ongoing in FY24 Mid-Year and total $7.3 ($3.4M+$3.9M from FY24 Mid-Year) ongoing in FY25 from FSP contracts Flex/Housing to support PSH initiative	On-Going
Adult/Older Adult	CSS	Adult/Older Adult - FSP	Reallocation $3.9M ongoing in FY24 Mid-Year and total $7.3 ($3.4M+$3.9M from FY24 Mid-Year) ongoing in FY25 from FSP contracts Flex/Housing to support PSH initiative	On-Going

BHSD SYSTEM OF CARE	MHSA COMPONENT	PROGRAM NAME	NEW RECOMMENDATIONS BEING CONSIDERED	FREQUENCY
BHSD	WET	WET3 - Career Pathways & Development	One-time reduction in number of CCP student Intern spots from 48 to 23 due to low number of CCP student interns participating in the WET stipend program	One-Time
Adult/Older Adult	PEI	Violence Prevention Program & Intimate Partner Violence Prevention (IPVP)	Termination of the IPV contract at the end of the FY24, on 6/30/2024. In alignment with the modernization of California MHSA, the Department is aiming to prioritize care and treatment for individuals with severe mental illness and substance use issues and optimize the usage of existing IPV programs and networking to reduce redundancy in programming.	On-Going
Adult/Older Adult	CSS	Adult/Older Adult - FSP	Reallocation of Intimate Partner Violence Prevention (IPVP) program 1.0 Program Manager II from PEI to CSS	On-Going
BHSD	CSS	FY25 COLA	Estimated 3% cost of living adjustment (COLA) for MHSA funded programs	On-Going
BHSD	PEI	FY25 COLA		On-Going
BHSD	INN	FY25 COLA		On-Going
BHSD	WET	FY25 COLA		On-Going

BHSD SYSTEM OF CARE	MHSA COMPONENT	PROGRAM NAME	NEW RECOMMENDATIONS BEING CONSIDERED	FREQUENCY
Access & Unplanned Services	INN	INN-15 CMR Community Mobile Response Project (TRUST)	In response to the BOS referral, TRUST will make the 10-digit phone number for the call center public. The call center will add 3.85 FTEs ($510,000) to cover extra demand and cover the costs of establishing the line ($10,000). Additionally, the budget for evaluation services will be expanded ($140,000) to cover the cost of analyzing and reporting on the project. Unspent INN funds that are at risk for reversion will be utilized.	On-Going
Children, Youth, & Families	PEI	Services for Children 0 - 5	Recommendation to utilize MHSA funding to support the continuation of KCN services to children birth through five and their family in Santa Clara County due to reduction in First 5 funds	On-Going
Access & Unplanned Services	CSS	Mobile Response & Stabilization Services (MRSS)	MRSS will generate new Medi-Cal revenue. This revenue will offset current MHSA expenditures.	On-Going
Access & Unplanned Services	INN	INN-15 CMR Community Mobile Response Project (TRUST)	TRUST will generate new Medi-Cal revenue. This revenue will offset current MHSA expenditures.	On-Going
Children, Youth, & Families	CSS	Eating Disorder	Eating Disorder will generate new Medi-Cal revenue. This revenue will offset current MHSA expenditures.	On-Going
Children, Youth, & Families	PEI	Integrated Prevention Services for Cultural Communities (IPSCC)	Reduction in service agreements to right size utilization. No impact on service delivery.	On-Going

BHSD SYSTEM OF CARE	MHSA COMPONENT	PROGRAM NAME	NEW RECOMMENDATIONS BEING CONSIDERED	FREQUENCY
Adult/Older Adult	CSS	Adult/Older Adult Crisis Residential	Reallocation of funds to make Crisis Residential program fully MHSA funded.	On-Going
Adult/Older Adult	CSS	Criminal Justice System (CJS) Full Service Partnership (FSP)	Reallocation of funds to make CJS FSP program fully MHSA funded.	On-Going
Adult/Older Adult	CSS	CJS THU	Reallocation of funds to make CJS THU program fully MHSA funded.	On-Going
Children, Youth, & Families	CSS	TAY Outpatient (Family & Children Drop In Center)	Reallocation of funds to make program fully MHSA funded	On-Going
Adult/Older Adult	CSS	County Clinics	Reduction of 3.0 FTEs due to Adult/Older Adult System of Care evaluating its services to optimize resources. Changes will have no impact on services or service delivery.	On-Going
Children, Youth, & Families	CSS	Commercially Sexually Exploited Children (CSEC)	Reduction in MHSA funds due to Children, Youth, & Families System of Care evaluating its services to optimize resources. No impact on service delivery.	On-Going

BHSD SYSTEM OF CARE	MHSA COMPONENT	PROGRAM NAME	NEW RECOMMENDATIONS BEING CONSIDERED	FREQUENCY
Adult/Older Adult	CSS	Adult/Older Adult	Reduction of funds due to multiple Momentum program closures. Services will be provided by other providers.	On-Going
Adult/Older Adult	CSS	Residential Care Facilities (RCF)	Reallocation of funds to make RCF program fully MHSA funded. Program will provide supplemental services in the form of specialized individualized rates/patches to assist individuals with severe mental health behavior issues and medical condition transition from institutional settings back into the community and prevent re-hospitalization.	On-Going
Adult/Older Adult	CSS	Central Wellness Benefits	New legislation may result in new Medi-Cal revenues. BHSD is evaluating and will provide details in the future.	On-Going
Adult/Older Adult	CSS	AOT augment SB43 Reserve	With the implementation of SB 43, broadening the definition of "gravely disabled," BHSD anticipates a rise in number of referrals to AOT. This recommendation reallocates existing MHSA AOT appropriations to fund SB 43 AOT reserve.	One-Time

BHSD SYSTEM OF CARE	MHSA COMPONENT	PROGRAM NAME	NEW RECOMMENDATIONS BEING CONSIDERED	FREQUENCY
Children, Youth, & Families	CSS	Mobile Response and Stabilization Services (MRSS)	Separate Post-Crisis Stabilization Services (PCSS) into another program to track independently. This program has been embedded in the exhibit A for MRSS and is a separate program from Mobile Response with separate funding. The recommendation is to separate PCSS and MRSS for MHSA reporting. No net fiscal impact	On-Going
Adult/Older Adult	CSS	Assisted Outpatient Treatment (AOT)	Redirect $260,956 of unused AOT operating cost funds to fund the Division Director position that oversees AOT and other intensive outpatient programs	On-Going
Adult/Older Adult	INN	Sunsetting Independent Living Empowerment Program (ILEP)	Termination of ILEP implementation after it reaches its term as an Innovation project on 3/31/2024. In alignment with the modernization of California Mental Health Services Act (MHSA), the Department is aiming to optimize the usage of existing housing programs to expand housing resources for individuals in intensive outpatient behavioral health services.	On-Going
BHSD	WET	WET 3: Career Pathways & Development	Pause restoring 1.0 FTE Management Analyst that was deleted for FY 24 budget deficit reductions. This position supported the Intern Programs, coordinated the Career Summer Institute and supported the training for psychiatrists so that they are able to receive their Continuing Medical Education (CME) credits required to maintain their licensure.	On-Going

Fiscal Impact as a Result of Recommended 3-Year Plan Modifications for FY 2025

The recommendations listed below were originally proposed and adopted in the MHSA FY24-26 three-year plan, but are now proposed to pause or not move forward as part of the FY 2025 annual plan update.

SYSTEM OF CARE	COMPONENT	PROGRAM	PREVIOUSLY APPROVED RECOMMENDATIONS IN THE FY24-26 3-YEAR PLAN THAT ARE PAUSED/NOT MOVING FORWARD	FREQUENCY	FY25 New Proposed Changes
Access & Unplanned Services	PEI	LGBTQIA + Wellness	Add 7.0 FTE to align program staffing to meet urgent County need for LGBTQIA+ Wellness Services	On-Going	$ (1,018,796.00)
AOA	CSS	CSI	AOT Master Lease Housing Expansion- to serve additional fifty (50) clients	On-Going	$ (1,290,990.00)
BHSD	WET	System Initiatives, Planning and Communication	Develop a new peer mentoring program for High School (HS) and Community College (CC) Students by introducing students to the benefits and rewards of entering the BH system of care.	On-Going	$ (185,818.00)
CYF	CSS	F&C Services	Redesign and expand Ethnic programming to support a range in services from Wellness through Intensive.	On-Going	$ (189,540.00)
CYF	CSS	FSP	Redesign and expand TAY and Child FSP programming to provide the range of FSP and IFSP services.	On-Going	$ (697,899.00)
CYF	CSS	Tay Services	Redesign and expand TAY OP programming to support a range in services from Wellness through Intensive.	On-Going	$ (506,915.00)
CYF	PEI	School Linked Services	Re-design PEI Universal Supports and Services to increases outreach, prevention supports and services, and access to Santa Clara County school districts	On-Going	$ (500,000.00)
CYF	PEI	School Linked Services	Re-design SLS BH OP/IOP programming to increases access to intensive services and allows for flexibility to serve your continuously based on need.	On-Going	$ (653,091.00)
BHSD	CSS	CSS Admin	Addition of evaluation budget to support MHSA team	On-Going	$ (50,000.00)

Fiscal Impact as a Result of Recommended 3-Year Plan Modifications for FY 2025

The recommendations listed below are new or updated proposals as part of the FY 2025 annual plan update.

SYSTEM OF CARE	COMPONENT	PROGRAM	NEW RECOMMENDATIONS BEING CONSIDERED	FREQUENCY	FY25 New Proposed Changes
Access & Unplanned Services	PEI	Psychiatrict Emergency Response Team (PERT)	INN12 - PERT Program transition to MHSA PEI in addition, 3.0 FTE new MHSA PEI positions	On-Going	$ 215,154.00
AOA	CSS	Adult Residential Treatment	Continue funds to ART program located at 431 N. White Road, San Jose, CA due to current increase in admissions and utilization for FY23. Moving program to be ongoing instead of one time	On-Going	$ 2,606,413.66
AOA	CSS	Adult Residential Treatment	Continue funds to ART program located at 650 Bascom, San Jose, CA due to current increase in admissions and utilization for FY23. Moving program to be ongoing instead of one time	On-Going	$ 1,597,479.34
AOA	CSS	Adult Residential Treatment	ART Reallocation of funds to make program fully MHSA funded	On-Going	$ 1,778,652.00
AOA	CSS	Adult/Older Adult - FSP	Reallocation $3.9M ongoing in FY24 Mid-Year and total $7.3 ($3.4M+$3.9M from Fy24 Mid-Year) ongoing in FY25 from FSP contracts Flex/Housing to support PSH initiative - SB43 Reserve	On-Going	$ 3,421,713.00
AOA	CSS	Adult/Older Adult - FSP	Reallocation $3.9M ongoing in FY24 Mid-Year and total $7.3 ($3.4M+$3.9M from Fy24 Mid-Year) ongoing in FY25 from FSP contracts Flex/Housing to support PSH initiative - SB43 Reserve	On-Going	$ (3,421,713.00)
BHSD	WET	WET3 - Career Pathways & Development	Reduce number of County Contracted Providers (CCP) Student Interns from 48 to 23.	One-Time	$ (372,420.00)
AOA	PEI	Violence Prevention Program & Intimate Partner Violence Prevention (IPVP)	Termination of the IPVP contract at the end of the FY24	On-Going	$ (514,887.00)
AOA	CSS	Adult / Older Adult - FSP	Reallocation of IPVP program 1.0 Program Manager II from PEI to CSS	On-Going	$ 230,000.00
BHSD	CSS	FY25 COLA	COLA Estimate	On-Going	$ 983,360.00

BHSD	PEI	FY25 COLA	COLA Estimate	On-Going	$ 380,960.00
BHSD	INN	FY25 COLA	COLA Estimate	On-Going	$ 13,527.00
BHSD	WET	FY25 COLA	COLA Estimate	On-Going	$ 45,840.00
Access & Unplanned Services	INN	INN-15 CMR Community Mobile Response Project (TRUST)	To create a 10-digit TRUST direct line; expand the Call Center staffing and increase funds for the evaluation team contract.	On-Going	$ 650,500.00
CYF	PEI	Services for Children 0 - 5	KidConnections Network (KCN)services continued under MHSA	On-Going	$ 937,469.00
Access & Unplanned Services	CSS	MRSS	Mobile Crisis: Recognize additional new Medi-Cal revenue	On-Going	$ (504,247.50)
Access & Unplanned Services	INN	TRUST	Mobile Crisis: Recognize additional new Medi-Cal revenue	On-Going	$ (363,058.20)
CYF	CSS	Eating Disorder	Eating Disorder: Recognize additional new Medi-Cal revenue	On-Going	$ (1,720,251.00)
CYF	PEI	IPSCC	Service Agreement - Ending	On-Going	$ (850,000.00)
AOA	CSS	AOA Crisis Residential	Reallocation of funds to make program fully MHSA funded	On-Going	$ 1,036,682.00
AOA	CSS	Criminal Justice System (CJS) Full Service Partnership (FSP)	Reallocation of funds to make program fully MHSA funded	On-Going	$ 293,679.00
AOA	CSS	CJS THU	Reallocation of funds to make program fully MHSA funded	On-Going	$ 825,978.00
CYF	CSS	TAY Outpatient (Family and Children Drop In Center)	Reallocation of funds to make program fully MHSA funded	On-Going	$ 75,363.00
AOA	CSS	County Clinics	Reduction of 3.0 FTE due to AOA System of Care evaluating its services to optimize recources. No impact on services or service delivery	On-Going	$ (415,546.00)
CYF	CSS	CSEC	Reduction in MHSA funds due to Children, Youth, & Families System of Care evaluating its services to optimize resources. No impact on service delivery.	On-Going	$ (412,080.00)
AOA	CSS	Adult/Older Adult	Momentum Closures	On-Going	$ (507,843.00)
AOA	CSS	RCF	Residential Care Facilities Increase	On-Going	$ 2,411,112.00
AOA	CSS	Central Wellness Benefits	Central Wellness and Benefits: Recognize additional new Medi-Cal revenue. MHSA reduction amount TBD	On-Going	TBD
AOA	CSS	AOT augment SB43 Reserve	Reallocate existing MHSA appropriations to fund a reserve to support an increase in AOT capacity to serve an additional 50 clients.	One-Time	$ 2,675,200.00

FY2023 ANNUAL PROGRAM UPDATES

COMPONENT INFORMATION AND OUTCOMES

MENTAL HEALTH SERVICES ACT

COMMUNITY SERVICES AND SUPPORTS (CSS)

ANNUAL PROGRAM UPDATES

FY2023

SANTA CLARA COUNTY BEHAVIORAL HEALTH SERVICES DEPARTMENT

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COMMUNITY SERVICES AND SUPPORTS (CSS) PLAN INTRODUCTION

CSS DESCRIPTION

The first component of the Mental Health Services Act (MHSA) was the Community Services and Supports (CSS) Plan. This component includes those elements of the Act that define the requirements of service delivery to children, youth, adults and older adults with serious emotional disturbances (SED) and/or severe mental illnesses (SMI). The County's original CSS proposal submitted to the State Department of Mental Health (DMH) in 2005 were evaluated for their contribution to meeting specific outcomes for the individuals served including:

- Meaningful use of time and capabilities
- Safe housing
- A network of supportive relationships
- Access to help in a crisis
- Reduction in incarceration
- Reduction in involuntary services

Five elemental concepts were required to be embedded in County plans. These include:

- Community collaboration and stakeholder involvement
- Cultural and language competence programs and services as methods for elimination of racial and ethnic mental health disparities
- Client/family driven mental health system.
- Wellness focus, which includes the concepts of recovery and resilience.
- Integrated service experiences for clients and their families throughout their interactions with the mental health system

Services were defined in three categories: Full-Service Partnerships, System Development, and Outreach/Engagement. This component of the MHSA is the largest, with 80% of ongoing MHSA funds to be allocated to these three categories of service.

ESSENTIAL PLAN PRINCIPLES

The County's initial CSS local planning process identified the following essential principles to guide the CSS plan:

- Lifespan approach
- Community engaged and supported.
- Cultural competence
- Social ecology focus
- Connectedness emphasis
- Recovery and resiliency guided.
- Consumer and family driven.
- Based in system partnerships.
- Emphasis on quality and continuous learning
- Grounded in respect, hope, self-help, and empowerment.

PRIMARY OBJECTIVE OF CSS

The local planning process prioritized the following objectives for the initial CSS Plan. Those objectives are to achieve the:

- Reduction of subjective suffering from mental illness
- Increase meaningful use of time and capabilities in school, work, and activity.

- Reduce homelessness and increase safe and permanent housing.
- Increase access to substance abuse treatment.
- Increase natural networks of supportive relationships.
- Reduction in multiple foster care placements
- Reduction in incarceration/juvenile justice involvement
- Reduction in disparities in service access
- Increase in self-help and consumer/family involvement.

CSS has allowed for the provision of all necessary mental health services for children with severe emotional disturbances and adults with serious mental health challenges. CSS funds the following service categories:

- Full-Service Partnerships (FSP): FSP seeks to engage children with severe emotional disturbances and adults with serious mental health challenges into intensive, team-based, and culturally appropriate services in the community.
- System Development (SD): SD works to develop and operate programs to provide mental health services to individuals across the lifespan who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention.
- Outreach and Engagement (OE): Identifying those in need, reaching out to target populations, and connecting those in need to appropriate treatment.
- Administrative: Costs or consulting fees related to conducting a needs assessment or evaluation and facilitating the Community Planning Process.

There are various CSS initiatives in Santa Clara County, organized by age group. Specifically, each age group has an FSP as well as other initiatives that represent GSD and O&E. Many of these initiatives were originally developed earlier in MHSA implementation and have been refined over a series of CPP processes to continuously meet the needs of County residents with mental health issues. The purpose of CSS-funded programs is to identify, assess, and serve individuals experiencing mental health problems throughout the lifespan and range from 0-5 screening and assessment programs through programs and services that provide increasing levels of mental health services, including FSP programs.

Local CSS Program Alignment with State Requirements

Program Name	
Full Service Partnership (FSP) Programs	
Child Full Service Partnership Continuum, includes Intensive Full Service Partnership	
Transitional Age Youth FSP Continuum, includes Intensive Full Service Partnership	
Adult Full Service Partnership	Adult Full Service Partnership
	Intensive Full Service Partnership
Criminal Justice FSP	
Forensic Assertive Community Treatment	
Assertive Community Treatment (ACT	
Older Adult Full Service Partnership	

Permanent Supportive Housing	Permanent Supportive Housing Program
	Abode HEAT (Homeless Engagement and Access Team)
Combined FSP and Non-FSP Programs	
Crisis Stabilization Unit and Crisis Residential Treatment	Crisis Stabilization Unit
	Crisis Residential Treatment
Criminal Justice Residential and Outpatient Treatment Programs	
Non-Full Service Partnership Programs	
Children & Family Behavioral Health Outpatient/IOP Services	Family & Children Behavioral Health Outpatient / Intensive Outpatient
	Family & Children Ethnic Outpatient Services.
	Family & Children Behavioral Health Integrated Outpatient Services
Specialty Services - Integrated MH/SUD	Specialty Services – Eating Disorders
Services for Juvenile Justice Involved Youth (Juvenile Justice Development)	
Commercially Sexually Exploited Children (CSEC) Program	
Mobile Crisis Stabilization Services (MRSS)	Mobile Response and Stabilization Services
	Post-Crisis Stabilization Services
Independent Living Program (ILP)	
TAY Outpatient Services	TAY Outpatient Program
	TAY LGBTQ
Intensive Outpatient Program (IOP).	
TAY Crisis and Drop In Center	
TAY Interdisciplinary Service Teams	
Adult Residential Treatment	
Assisted Outpatient Treatment (AOT)	
Specialty Outpatient Services	Ethnic Specific Outpatient Continuum
	Gender Affirming Care Clinic (GACC)
Outpatient Services for Adults	
Outpatient Services for Older Adults	
Hope Services: Integrated Mental Health and Autism Services	

CalWORKs Community Health Alliance	
Individualized Supported Services (Employment)	
County Clinics	
Mental Health Urgent Care	
Community Placement Team Services and IMD Alternative Program	
Criminal Justice Outpatient Services	CJS Aftercare
	CJS Intensive Outpatient
In-Home Outreach Teams	
Connections Program	

FULL-SERVICE PARTNERSHIP (FSP) INTRODUCTION AND FY 2023 PROGRESS REPORT

FY22 Progress Report

FY2022

FY2023

County of Santa Clara Behavioral Health Services
Full Service Partnership

Background

In November 2004, California voters approved Proposition 63, which became the Mental Health Services Act (MHSA). The MHSA has five components, each addressing a particular need identified as an essential element that will help consumers of mental health services move toward wellness and recovery. Key emphasis is placed on reducing negative outcomes that may result from untreated mental illness, such as incarcerations, school dropouts, unemployment, and homelessness. One of the main MHSA components is Community Services and Supports (CSS). The basis for CSS is the concept, "whatever it takes," to meet the mental health needs of those who are un-served and underserved. In Santa Clara County (SCC), part of CSS was developed into five Full Service Partnership (FSP) groups, as follows:

- Children/Youth FSP is a comprehensive program for children and youth, ages 0-15 years old, which combines critical core services within a Wraparound Model and incorporates age-appropriate elements from Transition to Independence approach. The target population is juvenile justice-involved and African-American, Native American and Latino children and youth, with priority consideration for those at risk of, or returning from, out-of-home placement and children and youth with multiple episodes of emergency psychiatric services and hospitalizations.

- Transitional Age Youth (TAY) FSP is a comprehensive program for transitional age youth, ages 16-25 years old, which combines components from the Wraparound Model, AB2034, and Transition to Independence approach, in a framework that addresses the transition needs of this young adult population.

- Adult FSP is a comprehensive program for adults, ages 26-59 years old, which is based on the AB2034 philosophy that provides treatment, case management, and community resources necessary to meet the needs of each individual's life circumstance.

- Older Adult (OA) FSP is a comprehensive program for older adults, ages 60 years old and above, which was designed to meet the needs of older adults with Serious Mental lllness. Some of these needs include: psychiatric, stable housing, hospital services, and addressing the risk of emotional or physical harm.

- Criminal Justice System (CJS) FSP. This is a comprehensive program for Criminal Justice System involved TAY and adults, ages 18-59 years old. This is a program of the Mental Health Department, in partnership with the CJS, to achieve the consumer's individual wellness and recovery goals. The FSP engages CJS involved consumers, including those who are dually-diagnosed.

- Assertive Community Treatment (ACT) and Forensic ACT (FACT): Assertive Community Treatment (ACT) is an evidence-based behavioral health program for people with serious mental illness who are at risk of or would otherwise be served in institutional settings (e.g. hospitals, jails/prisons) or experience homelessness. The ACT model is a comprehensive community-based model of treatment, support, and rehabilitation for individuals with serious mental illness who are unwilling or unable to engage in mental health services and who are experiencing frequent and repetitive hospitalizations and/or incarcerations, likely to be homeless, and may suffer from a co-occurring disorder. FACT's structure is similar to ACT for justice-involved consumers' needs.

- Intensive FSP: Intensive FSP refers to the full range of community and clinical services that provide higher per person funding allocation that was not previously available to serve clients with serious mental health needs. These services represent new intensive service slots that will assist children living with serious emotional disturbances and serious mental illness to reach their wellness and recover goals with fewer barriers with support from comprehensive services

Project Summary

Study Objective

The report of the FY2022 and FY2023 FSP programs focused on four primary questions:

1. ***Are FSP programs meeting contracted target capacities for consumer services?*** The data show that the Santa Clara County FSP programs are able to deliver services beyond contracted target capacities for consumer services in FY2022 in all programs. In FY22 the data shows that they are serving beyond contracted target capacities in most programs (Figure 2).

2. ***How do the FSP services impact FSP consumers with: emergency psychiatric services (EPS), psychiatric hospital admissions, and arrests, prior to their enrollment in the FSP program?***

   a) *FSP consumers with emergency psychiatric services:*

   - *In comparing the total number of EPS admissions, a year before FSP enrollment, and a year after FSP enrollment, all but one (Children/Youth FSP) the number of EPS admissions decreased a year after FSP enrollment. Children/Youth FSP shows the number of EPS admissions increasing a year after FSP enrollment. (Figure 3)*

   - *Among consumers who received at least a year of FSP services, the data show that the rate of EPS admissions a year after FSP enrollment decreased between 10% and 31% for all but two programs. For Children/Youth FSP there was no change and for FACT there was an increase of 5% for EPS admissions a year after FSP enrollment. Overall, the total decreased rate was 31%, at the consumer level. (Table 3)*

   b) *FSP consumers with psychiatric hospital admissions:*

   - *In comparing the unduplicated consumer number of Barbara Arons Pavilion (BAP) and contracted hospital inpatient admissions, a year before FSP enrollment, with a year after FSP enrollment, the data show an overall percentage decrease of 43% in BAP and contracted hospital inpatient admissions a year after FSP enrollment for all FSP programs. (Table 4)*

   - *The total number of psychiatric admissions a year after FSP enrollment, compared with the total number of psychiatric admissions a year before FSP enrollment, show that the rate of admissions declined for Child FSP, TAY FSP/IFSP, Adult FSP/IFSP, and ACT. The Child IFSP,OA FSP, CJS FSP, and FACT programs all showed an increase in the total number of admissions between 21% and 29%. Overall, the reduction rate was 36% of psychiatric admissions in county and contracted psychiatric hospitals, a year after FSP enrollment. (Table 5)*

c) *FSP consumers with arrests:*

- *Among consumers who received at least a year of FSP services, the data shows that the number of self-reported unduplicated consumers with arrests declined for all programs between 62% and 100%. Older Adult FSP remained unchanged at 0%. Overall the number of arrests declined by 90%. (Table 6)*

- *The total duplicate consumer self-reported arrests a year after FSP enrollment, compared with those a year before FSP enrollment, show a lower number for all programs except for Older Adult FSP that remained unchanged. (Figure 7)*

3. ***What happens to consumers after discharge from FSP services? Are they back and readmitted to the FSP program, or readmitted to EPS, or to a psychiatric hospital, such as BAP, or rearrested?***

As a percent of unduplicated number of FSP consumers disharged, the data show that:

- *EPS admission was between 1% and 29% across the ten programs, with the lowest EPS readmission in Children/Youth FSP at 1% and the highest in FACT at 29%. Overall EPS readmission was 20%. (Table 10)*

- *BAP and Inpatient admission was between 8% and 24% across the ten programs, with the lowest BAP and Inpatient readmission; 9% in Children/Youth, TAY followed by 10% in OA FSP. Overall BAP and Inpatient readmission was 11%. (Table 10)*

- *FSP readmission was between 8% and 37% across the five programs, with the lowest FSP readmission in Child IFSP (8%) and the highest in Adult IFSP (38%). Overall FSP readmission was 25%. (Table 10)*

4. ***What is the racial/ethnic penetration rate among consumers being served by the FSP program?***

The five major racial/ethnic groups depicted in the FSP Report are White, Hispanic, Black/African American, Asian/Pacific Islander and Native American. The FSP consumers who did not fall under any of these groups were identified as "Mixed Race," "Other Race" and "Unknown." The racial/ethnic penetration rate among FSP consumers changed in FY2023, when compared with the penetration rate in FY2022. (Figure 8)

- *There was slight change for White FSP consumers, 29% in FY2022 & 31% in FY2022.*

- *There was an decrease in Hispanic FSP consumers, albeit slightly 32% in FY2022 versus 25% in FY2023.*

- *Black/African American FSP consumers changed at 9% in FY2022 and at 8% in FY2023.*

Data Source and Collection Procedure

Data Source and Collection Procedure.

Data sources include:

- Mental Health Department's Unicare system.
- Behavioral Health Department's myAvatar system.
- Santa Clara Valley Medical Center's HealthLink system.
- The State of California's Department of Health Care Services' (DHCS) MHSA Data Collection and Reporting (DCR) Database system, part of the State's Behavioral Health Information Systems (BHIS) system.

Data on FSP consumer admissions, discharges, and total number of consumers served were extracted out of Unicare and myAvatar for FY2022 and FY2023. County Data on admissions for EPS and BAP were extracted out of HealthLink, and arrests were extracted out of the State's BHIS/DCR, in addition to Unicare. HealthLink is the Santa Clara Valley Medical Center's electronic database system.

Are FSP programs meeting contracted capacities for consumer services?

QUESTION 1 **Are FSP programs meeting contracted capacities for consumer services?**

Table 1 **Contracted Capacities and Number of FSP Consumers Served**

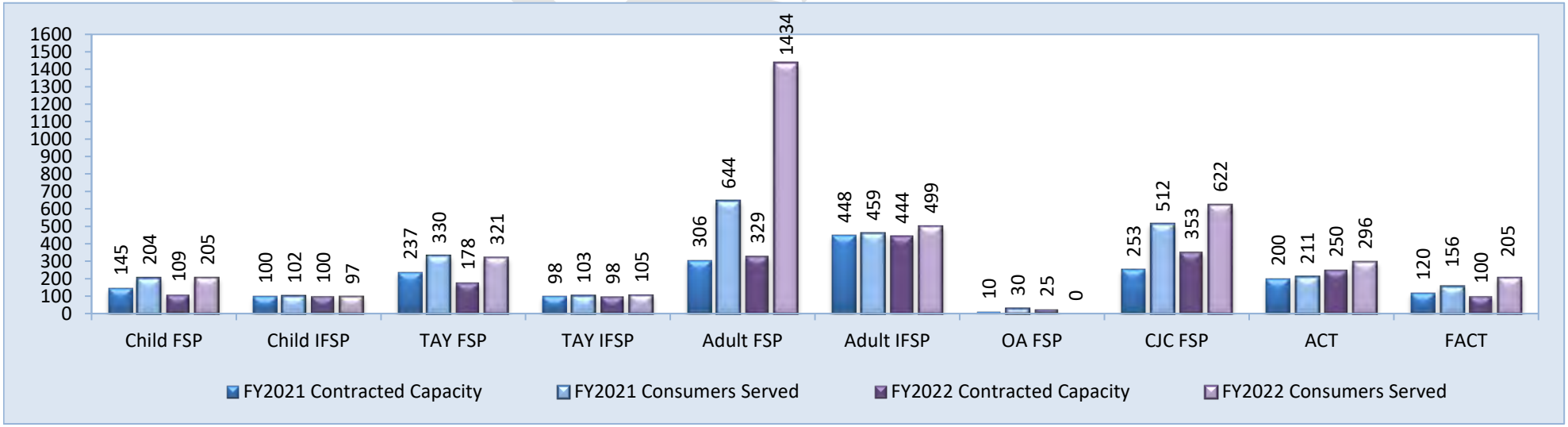
FSP Program	July 1, 2021 – June 30, 2022 (FY2022)				July 1, 2022 – June 30, 2023 (FY2023)			
	Contracted Capacity	Number of Newly Enrolled Consumers	Number of Consumers Served	Number of Discharged Consumers	Contracted Capacity	Number of Newly Enrolled Consumers	Number of Consumers Served	Number of Discharged Consumers
Child FSP	145	107	204	120	109	116	205	122
Child IFSP	100	41	102	64	100	46	97	40
TAY FSP	237	186	330	202	178	207	321	186
TAY IFSP	98	47	103	59	98	55	105	42
Adult FSP	306	342	644	214	329	464	1434	276
Adult IFSP	448	210	459	169	444	169	499	164
OA FSP	10	19	30	10	25	0	0	11
CJC FSP	253	378	512	345	353	433	622	396
ACT	200	116	211	21	250	80	296	75
FACT	120	70	156	59	100	116	205	68
Total	1917	1516	2751	1263	1986	1686	3784	1380

Table 1 shows the contracted capacities and number of consumers served in each FSP program in FY2022 and FY2023.

Data Source: Unicare & myAvatar

Figure 1 illustrates FSP contracted capacities for FY2022 and FY2023. The number of consumers served in most programs went beyond contracted capacities in both fiscal years (except for Child FSP and ACT were below contracted capacity FY2023).

Figure 1 **FY2022/FY2023 FSP Contracted Capacities and Number of Consumers Served**



Are FSP programs meeting contracted capacities for consumer services?

Table 2 **Consumers Served as a Percent of Capacity**

FSP Program	July 1, 2021 – June 30, 2022 (FY2022)				July 1, 2022 – June 30, 2023 (FY2023)			
	Contracted Capacity	Newly Enrolled Consumers as % of Capacity	% of Consumers Served Beyond Capacity	Discharged Consumers as % Newly Enrolled Consumers	Contracted Capacity	Newly Enrolled Consumers as % of Capacity	% of Consumers Served Beyond Capacity	Discharged Consumers as % Newly Enrolled Consumers
Child FSP	145	74%	41%	112%	109	106%	88%	105%
Child IFSP	100	41%	2%	156%	100	46%	-3%	87%
TAY FSP	237	78%	39%	109%	178	116%	80%	90%
TAY IFSP	98	48%	5%	126%	98	56%	7%	76%
Adult FSP	306	112%	110%	63%	329	141%	336%	59%
Adult IFSP	448	47%	2%	80%	444	38%	12%	97%
OA FSP	10	190%	200%	53%	25	0%	-100%	
CJS FSP	253	149%	102%	91%	353	123%	76%	91%
ACT	200	58%	6%	18%	250	32%	18%	94%
FACT	120	58%	30%	84%	100	116%	105%	59%
Total	1917	79%	44%	83%	1986	85%	91%	82%

Data Source: Unicare & myAvatar

Table 2 presents data on consumers served as a percent of contracted capacity.

Figure 2 **Percent of FSP Consumers Served Beyond the Target Set for FY2022 and FY2023**

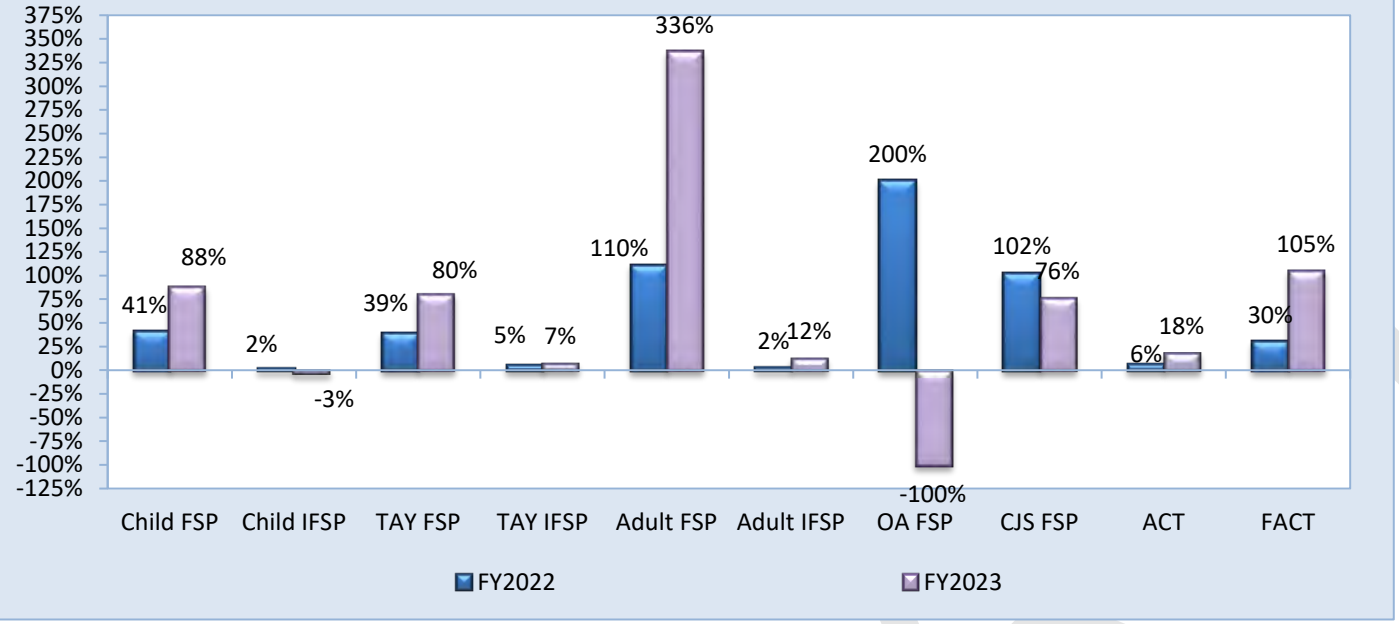


Figure 2 compares the percent of FSP consumers who were served beyond contracted capacity in FY2022 and FY2023. In both fiscal years, the FSP consumers were served beyond target capacity (except for Child and Adult IFSP where consumers served was below contracted capapcity for FY2022).

How do the FSP services impact FSP consumers with: emergency psychiatric services, psychiatric hospital admissions, and arrests, prior to their enrollment in the FSP program?

QUESTION 2a **How do the FSP services impact FSP consumers with emergency psychiatric services?**

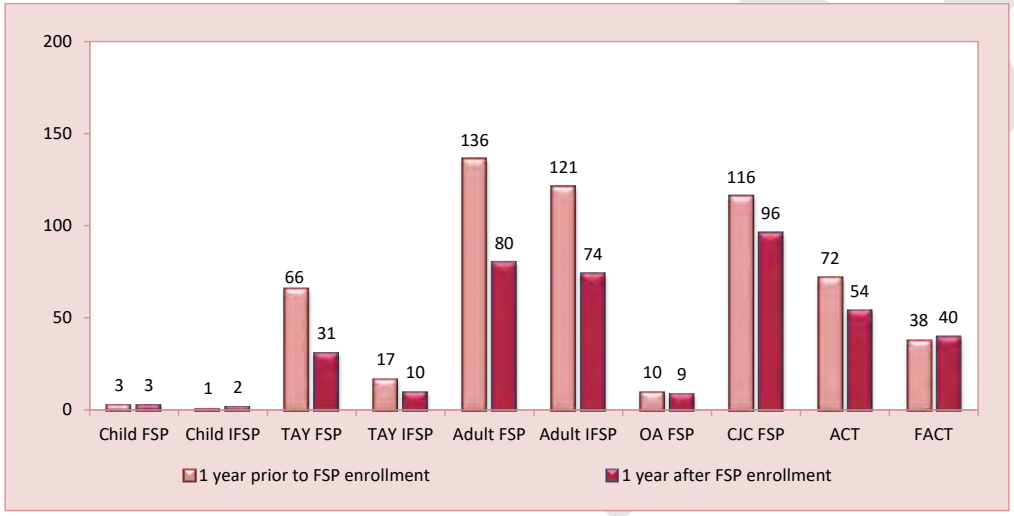
Table 3 **Unduplicated Consumers with EPS Admissions a Year Before and a Year After FSP Enrollment**

FSP Program	Unduplicated Consumers with EPS Admissions a a Year Before FSP Enrollment	Unduplicated Consumers with EPS Admissions a Year After FSP Enrollment	Change	% (-) Reduction / (+) Increase
Child FSP	3	3	0	0%
Child IFSP	1	2	1	100%
TAY FSP	66	31	-35	-53%
TAY IFSP	17	10	-7	-41%
Adult FSP	136	80	-56	-41%
Adult IFSP	121	74	-47	-39%
OA FSP	10	9	-1	-10%
CJS FSP	116	96	-20	-17%
ACT	72	54	-18	-25%
FACT	38	40	2	5%
Total	580	399	-181	-31%

Data Source: Unicare & Healthlink

Table 3 shows that, overall, the percent of unduplicated consumers with EPS admissions a year after FSP declined by 31%.

Figure 3 **Total EPS Admissions a Year Before and a Year After FSP Enrollment**



Data Source: Unicare & Healthlink

Figure 3 data shows that most programs declined in the number of EPS admissions a year after enrollment with the exception of Child FSP where there was a slight increase and Child IFSP where the number of admissions remained the same.

How do the FSP services impact FSP consumers with: emergency psychiatric services, psychiatric hospital admissions, and arrests, prior to their enrollment in the FSP program?

QUESTION 2b **How do the FSP services impact FSP consumers with psychiatric hospital admissions?**

Table 4 **Unduplicated Consumers with BAP & Contracted Hospital Admissions Before and After FSP Enrollment**

FSP Program	Unduplicated Consumers a Year Before FSP Enrollment	Unduplicated Consumers a Year After FSP Enrollment	Change	% (-) Reduction / (+) Increase
Child FSP	23	12	-11	-48%
Child IFSP	10	6	-4	-40%
TAY FSP	41	27	-14	-34%
TAY IFSP	21	10	-11	-52%
Adult FSP	59	25	-34	-58%
Adult IFSP	61	36	-25	-41%
OA FSP	6	1	-5	-83%
CJS FSP	18	16	-2	-11%
ACT	58	34	-24	-41%
FACT	18	13	-5	-28%
Total	315	180	-135	-43%

Data Source: Healthlink

Table 4 data shows an overall percentage decrease of 43% in unduplicated number of consumers in BAP and contracted hospital admissions a year after FSP enrollment .

Table 5 **Total BAP & Contracted Hospital Admissions a Year Before and a Year After FSP Enrollment***

FSP Program	Admissions a Year Before FSP Enrollment	Admissions a Year After FSP Enrollment	Change	% Reduction (-) / Increase (+)
Child FSP	27	15	-12	-44%
Child IFSP	18	9	-9	-50%
TAY FSP	50	35	-15	-30%
TAY IFSP	39	18	-21	-54%
Adult FSP	83	41	-42	-51%
Adult IFSP	104	71	-33	-32%
OA FSP	8	4	-4	-50%
CJS FSP	21	27	6	29%
ACT	80	45	-35	-44%
FACT	19	23	4	21%
Total	449	288	-161	-36%

Data Source: Healthlink

* a consumer can be admitted multiple times 1 year prior to and 1 year after FSP enrollment.

Table 5 data shows that admissions declined for most programs between 30% and 50% and increased for Child , CJS FSP, and FACT , between 21% and 29 %. Overall, the reduction rate was 36%.

How do the FSP services impact FSP consumers with: emergency psychiatric services, psychiatric hospital

Figure 4 **BAP & Contracted Hospital Admissions Before and After FSP Enrollment***

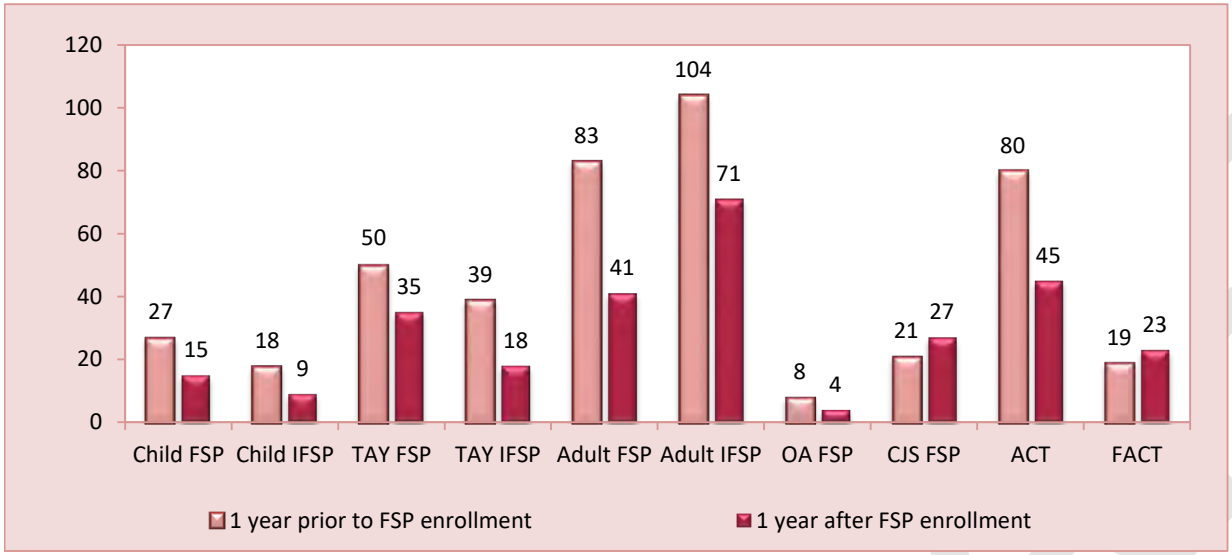


Figure 4 data shows a lower number of admissions, a year after FSP enrollment, for all programs, except for CJS FSP and FACT.

Data Source: Healthlink * a consumer can be admitted multiple times 1 year prior to and 1 year after FSP enrollment.

How do the FSP services impact FSP consumers with: emergency psychiatric services, psychiatric hospital admissions, and arrests, prior to their enrollment in the FSP program?

QUESTION 2c **How do the FSP services impact FSP Consumers with arrests?**

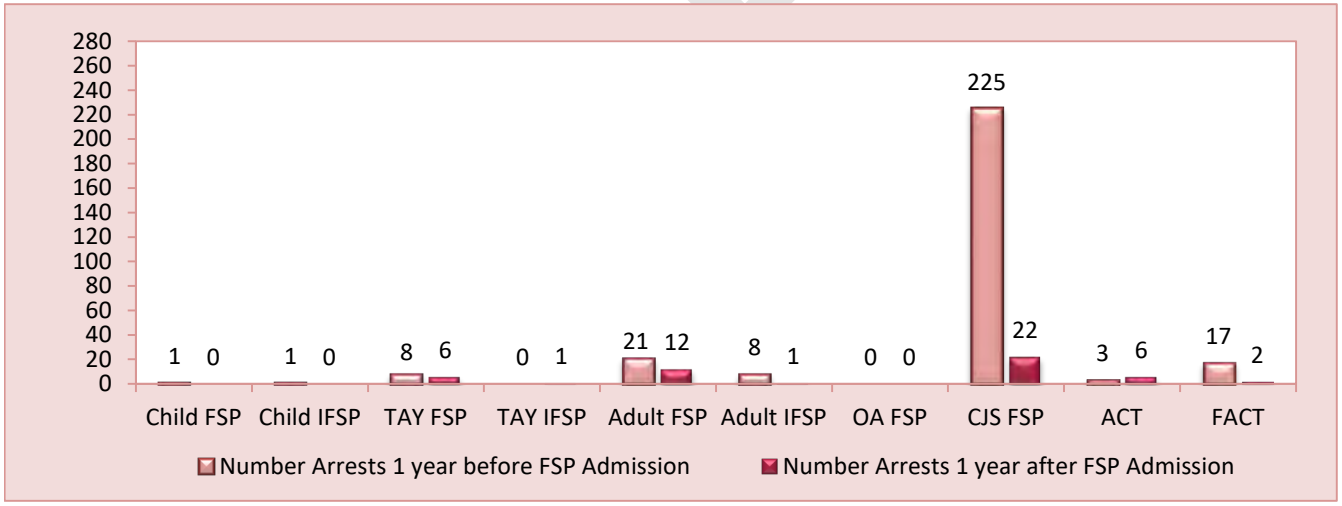
Table 6 **Self-Reported Unduplicated Consumers with Arrests a Year Before and a Year After FSP Enrollment**

FSP Program	Total Number of Consumers with Arrests a Year Before FSP Enrollment	Total Number of Consumers with Arrests a Year After FSP Enrollment	Change	% (-) Reduction / (+) Increase
Child FSP	1	0	-1	-100%
Child IFSP	1	0	-1	-100%
TAY FSP	13	5	-8	-62%
TAY IFSP	0	1	1	0%
Adult FSP	25	9	-16	-64%
Adult IFSP	11	1	-10	-91%
OA FSP	0	0	0	0%
CJS FSP	239	9	-230	-96%
ACT	4	6	2	50%
FACT	31	1	-30	-97%
Total	325	32	-293	-90%

Data Source: DCR.

Table 6 DCR data shows the number of self-reported unduplicated consumers with arrests declined for all programs with two exceptions, Older Adult FSP remained unchanged at 0% and TAY IFSP and ACT both had increases. Overall the number of arrests declined by 90%.

Figure 7 **Total Arrests a Year Before and a Year After FSP Enrollment**



Data Source: DCR.

Figure 7 DCR data shows a lower number of self-reported total arrests, a year after FSP enrollment for all programs but for Older Adult FSP arrests remained unchanged and for both TAY IFSP and ACT they had slight increases to the total arrests.

How do the FSP services impact FSP consumers with: emergency psychiatric services, psychiatric hospital admissions, and arrests, prior to their enrollment in the FSP program?

Table 8 **Aggregate Percentage Increase/Reduction in Arrest Among FSP Consumers**

FSP Program	% of Arrest (-) Reduction
Child FSP	-100%
Child IFSP	-100%
TAY FSP	-25%
TAY IFSP	0%
Adult FSP	-43%
Adult IFSP	-88%
OA FSP	0%
CJS FSP	-90%
ACT	100%
FACT	-88%
Total	-82%

Data Source: DCR.

Table 8 percentages show that there was no change for TAY IFSP and Older Adult FSP but there was a reduction in self-reported arrests among most other programs with the exception of the ACT program. Overall, there was a reduction of -82% in self-reported total arrests a year after FSP enrollment.

What happens to FSP consumers after their discharge from FSP services?

QUESTION 3 **What happens to FSP consumers after their discharge from FSP services?**

Table 9 **Post-FSP Discharge Admissions**

FSP Program	EPS Admissions After FSP Discharge	BAP & Contracted Hospital Admissions After FSP Discharge	FSP Readmissions After FSP Discharge	Other	None
Child FSP	1	11	12	112	60
Child IFSP	3	8	5	81	28
TAY FSP	48	28	21	114	137
TAY IFSP	49	21	11	61	32
Adult FSP	142	47	55	206	92
Adult IFSP	152	42	70	182	71
OA FSP	9	4	2	9	7
CJS FSP	255	50	146	418	127
ACT	24	8	10	22	11
FACT	46	14	22	102	22
Total	729	233	354	1307	587

Data Source: Unicare.

Table 9 shows data for FY2022 on the number of admissions to EPS, BAP & Contracted Hospitals, and FSP, after discharge from any of the FSP programs. "Other" refers to admission to other MHD programs after FSP discharge. "None" refers to FSP consumers who were not found in any County of Santa Clara MHD program, following FSP discharge.

Table 10 **Post-FSP Discharge Admissions as a Percentage of FSP Discharges**

FSP Program	EPS Admissions (% of Unduplicated FSP Consumers Discharged)	BAP & Contracted Hospital Admissions (% of Unduplicated FSP Consumers Discharged)	FSP Readmissions (% of Unduplicated FSP Consumers Discharged)	Unduplicated FSP Consumers Discharged
Child FSP	1%	8%	9%	120
Child IFSP	3%	9%	8%	64
TAY FSP	14%	9%	10%	202
TAY IFSP	27%	22%	17%	59
Adult FSP	24%	12%	24%	214
Adult IFSP	29%	15%	38%	169
OA FSP	20%	10%	20%	10
CJS FSP	25%	9%	37%	345
ACT	29%	24%	33%	21
FACT	29%	15%	32%	59
Total	**20%**	**11%**	**25%**	**1263**

Data Source: Unicare.

Table 10 data shows that, as a percent of unduplicated number of consumers discharged from FSP, EPS admissions were between 1% and 29%, BAP & Contracted Hospital admissions ranged from 8% to 24%; FSP readmissions from 9% to 38%.

What happens to FSP consumers after their discharge from FSP services?

QUESTION 3 **What happens to FSP consumers after their discharge from FSP services?**

Table 9 **Post-FSP Residential Program Discharge Service Type**

FSP Residential Program	FSP Residential	Outpatient	Other	None
Crisis	80	55	35	24

Data Source: Unicare & myAvatar

Table 9 **Post-FSP Residential Program Dishcarge Service Type**

FSP Age Group	FSP Residential	Outpatient	Other	None
0-17	0	0	0	0
18-25	9	7	6	2
26-59	62	45	27	16
60+	9	3	2	6
Total	80	55	35	24

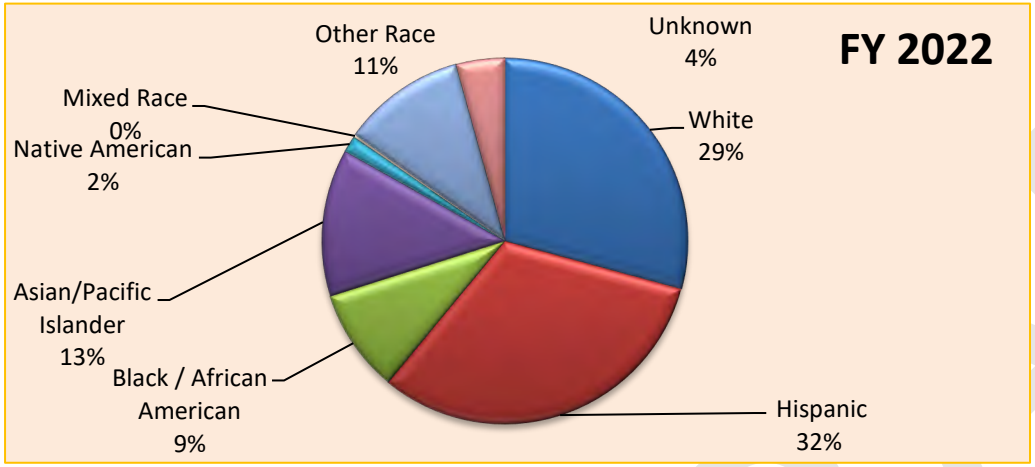
Data Source: Unicare & myAvatar

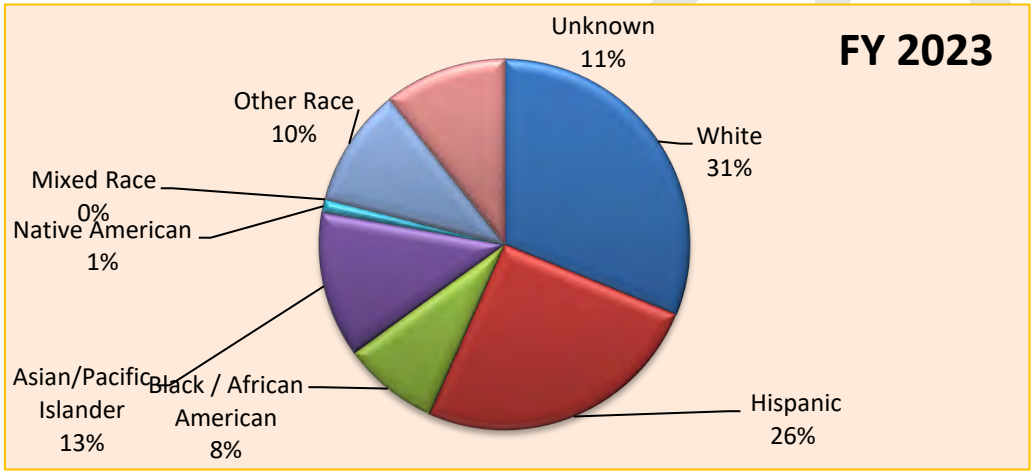
Table 9 shows data for FY2022 on the consumers who received a service to FSP Resdiential, Outpatient, Other Programs, or None, after discharge from any of the FSP Crisis Residential programs. "Other" refers to a service from other MHD programs after FSP Crisis Residential discharge. "None" refers to FSP consumers who were not found receiving services, following FSP Crsis Residential discharge.

What is the racial/ethnic profile of consumers being served by the FSP?

QUESTION 4 **What is the racial/ethnic penetration rate among consumers being served by the FSP?**

Figure 8 **Racial/Ethnic Profile of FSP Consumers for FY 2022 and FY 2023**





Data Source: Unicare

Figure 8 shows the distribution of FSP consumers among the following five racial/ethnic groups : White, Hispanic, Black/African American, Asian/Pacific Islander and Native American. FSP consumers who did not identify themselves in any of the above groups were identified as either "Mixed Race," "Other Race" or "Unknown."

The racial/ethnic penetration rate among FSP consumers changed in FY2023, when compared with the penetration rate in FY2022:

- The percent of White FSP consumers increased (31% in FY2023 versus 29% in FY2022)
- The percent of Hispanic FSP consumers decreased (26% in FY2023 versus 32% in FY2022).
- The Black/African American FSP consumers slightly decreased (8% in FY2023 versus 9% in FY2022)
- The Native American FSP consumers remained the same at 1% in FY2022 and 1% FY2023.
- The Asian/Pacific Islander FSP consumers remained the same at 13% in FY2022 & FY2023.

Consumer Perception Surveys

The Mental Health Department Consumer Perception Surveys (MHDCPS) are rated on a five-point scale, with "5" indicating the greatest satisfaction, or excellent rating. Consumer responses to the surveys are analyzed according to the Domains listed below. For data analysis, the items that comprise each of the Domains were averaged and then grouped into the following categories: 3.44 and below (68% and below) = Unsatisfactory; 3.45-3.99 (69%-78%) = Satisfactory; 4.00-4.44 (79%-88%) = Good; and 4.45-5.00 (89%-100%) = Excellent. As a general guideline, for interpretation, the national benchmark for satisfaction is an overall scale score above 3.5. Please note that averages were only calculated for those surveys where at least two-thirds of the items in the particular domain were completed.

Table 11 **Consumer Perception Survey Youth and Family Results (County-Wide)**

Domain	Youth & Family	
	June 2021	May2022
Satisfaction with Service Access	4.42	4.42
Satisfaction with treatment planning	4.28	4.28
Satisfaction with services provided	4.31	4.33
Satisfaction with cultural sensitivity	4.55	4.52
Satisfaction with treatment outcomes	3.95	3.96

Table 11 shows data for two cycles of consumer perception surveys accross five domains for Youth and Family consumers. The consumer satisfaction response for the most recent survey and the prior survey ranges between satisfactory and excellent across the five domains.

Table 12 **Consumer Perception Survey Adult and Older Adult Results (County-Wide)**

Domain	Adult & Older Adult	
	June 2021	May 2022
Satisfaction with Service Access	4.58	4.32
Satisfaction with treatment planning	4.6	4.31
Satisfaction with services provided	4.61	4.39
Satisfaction with quality and appropriateness of service	4.61	4.35
Satisfaction with treatment outcomes	4.49	4

Table 12 shows data for two cycles of consumer perception surveys accross five domains for Adult and Older Adult consumers. Overall, the consumer survey response ranges from satisfactory to excellent accorss the five domains.

Glossary: Santa Clara County Full Service Partnership Progress Report, FY2022/FY2023

Term	Definition
A Year After FSP Enrollment	One year (12 consecutive months) after a consumer was admitted to a Full Service Partnership (FSP) program.
A Year Before FSP Enrollment	One year (12 consecutive months) before a consumer is admitted to a Full Service Partnership (FSP) program.
AB2034	The Homeless and Mental Health legislation which establishes demonstration programs in California to reduce homelessness among people with mental illness, identifying people released from prison and jail as one key component of the target population.
ACT	Assertive Community Treatment Program
Active FSP Consumers	Consumers who have been admitted to the FSP program and have not yet been discharged.
Adult	Ages 26-59 years old.
Asian/Pacific Islander	The Census Bureau defines Asian as a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes 'Asian Indian,' 'Chinese', 'Filipino', 'Korean', 'Japanese', 'Vietnamese', and 'Other Asian'. Pacific Islander is a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicate their race as 'Native Hawaiian', 'Guamanian or Chamorro', 'Samoan', and 'Other Pacific Islander'.
BAP	Barbara Arons Pavilion (BAP) is a 50 bed acute (locked) facility located in the Santa Clara Valley Medical Center campus. It is one of two Acute Psychiatric Service Programs of the Santa Clara Valley Health and Hospital System.
Black/African American	The Census Bureau defines Black/African American as a person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as 'Black or African American,' or provide written entries such as African American, Afro American, Kenyan, Nigerian, or Haitian.
Case Management	The coordination of community services for mental health patients by a professional who is responsible for the assessment of need and implementation of care plans.
Children/Youth	Ages 0-15 years old.
CJS	The Criminal Justice System (CJS) is the system of practices and institutions of governments directed at upholding social control, deterring and mitigating crime, or sanctioning those who violate laws with criminal penalties and rehabilitation efforts.
Community Resources	A range of mental health services, which is available in Santa Clara County.
Contracted Capacity	The expected number of consumers to be served by a mental health agency, based on its contract with the Santa Clara County Mental Health Department.
CSS	Community Services and Supports (CSS) refers to MHSA's System of Care Services, which is intended to differentiate the MHSA Community Services and Supports from existing and previously existing System of Care programs funded at the Federal, State and Local governments.
DCR	The Data Collection and Reporting (DCR) database system is part of the State of California's Department of Mental Health Performance Outcomes & Quality Improvement (POQI) system.

Glossary: Santa Clara County Full Service Partnership Progress Report, FY2022/FY2023

Term	Definition
Discharged FSP Consumers	Consumers who have been transferred to a lower or higher level of care program, or who have been discharged from the mental health system.
Dually-Diagnosed	Consumers who are diagnosed with both substance abuse and mental illness.
EPS	Emergency Psychiatric Services (EPS) is an outpatient psychiatric emergency and crisis stabilization program located in the Santa Clara Valley Medical Center campus and is one of two Acute Psychiatric Service Programs of the Santa Clara Valley Health and Hospital System.
FACT	Forensic Assertive Community Treatment
FSP	Full Service Partnership.
FY2022	The period between July 1, 2021 and June 30, 2022.
FY2023	The period between July 1, 2022 and June 30, 2023.
Hispanic	The Census Bureau defines Hispanic or Latino as a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race.
IFSP	Intensive Full Service Partnership
Invision	The hospital information system used by the Santa Clara Valley Medical Center.
ITWS	Information Tehnology Web Services of the State of California's Performance Outcomes & Quality Improvement (POQI) system.
MHSA	Mental Health Services Act.
Mixed Race	Mixed Race describes people whose ancestries come from multiple races. Unlike the term biracial, which often is only used to refer to having parents or grandparents of two different races, the term mixed race may encompass biracial people but can also include people with more than two races in their heritage.
Native American	The Census Bureau defines Native American as American Indian and Alask Native, a person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.
Newly Enrolled Consumers	Consumers who have been newly admitted to the FSP program.
Number of Consumers Served	The actual number of consumers served by Santa Clara County mental health and contracted programs.
OA	Older adults, ages 60 years old and above.
Other Race	Other race includes all other responses not included in Asian/Pacific Islander, Black/African American, Hispanic, Mixed Race, Native American, Unkown, or White.
Out of Home Placement	Children are put in out-of-home placement when there has been confirmed abuse or neglect, or when a family is unable to care for its own children for a variety of reasons (medical or mental condition of child or parent or child has significant behavior or emotional problems, etc.). Out-of-home placements are used in conjunction with therapeutic intervention, parenting classes, and other tools to reach a permanent placement. A permanent placement is reached when a child is reunified with his/her family or adopted. Foster care is the most common type of out-of-home placement.

Glossary: Santa Clara County Full Service Partnership Progress Report, FY2022/FY2023

Term	Definition
POQI	The State of California's Department of Mental Health Performance Outcomes & Quality Improvement system. It is a web-based data reporting system.
Proposition 63	California ballot proposition on the November 2, 2004 ballot. Its official name and title on the ballot was the Mental Health Services Act. It passed with 6,191,691 (53.8%) votes in favor and 5,337,216 (46.2%) against. It was an initiative statute that levied an additional 1 percent state tax on incomes of $1 million or greater to fundamental health service programs beginning January 1, 2005.
Self-Reported	Data collected in the DCR and self-reported by consumers.
SMI	Serious Mental Illness.
TAY	Transitional age youth, ages 16-25 years old.
Transition to Independence Approach	An evidence-based program model that stresses the importance of providing access to appropriate services, engaging mental health consumers in their own future planning process, and utilizing services that focus on each individual's strengths.
Treatment	The management and care of a patient/consumer.
Unduplicated Number of Consumers	Refers to counting a consumer only once, irregardless of the number of times a consumer was admitted or discharged from a program and irregardless of the number of mental health services a consumer received.
Unicare	Clinical documentation software system that is used by the Mental Health Department of Santa Clara County Health and Hospital System. All services, progress notes and the Initial, Update and Psychiatric Assessments are entered into Unicare by mental health providers.
Unknown	Unknown race includes all other responses not included in Asian/Pacific Islander, Black/African American, Hispanic, Mixed Race, Native American, Other, or White.
White	The Census Bureau defines White as a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as "White" or report entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.
Wraparound Model	The wraparound model provides individualized, comprehensive, community-based services and supports to children and adolescents with serious emotional and/or behavioral disturbances so they can be reunited and/or remain with their families and communities.

FULL-SERVICE PARTNERSHIP PROGRAMS

CHILD FULL SERVICE PARTNERSHIP (FSP) & YOUTH INTENSIVE FULL SERVICE PARTNERSHIP (IFSP)

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Full-Service Partnership (FSP): Children & Youth refers to the collaborative relationship between the County, through contracted providers, and the parent of a child with serious emotional disturbance through which the providers plans for and provides the full spectrum of wraparound services so that the child can achieve their identified goals. County of Santa Clara's FSP provides intensive, comprehensive services for seriously emotionally disturbed (SED) children within a wraparound model.

Intensive FSP provides a full range of community and clinical services that are a higher level of service delivery to serve people with serious mental health needs. The services will assist children and youth ages 6-15 with SED or SMI, particularly African American, Native American, and Latino youth living with serious mental illness to reach their wellness and recovery goals. Youth and young adults served may be at risk of transition from out-of-home placement; engaged with child welfare and/or the juvenile justice system; or at risk of homelessness, incarceration, or hospitalization.

All FSP services include a team-based planning process intended to provide individualized and coordinated family-driven care. FSP should increase the "natural support" available to a family—as they define it— by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. FSP aims to engage underserved children and their families who have not yet benefited from traditional outpatient mental health services due to complex risk factors including substance abuse, community violence, interpersonal family violence, general neglect, and exposure to trauma. FSP requires that family members, providers, and key members of the child's social support network collaborate to build a creative plan that responds to the particular needs of the child and their support system. FSP services should build on the strengths of each child and their support system and be tailored to address their unique and changing needs. Services may include:

i. Mental health treatment, including individual and family/group therapy.
ii. Alternative treatment and culturally specific treatment approaches
iii. Family support including respite care and transportation of children/youth to their mental health appointments.
iv. Case management to assist the client and, when appropriate, the client's family in accessing needed medical, educational, social, vocational, rehabilitative, and/or other community services
v. Supportive services to assist the client and the client's family in obtaining and maintaining employment, housing, and/or educational opportunities.
vi. Referrals and linkages to community-based providers for other needed social services, including housing and primary care.

2. Program Goals, Objectives & Outcomes

❖ **Outcome**

i. Improve success in school and at home and reduce the institutionalization and out of home placements.
ii. Increase service connectedness for FSP enrolled children.
iii. Reduce involvement in child welfare and juvenile justice.

iv. Increase School engagement, attendance, and achievement.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
Total = 310 Child FSP = 201 Child IFSP = 109	Total = $5,706,848	$18,409.19

4. Evaluation Activities

The Full-Service Partnership and Intensive Full-Service Partnership Programs focused on mental health treatment, including a team approach that provides alternative and culturally specific treatments using peer support, individual services and support plan development. At times, crisis intervention, stabilization services are needed and there is personal service coordination to assist the beneficiary and when appropriate the beneficiary's family. The targeted population was geared towards improving the county mental health service delivery system for all clients and their families as well as finding strategies for reducing ethnic/racial disparities.

Service Providers utilize evidenced based practices and/or promising practices to ensure service delivery meets the needs of the individual. The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool created to support communication with the individual and identify needs and strengths to determine treatment focus and monitor outcomes. The CANS is completed in collaboration with the youth/young adult and their family to discuss needs and strengths during initial assessment, at six-month intervals and at discharge from services. For youth 18 and under, the Pediatric Symptom Checklist (PSC-35) is utilized to screen for general concerns in youth, from the caregiver's perspective. If a caregiver is not involved with the individual, the youth has the ability to answer on their behalf. Both these tools are entered into a County database. Information from the tools is used for individualized program planning to support treatment goals but also used to evaluate program outcomes an identify any needs in service delivery to support continuous quality improvement. Lastly, an annual Client Satisfaction Survey is distributed to beneficiaries receiving behavioral health services. These surveys are collected and used for system changes and improvement.

Beginning FY24, Child FSP and Youth IFSP will merge to allow expanded flexibility and continuity of care. The new program, Youth Full-Service Partnership Continuum (FSPC), will have the full range of services to meet the needs of the child or youth where they are at. Expanding the range of services available allows for additional flexibility and will decrease the need for transfers, supporting an alignment with the Trauma Transformed model.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	Child FSP = 169 Child IFSP = 98	Child FSP = 84.08 Child IFSP = 89.90
16 -25 years	Child FSP = 31	Child FSP = 15.42

	Child IFSP = 11	Child IFSP = 10.10
26- 59 years	Child FSP = 1 Child IFSP = 0	Child FSP = .50 Child IFSP = 0
60+ years		
Prefer not to answer		
Unknown		
Unduplicated Total	Child FSP = 201 Child IFSP = 109	Child FSP = 100 Child IFSP = 100

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native		
Asian	Child FSP = 11 Child IFSP = 2	Child FSP = 5.47 Child IFSP = 1.83
Black or African American	Child FSP = 8 Child IFSP = 5	Child FSP = 3.98 Child IFSP = 4.59
Native Hawaiian or Other Pacific Islander	Child FSP = 2 Child IFSP = 0	Child FSP = 1 Child IFSP = 0
White/ Caucasian	Child FSP = 21 Child IFSP = 10	Child FSP = 10.45 Child IFSP = 9.17
Other	Child FSP = 103 Child IFSP = 49	Child FSP = 51.24 Child IFSP = 44.95
More than one race		
Prefer not to answer	Child FSP = 1 Child IFSP = 0	Child FSP = .50 Child IFSP = 0
Unknown	Child FSP = 55 Child IFSP = 43	Child FSP = 27.36 Child IFSP = 39.46
Unduplicated Total	Child FSP = 201 Child IFSP = 109	Child FSP = 100 Child IFSP = 100

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	Child FSP = 122 Child IFSP = 69	Child FSP = 60.70 Child IFSP = 63.30
Other Hispanic/ Latino		
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	Child FSP = 35 Child IFSP = 21	Child FSP = 17.41 Child IFSP = 19.26
Non-Hispanic or Non-Latino Subtotal		

More than one ethnicity		
Prefer not to answer		
Unknown	Child FSP = 44 Child IFSP = 19	Child FSP = 21.89 Child IFSP = 17.44
Unduplicated Total	Child FSP = 201 Child IFSP = 109	Child FSP = 100 Child IFSP = 100

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	Child FSP = 81 Child IFSP = 39	Child FSP = 40.30 Child IFSP = 35.78
Female	Child FSP = 114 Child IFSP = 69	Child FSP = 56.72 Child IFSP = 63.30
Prefer not to answer		
Unknown	Child FSP = 6 Child IFSP = 1	Child FSP = 2.89 Child IFSP = .92
Unduplicated Total	Child FSP = 201 Child IFSP = 109	Child FSP = 100 Child IFSP = 100

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	Child FSP = 81 Child IFSP = 39	Child FSP = 40.30 Child IFSP = 35.78
Female	Child FSP = 114 Child IFSP = 69	Child FSP = 56.72 Child IFSP = 63.30
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		

Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	Child FSP = 6 Child IFSP = 1	Child FSP = 2.89 Child IFSP = .92
Unduplicated Total	Child FSP = 201 Child IFSP = 109	Child FSP = 100 Child IFSP = 100

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	Child FSP = 201 Child IFSP = 109	Child FSP = 100 Child IFSP = 100
Unduplicated Total	Child FSP = 201 Child IFSP = 109	Child FSP = 100 Child IFSP = 100

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	Child FSP = 129 Child IFSP = 59	Child FSP = 64.18 Child IFSP = 54.13
Spanish	Child FSP = 52 Child IFSP = 26	Child FSP = 25.87 Child IFSP = 23.85

Vietnamese	Child FSP = 3 Child IFSP =1	Child FSP = 1.49 Child IFSP = .92
Chinese		
Tagalog		
Farsi		
Other	Child FSP = 1 Child IFSP = 0	Child FSP = .50 Child IFSP = 0
Prefer not to answer		
Unknown	Child FSP = 16 Child IFSP = 23	Child FSP = 7.96 Child IFSP = 21.10
Unduplicated Total	Child FSP = 201 Child IFSP = 109	Child FSP = 100 Child IFSP = 100

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military	Child FSP = 0 Child IFSP = 1	Child FSP = 0 Child IFSP = .92
No Military	Child FSP = 78 Child IFSP = 11	Child FSP = 38.80 Child IFSP = 10.09
Prefer not to answer		
Unknown	Child FSP = 123 Child IFSP = 97	Child FSP = 61.20 Child IFSP = 88.99
Unduplicated Total	Child FSP = 201 Child IFSP = 109	Child FSP = 100 Child IFSP = 100

	FY 2023	
Disability*	**# Served**	**% of Served**

Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability	Child FSP = 68 Child IFSP = 21	Child FSP = 33.83 Child IFSP = 19.27
No Disability		
Prefer not to answer		
Unknown	Child FSP = 133 Child IFSP = 88	Child FSP = 66.17 Child IFSP = 80.73
Unduplicated Total	Child FSP = 201 Child IFSP = 109	Child FSP = 100 Child IFSP = 100

*Participants may choose more than one option for Disability.

6. Additional FSP Data Collection Requirements

Data not available for FY23. The program is exploring ways to collect and report this data in future reporting

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Employment Status	**# Served**	**% of Served**

Unduplicated Total		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to service (Separate out service that is provided, funded administered, or overseen by county mental health versus service that is not)	**Kind of service to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in service** (for service that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in service (defined as participating at least once in the service to which referred) and standard deviation** (for referrals to service that are provided by or overseen by county mental health)
Child FSP = 77 Youth IFSP = 51	Child FSP services Youth IFSP services Services include individual/group therapy, case management supports, medication assessment/management, occupational therapy supports	Child FSP = 48 Youth IFSP = 24	Child FSP = 9 days Youth IFSP = 7 days	Child FSP: 7-12 days Youth IFSP = 4-8 days

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
N/A	N/A	N/A

9. Detailed Outcomes

There are three (3) County Contracted Providers (CCP's) who provided Child Full-Service Partnership (FSP) Programs, two (2) of which also provided Child (Youth) Intensive Full Service Partnership (IFSP) Program. On average, for Child FSP it took 9 days for a client to receive their first assessment appointment. On average for Child FSP, there were 67 discharges and of these 52 beneficiaries had a successful discharge from services. On average for Youth IFSP, it took 7 days for a client to receive their first assessment appointment two days better than FY 22. On average, there were 26 discharges and of these 18 beneficiaries had a successful discharge from services.

For the Child FSP program CANS outcomes demonstrated a 15% positive improvement in the Behavioral and Emotional Needs domain, 35% positive change in the risk behavior domain, and a 9% positive change in the life functioning domain.

For the Youth IFSP program CANS outcomes demonstrated a 11% positive improvement in the Behavioral and Emotional Needs domain, 50% positive change in the risk behavior domain, and a 10% positive change in the life functioning domain.

Staffing shortages greatly impacted the Full Service Partnership and Intensive Full Service Partnership programs throughout the Fiscal Year. Despite the staffing shortages, programs were able to shift services by using other clinical staff from other programs to support client needs. This opportunity for cross-training resulted in providing clinicians a wider range of expertise.

10. Evaluation Summary

Fiscal Year 2023 had many challenges as well as successes. Clients who are receiving services sometimes disengage from services without notice. This year, there was a focus to implement and monitor re-engagement effort for those that disengage with services. Having the option to re-engage clients who previously no showed or stop coming to services, was very successful. Many of the clients who had disengaged, re-engaged into therapeutic services.

Additionally, here were a few other successes shared this year:

i. There was a youth who had high impulsivity and was in and out of the Crisis Stabilization Unit, and she has been successfully stepped down into Intensive Outpatient Program. She continuously had suicidal ideations and expressed not wanting to live past 16 years of age and now she is 16.5. Success was possible for this youth because of the consistency of staff who were able to stay with her and support her.
ii. A youth gained confidence, applied and was awarded a volleyball camp scholarship.

The FSP and IFSP programs continue to provide support to youth, and their families with services that impact and transform lives.

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The TAY Full Service Partnership (FSP) is a comprehensive, intensive mental health service designed specifically to help TAY address high acuity behavioral health challenges and launch successfully into adulthood. FSP provides an individualized, team approach that aims to address the entire family, as defined by the youth. Through a coordinated range of services, FSP supports youth as they develop social, educational, and vocational skills. FSP serves youth ages 16-25 who are experiencing physical, social, behavioral, and emotional distress. Through its family-centered approach, FSP also provides support for parents or adult caregivers, and helps youth improve their interpersonal relationships. FSP Outreach Services assess the desire and readiness of youth for entering into partnership with the BHSD for services. Using age-appropriate strategies during a maximum 30-day outreach period, FSP informs potential clients about available services and determines if a partnership will be established. Once youth enter the program, FSP requires chosen family, providers, and key members of the youth's social support network to collaborate in building a creative plan responsive to the particular needs of the youth and their support system. The following are key services and activities of TAY FSP:

i. Mental Health treatment, including individual/family treatment.
ii. Alternative and culturally specific treatment approaches
iii. Chosen family support, including transportation of youth to their mental health appointments.
iv. 24/7 crisis support and Medication services.
v. Peer mentoring
vi. Case management to assist youth and when appropriate their chosen family in accessing needed medical, education, social, vocational rehabilitative and/or other community services.
vii. Supportive services to assist youth and their chosen family in obtaining and maintaining employment, housing, and/or educational opportunities.
viii. Referrals and linkages to community-based providers for other needed social services, including housing and primary care.

Intensive FSP provides a full range of community and clinical services that are a higher level of service delivery to serve people with serious mental health needs. The services will assist TAY, ages 16-25 with SED or SMI, particularly African American, Native American, and Latino youth living with serious mental illness to reach their wellness and recovery goals. Youth and young adults served may be at risk of transition from out-of-home placement; engaged with child welfare and/or the juvenile justice system; or at risk of homelessness, incarceration, or hospitalization.

2. Program Goals, Objectives & Outcomes

❖ TAY FSP/IFSP Outcomes

i. Reduce out-of-home placements.
ii. Increase service connectedness.
iii. Reduce involvement in child welfare and juvenile justice.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 483		
Number Served	Program Expenditure	Cost per Person
Total = 483 TAY FSP = 336 TAY IFSP = 147	$6,465,050	$13,385.20

4. Evaluation Activities

The Full-Service Partnership and Intensive Full-Service Partnership Programs focused on mental health treatment through a team approach that provides alternative and culturally specific treatments using peer support, individual services and support plan development. At times, crisis intervention, stabilization services are needed and there is personal service coordination to assist the beneficiary, and when appropriate the beneficiary's family, ensuring that services equitable and specific to the needs of the youth or young adult.
Service Providers utilize evidenced based practices and/or promising practices to ensure service delivery meets the needs of the individual. The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool created to support communication with the individual and identify needs and strengths to determine treatment focus and monitor outcomes. The CANS is completed in collaboration with the youth/young adult and their family to discuss needs and strengths during initial assessment, at six-month intervals and at discharge from services. For youth 18 and under, the Pediatric Symptom Checklist (PSC-35) is utilized to screen for general concerns in youth, from the caregiver's perspective. If a caregiver is not involved with the individual, the youth has the ability to answer on their behalf. Both these tools are entered into a county database. Information from the tools is used for individualized program planning to support treatment goals but also used to evaluate program outcomes an identify any needs in service delivery to support continuous quality improvement. Lastly, an annual Client Satisfaction Survey is distributed to beneficiaries receiving behavioral health services. These surveys are collected and used for system changes and improvement.
Beginning FY24, TAY FSP and IFSP will merge to allow expanded flexibility and continuity of care. The new program, Full Service Partnership Continuum (FSPC) will have the full range of services to meet the needs of the TAY where they are at. The range of services available, within one program, allows for additional flexibility and will decrease the need for transfers, supporting an alignment with the Trauma Transformed model.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	TAY FSP = 3 TAY IFSP = 0	TAY FSP = .89 TAY IFSP = 0
16 -25 years	TAY FSP = 316 TAY IFSP = 144	TAY FSP = 94.05 TAY IFSP = 97.96
26- 59 years	TAY FSP = 17 TAY IFSP = 3	TAY FSP = 5.06 TAY IFSP = 2.04
60+ years		

Prefer not to answer		
Unknown		
Unduplicated Total	TAY FSP = 336 TAY IFSP = 147	TAY FSP = 100 TAY IFSP =100

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	TAY FSP = 2 TAY IFSP = 1	TAY FSP = .60 TAY IFSP = .68
Asian	TAY FSP = 44 TAY IFSP = 21	TAY FSP = 13.09 TAY IFSP = 14.29
Black or African American	TAY FSP = 26 TAY IFSP = 14	TAY FSP = 7.74 TAY IFSP = 9.52
Native Hawaiian or Other Pacific Islander	TAY FSP = 2 TAY IFSP = 2	TAY FSP = .60 TAY IFSP = 1.36
White/ Caucasian	TAY FSP = 44 TAY IFSP = 22	TAY FSP = 13.09 TAY IFSP = 14.97
Other	TAY FSP = 159 TAY IFSP = 66	TAY FSP = 47.32 TAY IFSP = 44.89
More than one race		
Prefer not to answer	TAY FSP = 1 TAY IFSP = 0	TAY FSP = .30 TAY IFSP = 0
Unknown	TAY FSP = 58 TAY IFSP = 21	TAY FSP = 17.26 TAY IFSP = 14.29
Unduplicated Total	TAY FSP = 336 TAY IFSP = 147	TAY FSP = 100 TAY IFSP =100

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	TAY FSP = 171 TAY IFSP = 79	TAY FSP = 50.89 TAY IFSP = 53.75
Other Hispanic/ Latino		
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		

Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	TAY FSP = 98 TAY IFSP = 48	TAY FSP = 29.17 TAY IFSP = 32.65
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer		
Unknown	TAY FSP = 67 TAY IFSP = 20	TAY FSP = 19.94 TAY IFSP = 13.60
Unduplicated Total	TAY FSP = 336 TAY IFSP = 147	TAY FSP = 100 TAY IFSP =100

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	TAY FSP = 152 TAY IFSP = 62	TAY FSP = 45.24 TAY IFSP = 42.18
Female	TAY FSP = 183 TAY IFSP = 85	TAY FSP = 54.46 TAY IFSP = 57.82
Prefer not to answer		
Unknown	TAY FSP = 1 TAY IFSP = 0	TAY FSP = .30 TAY IFSP = 0
Unduplicated Total	TAY FSP = 336 TAY IFSP = 147	TAY FSP = 100 TAY IFSP =100

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	TAY FSP = 152 TAY IFSP = 62	TAY FSP = 45.24 TAY IFSP = 42.18
Female	TAY FSP = 183 TAY IFSP = 85	TAY FSP = 54.46 TAY IFSP = 57.82
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		

Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	TAY FSP = 1 TAY IFSP = 0	TAY FSP = .30 TAY IFSP = 0
Unduplicated Total	TAY FSP = 336 TAY IFSP = 147	TAY FSP = 100 TAY IFSP =100

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	TAY FSP = 336 TAY IFSP = 147	TAY FSP = 100 TAY IFSP =100
Unduplicated Total	TAY FSP = 336 TAY IFSP = 147	TAY FSP = 100 TAY IFSP =100

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	TAY FSP = 293 TAY IFSP = 138	TAY FSP = 87.20 TAY IFSP = 93.88
Spanish	TAY FSP = 31 TAY IFSP = 6	TAY FSP = 9.26 TAY IFSP = 4.08
Vietnamese	TAY FSP = 3 TAY IFSP = 1	TAY FSP = .87 TAY IFSP = .68
Chinese		
Tagalog	TAY FSP = 0 TAY IFSP = 1	TAY FSP = 0 TAY IFSP = .68
Farsi		
Other	TAY FSP = 4 TAY IFSP = 1	TAY FSP = 1.19 TAY IFSP = .68
Prefer not to answer		

Unknown	TAY FSP = 5 TAY IFSP = 0	TAY FSP = 1.48 TAY IFSP = 0
Unduplicated Total	TAY FSP = 336 TAY IFSP = 147	TAY FSP = 100 TAY IFSP =100

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military	TAY FSP = 62 TAY IFSP = 13	TAY FSP = 18.45 TAY IFSP = 8.84
Prefer not to answer		
Unknown	TAY FSP = 274 TAY IFSP =134	TAY FSP = 81.55 TAY IFSP = 91.16
Unduplicated Total	TAY FSP = 336 TAY IFSP = 147	TAY FSP = 100 TAY IFSP =100

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility	TAY FSP = 1 TAY IFSP = 0	TAY FSP = .30 TAY IFSP = 0
Chronic Health Condition		
Other non-communication disability	TAY FSP = 75 TAY IFSP = 40	TAY FSP = 22.32 TAY IFSP = 27.21
No Disability		
Prefer not to answer		
Unknown	TAY FSP = 260 TAY IFSP = 107	TAY FSP = 77.38 TAY IFSP = 72.79
Unduplicated Total	TAY FSP = 336 TAY IFSP = 147	TAY FSP = 100 TAY IFSP =100

*Participants may choose more than one option for Disability.

6. Additional FSP Data Collection Requirements

Data not available for FY23. The program is exploring ways to collect and report this data in future reporting.

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to service (Separate out service that is provided, funded administered, or overseen by county mental health versus service that is not)	**Kind of service to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in service** (for service that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in service (defined as participating at least once in the service to which referred) and standard deviation** (for referrals to service that are provided by or overseen by county mental health)
TAY FSP = 197 TAY IFSP = 72	TAY FSP & TAY IFSP services including individual/group therapy, case management supports, medication assessment/management, occupational therapy supports	TAY FSP = 93 TAY IFSP = 38	TAY FSP = 8 days TAY IFSP = 9 days	

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
N/A	N/A	N/A

9. Detailed Outcomes

There are three (3) County Contracted Providers (CCP's) who provided TAY Full-Service Partnership (FSP) Programs, two (2) of which also provided TAY Intensive Full-Service Partnership (IFSP) Programs. On average, for TAY FSP it took 8 days for a client to receive their first assessment appointment. On average for TAY FSP, there were 58 discharges and 48% of these beneficiaries had a successful discharge from services. TAY IFSP averaged 9 days for a client to receive their first assessment appointment. On average, there were 17 discharges and 41% of these beneficiaries had a successful discharge from services.

For the TAY FSP program CANS outcomes demonstrated a 9% positive improvement in the Behavioral and Emotional Needs domain, 14% positive change in the risk behavior domain, and a 16% positive change in the life functioning domain. For the TAY IFSP CANS outcomes demonstrated a 5% positive improvement in the Behavioral and Emotional Needs domain, 58% positive change in the risk behavior domain, and no change in the life functioning domain. The life functioning domain outcome demonstrates a steady status in the life functioning of youth and young adults in the program and that the program is effectively ensuring that life functioning is not decreasing as the program is addressing other areas of risk.

Staffing shortages greatly impacted the Full-Service Partnership and Intensive Full-Service Partnership programs throughout the Fiscal Year. Despite the staffing shortages, programs were able to shift by using other clinical staff from other programs to support client needs. This opportunity for cross-training resulted in providing clinicians a wider range of expertise.

10. Evaluation Summary

Fiscal Year 2023 had many challenges as well as successes. Clients who are receiving services sometimes disengage from services without notice. This year, there was a focus to implement and monitor re-engagement effort for those that disengage with services. Having the option to re-engage clients who previously no-showed or stop coming to services, was very successful. Many of the clients who had disengaged, re-engaged into therapeutic services.

Additionally, here were a few other successes shared this year:

- There were a numerous youth who graduated from High School this year and have plans to continue on with a four-year college or vocational schools.
- Despite the staffing shortage, once the youth had gotten the right team of staff supporting them, the youth was able to put effort into finding herself. She had disengaged from services many times but because there was a higher attempt to re-engage the youth, this youth was successfully re-engaged back into IFSP services.

The FSP and IFSP programs continue to provide support to TAY and their families with services that impact and transform lives.

Adult Full Service Partnership Program

The Adult Full Service Partnership program in Santa Clara County covers 2 different programs.

1. Adult Full Service Partnership
2. Intensive Full Service Partnership

The total cost per person, across all programs in this category can be found below. The following pages are detailed reports for each individual program in this category.

FY 2023		
Number Served	Program Expenditure	Cost per Person
1,357	$27,173,247	$ 20,024.50

ADULT FULL-SERVICE PARTNERSHIP (FSP)

CSS Adult Full-Service Partnership (FSP) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The County's Adult (26 to 59) Full-Service Partnership (FSP) program is a Community Contract Provider (CCP)operated program with services provided by six CCP's: Community Solutions, Gardner Family Health Network, Indian Health Center, Mekong, Momentum for Mental Health, and Ujima.
The program provides intensive, wraparound services to individuals with serious mental illness in a low staff to consumer ratio (1:10) through a "whatever it takes" approach, to:

i. Promote recovery and increased quality of life.
ii. Decrease negative outcomes such as Mental Health stigma, incarceration, hospitalization, and homelessness; and
iii. Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports (e.g., psychosocial outcomes).

This program offers intensive services designed to meet the unique biopsychosocial needs of adults ages 26 to 59. FSP services are client- and family-driven and designed for older adults at risk of inappropriate or premature out-of-home placement due to a serious mental illness and— in many instances— co-occurring medical conditions that impact their ability to remain in their home and community environments. FSP services are client- and family-driven and designed for older adults at risk of inappropriate or premature out-of-home placement due to a serious mental illness and— in many instances— co-occurring medical conditions that impact their ability to remain in their home and community environments.
Additionally, the program was designed to provide full spectrum of community services necessary to attain each consumer's quality of life goals that reflect their cultural values, which may include living arrangements, social supports, education, and employment.

2. Program Goals, Objectives & Outcomes

❖ **Goals**

i. The program was designed to reduce homelessness and increase safe and permanent housing
ii. Increase access to substance abuse treatment.
iii. Increase natural networks of supportive relationships.
iv. Increase self-help and client/family involvement.
v. Reduce of disparities in access to mental health services
vi. Reduce disparities in service access.
vii. Reduction of psycho-social impact of trauma

❖ **Objectives**

The program was created to engage underserved consumers who have not benefitted from traditional outpatient mental health services due to complex risk factors including substance abuse; community violence; interpersonal family violence; general neglect and exposure to trauma; social and emotional isolation; and physical decline and losses by providing culturally and linguistically proficient services 24/7.

❖ Outcomes

For this period, the programs have been overserving in capacity. Successful discharge rate varies among the providers. For those successfully discharged clients, some obtained housing, some reported to have obtained employment, and some were discharged to outpatient services due to increase functioning.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 570		
Number Served	**Program Expenditure**	**Cost per Person**
Adult: 602	See cover page	See cover page

4. Evaluation Activities

The following outcomes and measures are established by Santa Clara County expected of FSP program:

i. Timeliness and Access

The FSP program shall monitor its compliance with the timeliness and access requirements as set forth in Code of Federal Regulations (CFR) 42, Section 438. The FSP program must adhere to these requirements for all geographic areas within Santa Clara County and adhere to the State standards for time and distance requirements. Based on population density, the FSP program must provide behavioral health services within ten (10) working days. Services must be accessible within fifteen (15) miles or thirty (30) minutes from a beneficiary's residence.

ii. Engagement in Services (Timeliness/Access)

a. Performance Objective: Decrease the number of business days from the date of request to an appointment being offered for mental health services to ten (10) days.
b. Performance Objective: Decrease the percent of open client no shows to 25%.

iii. Successful Discharges (Quality)

Performance Objective: Increase the percent of successful discharges to 60%.

iv. Acute Care Readmissions (Quality)

a. Targeted System Performance: No more than 5% of clients receiving inpatient hospital services are readmitted within thirty (30) days.
b. Metric: Number and percentage of clients discharging from acute care services who are readmitted within thirty (30) days for any reason.
c. Improvement Objective: Reduce the percentage of clients receiving inpatient hospital services who are readmitted within thirty (30) days to no more than 7%.

The following evidence-based practice standard and promising practice standard are established by Santa Clara County expected of the FSP program. The FSP program shall document that all staff have been trained in accordance with licensing requirements. In addition to licensing requirements, the FSP program staff shall have the following additional experience, training and skills:

i. Each FSP team shall have specific expertise in working with their target population.
ii. FSP teams shall reflect the ethnic, cultural, and linguistically diverse target populations.

iii. Desirable staff skills include Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT), Motivational Interviewing, experience working with adult victims of abuse and trauma, dual diagnosis, and co-occurring disorders.
iv. Use of peer support and/or family/caregiver partners is highly encouraged.
v. Confidentiality
vi. Crisis Assessment and Intervention
vii. Understanding of Wellness and Recovery Principles
viii. Knowledge of local community resources available to the client population, including self-help centers and ethnic community resources
ix. Understanding of the BHSD System of Care
x. Capability to collaborate and coordinate with local providers of health and human services.

5. Demographic Data

The demographics in section 5 were reported by BHSD Analytics and Reporting Unit. The data came from two electronic records systems Unicare and myAvatar, as contract providers were still being onboarded into myAvatar throughout FY23. Care was taken to remove any duplicates, however, some inconsistencies between county level data and provider-reported data remained. This should be resolved in the next FY when all programs' data will be sourced from myAvatar.

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	1	0%
16 -25 years	7	1%
26- 59 years	482	85%
60+ years	61	11%
Unknown	19	3%
Unduplicated Total	570	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	12	2%
Asian	82	14%
Black or African American	46	8%
Native Hawaiian or Other Pacific Islander	3	1%

White/ Caucasian	199	35%
Other	185	32%
Prefer not to answer	3	1%
Unknown/Not Reported	40	7%
Unduplicated Total	570	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Caribbean	1	0%
Central American	55	10%
European	3	1%
Hispanic/Latino (undefined)	6	1%
Other Hispanic/Latino	120	21%
Other Non-Hispanic/ Non-Latino	343	60%
Prefer not to answer	10	2%
Unknown	32	6%
Unduplicated Total	570	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Female	275	48%
Male	295	52%
Unduplicated Total	570	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Female	275	48%
Maler	295	52%
Unduplicated Total	570	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Another sexual orientation	2	0%
Bisexual	16	3%
Gay or Lesbian	6	1%
Heterosexual/Straight	224	39%
Prefer not to answer	138	24%
Unknown	184	32%
Unduplicated Total	570	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
Chinese	4	1%
English	497	87%
Farsi	2	0%
Other	7	1%
Spanish	33	6%
Tagalog	1	0%
Unknown	7	1%
Vietnamese	19	3%
Unduplicated Total	570	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Not Military	122	21%
unknown	448	79%
Unduplicated Total	570	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
No Disability	28	5%
Other	4	1%

Other non-communication disability	311	55%
Physical/mobility	1	0%
Unknown	226	40%
Unduplicated Total	570	100%

*Participants may choose more than one option for Disability.

6. Additional FSP Data Collection Requirements

Below data is collected and provided by the following FSP providers: Community Solutions, Momentum for Health, Gardner, Mekong, and Ujima. In the future, BHSD A&R Division is working on tracking this data set for the following year when they are available in Avatar. Additionally, BHSD needs support from MHSA to clarify and standardize the data definition in order for the BHSD A&R Division to report on.

	FY 2023	
Residential Status	**# Served**	**% of Served**
Housed	202	38%
Unhoused	30	6%
Not Available - Data not available at the time of the report	299	56%
Unduplicated Total	531	100%

	FY 2023	
Educational Status	# Served	% of Served
Elementary School	22	4%
Middle School	8	2%
High School	91	17%
GED	11	2%
Associate degree	16	3%

Bachelor's Degree	62	12%
Master's Degree	3	1%
Doctor of Philosophy	0	0%
Other	7	1%
Not Available - Data not available at the time of the report	311	59%
Unduplicated Total	531	100%

	FY 2023	
Employment Status	**# Served**	**% of Served**
Employed, Full Time	11	2%
Employed, Part Time	14	3%
Disabled	55	10%
Full Time - Homemaker	0	0%
Military Duty	1	0%
Other	2	0%
Retired	6	1%
Student	1	0%
Unemployed	153	29%
Not Available - Data not available at the time of the report	288	54%
Unduplicated Total	531	100%

	FY 2023

Sources of Financial Support	# Served	% of Served
Partner's Wages	19	3%
Partner's Spouse/Significant Other's Wages	3	1%
Savings	5	1%
Other Family Member/Friend	36	6%
Veteran's Assistance Benefits	1	0%
Housing Subsidy	8	1%
General Relief/General Assistance	9	2%
Food Stamps	23	4%
TANF	1	0%
SSI/SSP	110	19%
SSDI	11	2%
SDI	0	0%
Other	15	3%
No Financial Support	12	2%
Not Available - Data not available at the time of the report	332	57%
Unduplicated Total	531	100%

	FY 2023	
Health Status	**# Served**	**% of Served**
Fair Health	123	23%
Poor Health	9	2%
Not Available - Data not available at the time of the report	399	75%
Unduplicated Total	531	100%

	FY 2023

Substance Abuse Issues	# Served	% of Served
Substance Abuse Issues	112	21%
No Substance Abuse Issues	122	23%
Not Available - Data not available at the time of the report	297	56%
Unduplicated Total	531	100%

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
1 - Extreme Risk	0	0%
2 – High Risk/Not Engaged	3	1%
3 – High Risk/Engaged	7	1%
4 – Poorly Coping/Not Engaged	14	3%
5 – Poorly Coping/Engaged	88	17%
6 – Coping/Rehabilitating	97	18%
7 – Early Recovery	12	2%
Not Available - Data not available at the time of the report	310	58%
Unduplicated Total	531	100%

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Client with No Emergency Intervention in FY23	210	40%
Client with Emergency Intervention in FY23	33	6%
Not Available – Data not available at the time of the report	288	54%
Unduplicated Total	531	100%

7. Referrals

FY 2023				
Unduplicated N = 570				
Number of individuals with serious mental illness referred to service (Separate out service that is provided, funded administered, or overseen by county mental health versus service that is not)	**Kind of service to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in service** (for service that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in service (defined as participating at least once in the service to which referred) and standard deviation** (for referrals to service that are provided by or overseen by county mental health)
Per providers, a total of 265 referrals (including transfers) were received.	FSP Adult provides Mental Health services including case management to link clients to community resources, individual rehabilitation to educate clients on life functioning skills, therapy to allow clients to process underlying issues and learn healthy coping skills, collateral to educate client's support persons on their mental health condition and teach supportive skills, and psychiatric support services to provide medication management and education from a psychiatrist and psychiatric nurse	Per providers, out of 265 referrals received180 of them were opened and followed through on the referral.	Prior to FSP, clients have either engaged in Emergency services or came from another level of care and had been triaged prior to intake.	4 - 6 days

8. Group Services Delivered

Below data is collected and provided by two FSP CCP's: Community Solutions and Gardner. The rest four CCP's (Momentum for Health, Indian Health Center, Mekong, and Ujima) either don't offer groups, are not tracking this data, or don't have sufficient data to report on. Community Solutions offers one group per week and Gardner offers four with a total average attendance per group around 9. Since these four groups are open to all FSP, OAFSP, and IFSP clients, the total attendance may not be representative for FSP.

FY 2023

Unduplicated N = 570		
Number of Groups Per Week	**Attendance**	**Average Attendance per Group**
4	1872	9

9. Detailed Outcomes

Due to ongoing transition into myAvatar during FY 23, there are some discrepancies between county records and provider-reports on charges for services, admissions, discharges, and timeliness. The outcomes indicators data are affected by these discrepancies, and we are working on resolving the issues for the future reports. The following is based on the data available in county records per FY23 MHSA Outcomes July22-Jun23 provided BHSD Quality Management and Unduplicated Client Count Data provided by BHSD A&R Division. FSP outcomes and performances are as followed:

i. Out of 329 contracted capacity, 570 unduplicated clients were served. Unduplicated clients overserved by 241 or 73%.
ii. Number of referrals received is 235 and out of which 149 were opened. Conversion rate is 63%.
iii. Percentage of Clients Received Assessment Appointment within 10 Business Days is on average 39%.
iv. Average Days to First Offered Assessment Appointment is 6.67 days.
v. Engagement – No Show is on average 27%.
vi. Number of discharges is 76 and out of which 47 were successful. Successful discharge rate is 62%.

10. Evaluation Summary

In FY2023, Adult FSP program continued to have overserved and performed on target. Providers were able to sustain quantity and quality of staffing to meet the needs of our beneficiaries. Staff continued to use Evidence-Based Practices and have been modeling the “whatever it takes” approach by being in the community and wrapping clients with whole person support. FSP program continued to benefit from MHSA funding. Last but not least, FSP providers continued to have been able to take proactive approach and utilize creative interventions to maintain beneficiaries’ housing stability, decrease occurrences of crisis episodes, and build strength and resources towards recovery.

FSP program continued to receive an influx of referrals needing care throughout the fiscal year to which FSP staff worked diligently to provide the support to our beneficiaries. While CalAIM was presented mid-year, FSP providers learned to quickly adapt to the CalAIM expectations and have been succeeding in the implementation.

Below is program highlight and success story shared by Gardner:

“FSP Adult program has witnessed many success stories throughout the fiscal year; however, the following cases highlight the success of the program. FSP Adult was given a referral for a client who was experiencing major depressive symptoms which was impacting their relationships. FSP staff was made aware early into the services that client’s family and support persons did not understand the client’s diagnosis and how to support. Client also faced challenges in addressing their rights as a US citizen and how it conflicted with their culture. Through the FSP Adult staff’s rehabilitation and collateral services, client was able to learn their rights as a US citizen understand their mental health rights, advocate for their needs and find family to support their choices to strengthen their daily functioning. Client reported feeling grateful for the support given by FSP Adult staff and the knowledge of their rights and finding the freedom to make healthy choices. Another success story focuses on a client that was transferred from the IFSP program due to needing a lower level of care. Client was able to maintain employment, find supportive housing and engage in therapy support services to where client and clinician agreed

client no longer needed FSP services. Client was transferred into the Adult OP program and is currently thriving."

Below is program highlight and success story shared by Ujima:

"Example: Adult male client who has been homeless for over 15 years uses our office address for his mail and we have assisted with getting on housing waiting lists. He was contacted by Santa Cruz Housing Authority. We were able to get him a car (donated vehicle) and he was able to drive there to apply for an apartment. He was focused on finding housing and encouraged and hopeful since he had the support and a car. Due to housing barriers and having no connections in Santa Cruz this was difficult. His symptoms increased and jail and EPS contacts increased. The clinician spoke to the Housing Authority worker and learned that we could request a transfer to Santa Clara. It was approved. He is hopeful now and focused on housing again. He drops into this clinic twice a week to check in, get support and stay focused on his goal of housing."

Below is program highlight and success story shared by Community Solutions:

"Staff have been able to maintain creative interventions towards building independent and have had cl successes such as a client that started out unable to leave his home and now able to take a vacation abroad and is getting ready to graduate from FSP. We have connected client to natural supports that some of those clients are now living with and being supported by."

INTENSIVE FULL-SERVICE PARTNERSHIP (IFSP)

CSS Intensive Full-Service Partnership (IFSP) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The County's Adult (26 to 59) and Older Adult (age 60 and up) Intensive Full-Service Partnership (IFSP) program is a Community Contract Provider (CCP)operated program with services provided by four CCP's: Community Solutions, Gardner Family Health Network, Momentum for Health, and Telecare Corporation.
The program provides intensive, wraparound services to individuals with serious mental illness in a low staff to consumer ratio (1:10) through a "whatever it takes" approach, to:

i. Promote recovery and increased quality of life.
ii. Decrease negative outcomes such as Mental Health stigma, incarceration, hospitalization, and homelessness; and
iii. Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports (e.g., psychosocial outcomes).

This program offers intensive services designed to meet the unique biopsychosocial needs of older adults ages 60 and above. IFSP services are client- and family-driven and designed for older adults at risk of inappropriate or premature out-of-home placement due to a serious mental illness and— in many instances— co-occurring medical conditions that impact their ability to remain in their home and community environments. IFSP services are client- and family-driven and designed for older adults at risk of inappropriate or premature out-of-home placement due to a serious mental illness and— in many instances— co-occurring medical conditions that impact their ability to remain in their home and community environments that require more dosage in IFSP.
Additionally:

i. Intensive Full-Service Partnership (IFSP) programs are designed to provide intensive, wraparound services that are recovery oriented, consumer driven, culturally responsive, trauma-informed, and co-occurring capable. Services are intended to be "full service" in that IFSP programs do "whatever it takes" to support a consumer in their recovery process 24 hours per day, seven days a week.
ii. IFSP provides full spectrum of community services necessary to attain the goals identified in each consumer's Personal Service Plan (PSP), as well as any services that may be deemed necessary through collaborative planning between the County, the consumer, and/or the consumer's family to address unforeseen circumstances in the consumer's life that could be but have not yet been included in the PSP. The PSP must not contain symptom reduction goals only but also quality of life goals that reflect the consumer's cultural values, which may include living arrangements, social supports, education, and employment.

2. Program Goals, Objectives & Outcomes

❖ **Goals**

i. Engage clients who are experiencing homelessness, incarceration, crisis, and hospitalization in intensive wraparound services.
ii. Reduce experiences of homelessness, incarceration, crisis, hospitalization, substance use, violence, and victimization.

iii. Strengthen recovery, self-sufficiency, and other positive psychosocial outcomes, including housing stability, improved family relationships, and participation in meaningful activities, secured income, and access to entitlement benefits.
iv. Develop, increase, and strengthen natural networks of supportive relationships.
v. Reduce the negative outcomes of mental illness.
vi. Reduce the impact of trauma.
vii. Increase capacity and engagement in school, work, and social activities.
viii. Increase the use of psychotropic medication and other means of symptom reducing strategies by increasing education in client/family environment

❖ **Objectives**

i. Provide services to clients twenty-four (24) hours a day, seven (7) days a week to engage clients who have not benefited from regular Full-Service Partnership (FSP) services due to complex risk factors including substance use, community violence, interpersonal family violence, and exposure to psychosocial trauma.
ii. Reduce homelessness, incarceration, hospitalization, and crisis services.
iii. Administer culturally and linguistically proficient client-centered services that integrate or directly provide the full range of treatment modalities and rehabilitation services and resources to meet the needs of clients and their families in their recovery process.
iv. Recovery based services that are guided by a care plan/treatment plan developed by and with the client's input.
v. The care plan will involve asking the client his/her vision of recovery and doing whatever is necessary for the client to assume management of their illness and control of their life choices.
vi. Self-help and peer support opportunities will be provided to clients.
vii. Transitional planning will begin at assessment with step down planning as a part of the client's overall plan. The status of the client's progress will be assessed as often as needed to assure successful completion of goals and objectives. d capabilities in school, work, and social activities
viii. Develop, increase, and strengthen natural networks of supportive relationships.
ix. Reduction of psychosocial impact of trauma Increase use of psychotropic medication and other means of symptom reducing strategies by increasing education among consumer/family environment.

❖ **Outcomes**

For this period, the programs have been overserving in capacity. Successful discharge rate varies among the providers. For those successfully discharged clients, some obtained housing, some reported to have obtained employment, and some were discharged to outpatient services due to increase functioning.
Intended outcomes to be achieved:

i. Unserved and/or underserved communities who have struggled to engage in planned mental health services and reduced reliance on crisis and inpatient 137 psychiatric care.
ii. Successfully transition a client to lower levels of care while maintaining a successful recovery process
iii. Improved functioning as defined through MORS score and Daily Living Activities Functional Assessment (DLA-20)
iv. Increase in the number of clients engaged in educational and vocational activities.
v. Increased positive client service experience.
vi. Decrease in the number of clients frequenting inpatient psychiatric hospitals.
vii. Decrease in the number of hospital and institution days. Increase in the number of client reporting satisfaction with services received twice a year.

3. Clients Served & Annual Cost per Client Data

FY 2023

Unduplicated N = 576		
Number Served	**Program Expenditure**	**Cost per Person**
755	See cover page	See cover page

4. Evaluation Activities

The following outcomes and measures are established by Santa Clara County expected of IFSP program:

i. Timeliness and Access

The IFSP program shall monitor its compliance with the timeliness and access requirements as set forth in Code of Federal Regulations (CFR) 42, Section 438. The IFSP program must adhere to these requirements for all geographic areas within Santa Clara County and adhere to the State standards for time and distance requirements. Based on population density, the IFSP program must provide behavioral health services within ten (10) working days. Services must be accessible within fifteen (15) miles or thirty (30) minutes from a beneficiary's residence.

ii. Engagement in Services (Timeliness/Access)

a. Performance Objective: Decrease the number of business days from the date of request to an appointment being offered for mental health services to ten (10) days.
b. Performance Objective: Decrease the percent of open client no shows to 25%.

iii. Successful Discharges (Quality)

Performance Objective: Increase the percent of successful discharges to 60%.

iv. Acute Care Readmissions (Quality)

a. Targeted System Performance: No more than 5% of clients receiving inpatient hospital services are readmitted within thirty (30) days.
b. Metric: Number and percentage of clients discharging from acute care services who are readmitted within thirty (30) days for any reason.
c. Improvement Objective: Reduce the percentage of clients receiving inpatient hospital services who are readmitted within thirty (30) days to no more than 7%.

The following evidence-based practice standard and promising practice standard are established by Santa Clara County expected of the FSP program. The FSP program shall document that all staff have been trained in accordance with licensing requirements. In addition to licensing requirements, the FSP program staff shall have the following additional experience, training and skills:

i. Each IFSP team shall have specific expertise in working with their target population
ii. IFSP teams shall reflect the ethnic, cultural, and linguistically diverse target populations
iii. Desirable staff skills include Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT), Motivational Interviewing, experience working with adult victims of abuse and trauma, dual diagnosis, and co-occurring disorders
iv. Use of peer support and/or family/caregiver partners is highly encouraged
v. Confidentiality
vi. Crisis Assessment and Intervention
vii. Understanding of Wellness and Recovery Principles
viii. Knowledge of local community resources available to the client population, including self-help centers and ethnic community resources
ix. Understanding of the BHSD System of Care

x. Capability to collaborate and coordinate with local providers of health and human services

5. Demographic Data

The demographics in section 5 were reported by BHSD Analytics and Reporting Unit. The data came from two electronic records systems Unicare and myAvatar, as contract providers were still being onboarded into myAvatar throughout FY23. Care was taken to remove any duplicates, however, some inconsistencies between county level data and provider-reported data remained. This should be resolved in the next FY when all programs' data will be sourced from myAvatar.

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	2	0%
16 -25 years	5	1%
26- 59 years	422	73%
60+ years	128	22%
Unknown	19	3%
Unduplicated Total	576	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	9	1%
Asian	62	11%
Black or African American	41	7%
Native Hawaiian or Other Pacific Islander	1	0%
White/ Caucasian	237	41%
Other	191	33%
Prefer not to answer	7	1%
Unknown	31	5%
Unduplicated Total	576	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Caribbean	2	0%
Central American	68	12%
Hispanic/Latino (undefined)	5	1%
Non-Hispanic/ Non-Latino (undefined)	1	0%

Other Hispanic/Latino	117	20%
Other Non-Hispanic/ Non-Latino	336	58%
Prefer not to answer	8	1%
South American	1	0%
Unknown	38	7%
Unduplicated Total	576	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Female	232	40%
Male	344	60%
Unduplicated Total	576	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Female	232	40%
Male	344	60%
Unduplicated Total	576	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Another sexual orientation	2	0%
Bisexual	3	1%
Gay or Lesbian	3	1%
Heterosexual/Straight	155	27%
Prefer not to answer	173	30%
Unknown	240	42%
Unduplicated Total	576	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
Chinese	4	1%
English	519	90%
Other	7	1%
Spanish	28	5%
Tagalog	1	0%
Unknown	6	1%
Vietnamese	11	2%
Unduplicated Total	576	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Not Military	238	41%
Unknown	335	58%
Veteran	3	1%
Unduplicated Total	576	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
No disability	8	1%
Other	1	0%
Other non-communication disability	399	69%
Physical/mobility	3	1%
Physical/mobility domain	3	1%
Unknown	165	29%
Unduplicated Total	576	100%

*Participants may choose more than one option for Disability.

6. Additional FSP Data Collection Requirements

Below data is collected and provided by the following IFSP providers: Community Solutions, Momentum for Health, Gardner, and Telecare. In the future, BHSD A&R Division is working on tracking this data set for the

following year when they are available in myAvatar. Additionally, BHSD needs support from MHSA to clarify and standardize the data definition in order for the BHSD A&R Division to report on.

	FY 2023	
Residential Status	**# Served**	**% of Served**
Housed	403	73%
Unhoused	30	5%
Not Available – Not Enough Data	118	21%
Unduplicated Total	551	100%

	FY 2023	
Educational Status	**# Served**	**% of Served**
Elementary School	18	3%
Middle School	4	1%
High School or GED	164	30%
Associate Degree	117	21%
Bachelor's Degree	9	2%
Master's Degree	3	1%
Doctor of Philosophy	0	0%
Enrolled in Educational Setting	2	0%
Not Enrolled in Educational Setting	85	15%
Other	1	0%
Unknown	148	27%
Unduplicated Total	551	100%

	FY 2023	
Employment Status	**# Served**	**% of Served**
Employed	37	7%
Unemployed or Students or on Disability	396	72%
Not Available - Data not available at the time of the report	118	21%
Unduplicated Total	551	100%

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
SSI/SSA Disability and Other Governmental Support	339	62%
Employment or Family Support	17	3%
No Financial Support	77	14%
Not Available - Data not available at the time of the report	118	21%
Unduplicated Total	551	100%

	FY 2023	
Health Status	**# Served**	**% of Served**
Fair Health Status	286	52%
Poor Health Status	36	7%
Not Available - Data not available at the time of the report	229	42%
Unduplicated Total	551	100%

	FY 2023

Substance Abuse Issues	# Served	% of Served
Substance Abuse Issues	160	29%
No Substance Abuse Issues	186	34%
Not Available – Data is not available at the time of the report	205	37%
Unduplicated Total	551	52%

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
1 - Extreme Risk	3	1%
2 – High Risk/Not Engaged	2	0%
3 – High Risk/Engaged	7	1%
4 – Poorly Coping/Not Engaged	31	6%
5 – Poorly Coping/Engaged	292	53%
6 – Coping/Rehabilitating	10	2%
7 – Early Recovery	0	0%
Not Available – Data is not available at the time of the report	206	37%
Unduplicated Total	551	100%

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Client with No Emergency Intervention in FY23	284	52%
Client with Emergency Intervention in FY23	57	10%
Not Available – Data is not available at the time of the report	210	38%

Unduplicated Total	551	100%

7. Referrals

FY 2023				
Unduplicated N = 576				
Number of individuals with serious mental illness referred to service (Separate out service that is provided, funded administered, or overseen by county mental health versus service that is not)	**Kind of service to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in service** (for service that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in service (defined as participating at least once in the service to which referred) and standard deviation** (for referrals to service that are provided by or overseen by county mental health)
Per providers, a total of 230 referrals (including transfers) were received.	IFSP Adult and Older Adult provides Mental Health Services consisting of Psychiatric Services, Therapy, Rehabilitation Services that teach clients to improve life functioning skills, Collateral Services to support Client's Support People provide care and support with maintaining and stabilization, and Case Management that provides Community Resources and placement support.	Per providers, out of 230 referrals received 168 of them were opened and followed through on the referral.	Before participating in IFSP clients referred are chronically unhoused or chronically attending emergency services. Clients referred to service had utilized emergency services such as EPS and MH hospitalization. All clients were triaged and assessed before opening.	Per providers, the average interval varies depending on capacity and client's housing status which drives the length of outreach time. Community reported 4 -6 days; Gardner 3 – 5 days; and Telecare 33 days

8. Group Services Delivered

Below data is collected and provided by two IFSP CCP's: Community Solutions and Gardner. The other two CCP's (Momentum for Health and Telecare) either don't offer groups, are not tracking this data, or don't have

sufficient data to report on. Community Solutions offers one group per week and Gardner offers three with a total average attendance per group around 9. Since these four groups are open to all FSP, OAFSP, and IFSP clients, the total attendance may not be representative for FSP.

FY 2023		
Unduplicated N = 576		
Number of Groups Per Week	Attendance	Average Attendance per Group
4	1872	9

9. Detailed Outcomes

Due to ongoing transition into myAvatar during FY 23, there are some discrepancies between county records and provider-reports on charges for services, admissions, discharges, and timeliness. The outcomes indicators data are affected by these discrepancies, and we are working on resolving the issues for the future reports. The following is based on the data available in county records per FY23 MHSA Outcomes July22-Jun23 provided BHSD Quality Management and Unduplicated Client Count Data provided by BHSD A&R Division. IFSP outcomes and performances are as followed:

i. Out of 448 contracted capacity, 576 unduplicated clients were served. Unduplicated clients overserved by 128 or 29%.
ii. Number of referrals received is 101 and out of which 51 were opened. Conversion rate is 50%.
iii. Percentage of Clients Received Assessment Appointment within 10 Business Days is on average 15%.
iv. Average Days to First Offered Assessment Appointment is 8.5 days.
v. Engagement – No Show is on average 38%.
vi. Number of discharges is 74 and out of which 26 were successful. Successful discharge rate is 35%.

10. Evaluation Summary

In FY2023, Adult and Older Adult IFSP program continued to have overserved and performed on target. Most of our providers were able to sustain quantity and quality of staffing to meet the needs of our beneficiaries. Staff has diligently provided services to this intensive population supporting the beneficiaries to improve their level of functioning and be able to connect with resources that are available to them in their community in a way that has been inclusive and nonjudgmental.

IFSP program continued to receive an influx of referral's needing care throughout the fiscal year to which IFSP staff worked diligently to provide the support to our beneficiaries. Due to the intensity of this population, IFSP program provides 50-80 community-based services as this is the true way to engage and provide the most effective client care possible. Providers are also equipped with Telehealth capability to provide virtual services to our beneficiaries. Last but not least, CalAIMs was presented mid-year. All our IFSP providers attended trainings to learn and adapt to the CalAIMs expectations.

Below is program highlight and success story shared by Gardner:

"IFSP Gardner has had successes this year where we had clients be able to stabilize and step down to a lower level of care remaining stable and continue to work towards improving their standard of living. One great example is one of our clients that stepped down to a lower level of care is attending college and living independently."

ASSERTIVE COMMUNITY TREATMENT (ACT)

CSS Full Service Partnership (FSP) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Assertive Community Treatment (ACT) is an evidence-based behavioral health program for adults (18 and over) with serious mental illness who are at risk of or would otherwise be served in institutional settings (e.g., hospitals, jails/prisons) or experience homelessness. The ACT model is a comprehensive community-based model of treatment, support, and rehabilitation for individuals with serious mental illness who are unwilling or unable to engage in mental health services and who are experiencing frequent and repetitive hospitalizations and/or incarcerations, likely to be homeless, and may suffer from a co-occurring disorder. Often referred to as a "hospital without walls", ACT teams provide community support characterized by:

i. An interdisciplinary team with a low staff to consumer ratio that includes specific positions, including team leader, psychiatrist (1:100) ratio, nurse (1:50), vocational and substance abuse specialists (1:50), and peer counselor.
ii. A team approach to care in which: 1) all ACT team members know and work with all ACT consumers, and 2) a practicing ACT team leader spends more than 50% of their time providing direct services to ACT consumers.
iii. A high frequency and intensity of community-based services with at least four face-to-face contacts per week for a minimum of two hours total per week, where at least 80% of services are provided in the community, not in an office.
iv. Assertive engagement mechanisms that allow for longer periods of outreach prior to treatment admission, including street outreach, working with informal support networks (e.g., family, landlord, employer), and coordination of legal mechanisms such as outpatient commitment and court orders.
v. ACT teams assuming total responsibility for treatment services, including crisis response, so that all service needs can be met by ACT staff members who are available 24 hours per day, 7 days per week, 365 days per year.

2. Program Goals, Objectives & Outcomes

❖ **Goals**

i. Decrease or prevent the debilitating symptoms of mental illness and co-occurring substance use that the individual may experience.
ii. Meet basic needs and enhance the quality of life in daily living activities.
iii. Improve socialization and development of natural supports.
iv. Improve support with finding and keeping competitive employment.
v. Reduce hospitalization, homelessness, and institutionalized care.
vi. Decrease the role of families and significant others in providing care while increasing days in the community through housing stability.
vii. Reduce experiences of crisis as well as substance use, violence, and victimization.
viii. Strengthen recovery, self-sufficiency, and other psychosocial outcomes, including housing, education, employment/income, and access to entitlement benefits.

ix. Increase integration into community life with a focus on stability, particularly in the area of symptom management and reduction of harmful behaviors and suicide.

❖ **Objectives**

i. Implement with and meet a high level of fidelity to the ACT Model.
ii. Identifying issues including, but not limited to mental health, co-occurring, and physical conditions/disabilities.
iii. Increasing mental health and/or substance use treatment retention through outreach and engagement efforts.
iv. Engage individuals who are experiencing homelessness, incarceration, and/or crisis and hospitalization in intensive, wraparound mental health services.
v. Decreasing service fragmentation.
vi. Identifying and assisting clients with housing needs.
vii. Providing access to peer support staff who shall assist clients in modeling personal recovery
viii. Provide a safe alternative to the streets by offering non-stigmatizing access to Behavioral Healthcare, basic needs (e.g., food, clothing, personal hygiene items, etc.) and crisis intervention
ix. Increasing educational and employment opportunities.
x. Treat and ameliorate behavioral health symptoms in the least restrictive and intrusive manner.
xi. Provide culturally and linguistically proficient client centered services that integrate the full range of treatment and rehabilitation modalities, which are key to the ACT Model and shall assist clients in their recovery process.
xii. Utilization of comprehensive age specific evidence-based and informed/promising practices that address the behavioral health, substance use and physical health issues effective with ethnic and cultural Adult and Older Adult clients.
xiii. Implement stepped care procedures when and if clients require a less intensive level of care to address their current behavioral health needs.

❖ **Outcomes**

i. Increase self-help activities and promote health with wellbeing for clients within a safe environment by providing outreach and engagement activities.
ii. Assist the highest risk client with behavioral health needs to remain within the community, attend school/work, prevent hospitalization and involvement in the justice systems.
iii. Improve access for and engagement of underserved Adults and Older Adult clients to assist in managing their behavioral health needs.
iv. Decrease hospital and other institutional utilization by engaging clients in services that are relevant and include evidence-based models/promising practices in the provision of individual, group, and family treatment modalities.
v. Increased awareness and education regarding needs of the target population by integrating partnerships with adult and older adult service systems, housing, and other community resources.

3. Clients Served & Annual Cost per Client Data

ACT program expenditures cover some housing and flex expenses for AOT clients, as AOT services were rolled out as part of ACT program. In the future, BHSD is considering separating the AOT and ACT services into two programs. In addition, BHSD is working on addressing issues with service data submission by providers into the county system, which may have also affected the cost calculations.

FY 2023
Unduplicated N =251

Number Served	Program Expenditure	Cost per Person
251	$10,174,591	$40,536.22

4. Evaluation Activities

Focus Areas including:

i. The Access and Linkage: Access to the ACT level of care is through the Santa Clara County Call Center in conjunction with BHSD 24-hour care and BHSD program manager. Upon referral, the individual is assigned to the ACT team. BHSD monitors timely access to first appointment and to medication evaluation appointment following the referral.

ii. Peer support: Peer Support Specialists (PSS) are an integral part of ACT team and provide various services to individuals and families, including Wellness and Recovery Plan (WRAP). Each ACT team is expected to have a PSS. BHSD monitors providers to assure adequate staffing via monthly meetings and annual ACT fidelity reviews.

iii. Mental health services and supports: BHSD established contractual obligations for ACT providers to maintain high intensity of mental health services in ACT level of care. BHSD monitors service provision and utilization using data in electronic health records.

iv. Non-mental health services and supports including housing, employment, and education: ACT offers housing, flex funds, and other services to support client's stabilization in the community. BSHD monitors provision of these services via monthly reports on clients' housing arrangements, rents, and other expenditures to support clients' needs.

The ACT program performance outcomes are evaluated by annual ACT Fidelity Audits, reports from Data Collection and Reporting (DCR) system required by DHCS for all FSP and ACT providers, scores on standardized client outcomes assessment scales, and Client Experience Surveys.

5. Demographic Data

The demographics in section 5 were reported by BHSD Analytics and Reporting Unit. The data came from two electronic records systems Unicare and myAvatar, as contract providers were still being onboarded into myAvatar throughout FY23. Care was taken to remove any duplicates, however, some inconsistencies between county level data and provider-reported data remained. This should be resolved in the next FY when all programs' data will be sourced from myAvatar.

	FY 2023	
Age Group	# Served	% of Served
0 – 15 years	0	
16 -25 years	12	4%
26- 59 years	206	79%
60+ years	73	24%
Prefer not to answer	0	
Unknown	9	3%

Unduplicated Total	300	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native		
Asian	51	17%
Black or African American	23	8%
Native Hawaiian or Other Pacific Islander	3	1%
White/ Caucasian	118	39%
Other	81	27%
More than one race		
Prefer not to answer	2	<1%
Unknown	22	7%
Unduplicated Total	300	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	2	<1%
Central American	27	9%

Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	1	<1%
Other Hispanic/ Latino	51	17%
Hispanic or Latino Subtotal	**81**	**27%**
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		

Non-Hispanic or Non-Latino Subtotal	**193**	**64%**
More than one ethnicity		
Prefer not to answer	1	<1%
Unknown	25	8%
Unduplicated Total	300	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	172	57%
Female	127	42%
Prefer not to answer		
Unknown	1	<1%
Unduplicated Total	300	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	172	57%
Female	127	42%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	1	<1%
Unduplicated Total	300	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	2	<1%
Heterosexual/ Straight	57	19%
Bisexual	2	<1%
Questioning/ Unsure		
Queer		
Another sexual orientation	1	<1%
Prefer not to answer	71	24%
Unknown	167	56%
Unduplicated Total	300	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	251	85%
Spanish	8	3%
Vietnamese	17	6%
Chinese	4	1%
Tagalog		
Farsi	1	<1%
Other	1	<1%
Prefer not to answer		
Unknown	15	5%
Unduplicated Total	300	100%

	FY 2023

Military Status	# Served	% of Served
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military	29	10%
Prefer not to answer		
Unknown	271	90%
Unduplicated Total	300	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	1	<1%
Difficulty hearing or speaking	1	<1%
Other communication disability		
Cognitive	1	0.3%
Physical/ Mobility	2	<1%
Chronic Health Condition		
Other non-communication disability	216	72%
No Disability	5	2%
Prefer not to answer		
Unknown	75	25%
Unduplicated Total	300	100%

*Participants may choose more than one option for Disability.

6. Additional FSP Data Collection Requirements

	FY 2023	
Residential Status*	**# Served**	**% of Served**

Housed (board and care, sober living environment, single room occupancy)	279	99%
Unhoused (or AWOL)	2	1%
Unduplicated Total	281	100%

*Data on residential status was reported by service providers and not available in county records system. Therefore, there is a difference in # and % served when compared to the demographic data tables above.

	FY 2023	
Educational Status*	**# Served**	**% of Served**
Unduplicated Total		

*Education status categories were not defined. Of the two ACT provider agencies, one reported education attainment, with 96% of clients served by the program not having completed high school education. And another provider reported enrollment in school setting while in ACT program, with 97% of clients not being enrolled in school. In the future we will work on defining standard categories to report on.

	FY 2023	
Employment Status*	**# Served**	**% of Served**
Acquired employment-actively employed	5	4%
No current employment	166	96%
Unduplicated Total	171	100

*Employment status categories were not defined. And were reported by one provider agency only, as shown in the table above. The other ACT provider has the employment information in the client's clinical record and is working on modifying their Electronic Health Record system to collect this data in a format amenable for quantitative reports.

	FY 2023	
Sources of Financial Support*	**# Served**	**% of Served**
SSI/SSDI/GA/other wages	269	96%

No financial support	12	4%
Unduplicated Total	281	100%

*Sources of financial support categories were not defined.

	FY 2023	
Health Status*	**# Served**	**% of Served**
Linked to PCP-receiving services	171	100%
Not currently receiving PCP services	0	0
Unduplicated Total	171	100%

*Health Status measure was not defined and was reported by one provider agency as shown in the table above. Linkage with Primary Care Physician is aligned with behavioral health assessment and care planning requirements. The other ACT provider has the health status and linkage with PCP information in the client's clinical record and is working on modifying their Electronic Health Record system to collect this data in a format amenable for quantitative reports.

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Yes - Co-occurring substance use disorder	133	47%
No - Co-occurring substance use disorder	148	53%
Unduplicated Total	281	100%

	FY 2023	
Assessment of Daily Living Functions, when appropriate*	**# Served**	**% of Served**
Unduplicated Total		

*Service providers assess and record all pertinent information in client's health record, however daily living functions assessment is not available as quantitative data report. We are currently not mandating a standardized measure on ADL functions.

	FY 2023	
Emergency Interventions*	**# Served**	**% of Served**
Unduplicated Total		

*Service providers maintain record of emergency and crisis interventions in client's health record, as well as incident reports. This data was not available as an aggregate quantitative report.

7. Referrals

FY 2023				
Unduplicated N =119				
Number of individuals with serious mental illness referred to service (Separate out service that is provided, funded administered, or overseen by county mental health versus service that is not)	**Kind of service to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in service** (for service that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in service (defined as participating at least once in the service to which referred) and standard deviation** (for referrals to service that are provided by or overseen by county mental health)
119 (as reported by service providers)	ACT, including mental health services, housing, benefits, employment and other supports.	96 (as reported by service providers)	Unknown. Most individuals are referred to ACT services following multiple inpatient psychiatric admissions during the prior year.	15-30 days – the interval between referral and service provision in ACT program is often affected by the IMD discharge planning timelines.

8. Group Services Delivered

Summary by provider 1: We are currently providing 3 rehabilitation groups: Family Support group and two Recovery Support Groups, one onsite and one offsite in the community. Our family support provides psychoeducation and alliance services. Our recovery support group for individuals with co-occurring disorders is a recovery-centered support group that aims to provide support around living with a co-occurring disorder and learning about stages of change and substance use recovery/harm reduction.

Summary by provider 2: The groups were a variety and combination of skill building, social skills, and independent living. All of our groups were facilitated in our Master Lease, Lewis' house, by our clinical case managers or staff. Everyone at the house and in the community were invited to join the group, however usually only clients who reside in Lewis house would join. Our staff offered the following groups to our clients; mindfulness, anger management, exercise, copping mechanism, money management, communal living skills, cooking, nutrition, art, and gardening groups.

FY 2023		
Unduplicated N =63		
Number of Groups per Week	**Attendance**	**Average Attendance per Group**
3	63	4-5

9. Detailed Outcomes

Referral to admission conversion rate was used as an indicator for successful engagement into treatment. Based on provider reports, in FY 23, ACT program received 119 referrals of which 96 were admitted into the program, resulting in 81% conversion rate. The interval between referral and service provision in ACT program is often affected by the IMD discharge planning timelines, as majority of the referral into ACT are for clients ready to transition from IMD into community-based treatment. Currently, ACT providers are reporting 15-30 days between referral and service enrollment. We are working on strategies to reduce the interval.

Due to ongoing transition into myAvatar during FY 23, there are some discrepancies between county records and provider-reports on charges for services, admissions, discharges, and timeliness. The outcomes indicators data are affected by these discrepancies, and we are working on resolving the issues for the future reports. The following is based on the data available in county records and monitored by the BHSD Quality Management for timeliness indicators and Research and Outcomes Measurement Unit for discharge related indicators.

i. Average days to initial service: M=21, Range for monthly average 13 to 33 days. This indicator is affected by the nature of referrals into ACT: referred individuals are usually in discharge planning stages in IMDs, which may take time, and ACT team needs to coordinate their next housing placement prior to intake.
ii. % with assessment appointment within 10 business days: one provider with 0%, and the second provider with 5%. This indicator is affected by the same factors as described above regarding average days to service.
iii. Average days to first offered assessment appointment: The average was 17 days for one provider and 7 days for the second provider.
iv. No show rates: ACT services are provided in the community and are not clinic-based, thus no show rates are not very accurate indicator of client engagement. One provider reported 7% and the second provider reported 36% no show rates. We will explore the reason for this discrepancy and standardize the definition if no show for ACT services.
v. Total discharges: 56
vi. % successful discharges: 23%. After inclusion of administrative discharges without adverse outcomes successful discharges were 50%. We will be exploring how ACT providers report on discharge categories used to define successful discharges, and how these definitions apply to ACT services.

10. Evaluation Summary

The continuous collaboration and coordination of care with our current partners such as community providers, hospitals, Board and Care facilities, and the Public Guardian's office are among some of the successes of the ACT program. Providers continued implementing trauma-informed and evidence-based practices and had successful ACT fidelity reviews by an independent expert reviewer. Fidelity review indicated appropriate staffing levels, commitment to team approach, delivery of services in the community rather than the clinic, and assertive outreach to clients by all team members.

The ACT program faced several challenges throughout the FY22/23. One provider stressed the difficulty recruiting clinicians who were BBS registered and were willing to work in community-based intensive mental health services. The provider tried various strategies, including working with a recruiter. Cost of housing and finding housing for individuals in intensive mental health services was another challenge. The operators of independent living homes can be reluctant to lease to mental health services consumers. The housing coordinators and treatment staff worked to build rapport with landlords and convince them to become vendors for Master Lease housing program. More than 50% of ACT clients are conserved and in need of a licensed Board and Care which increases the program's costs of housing. The changing regulatory environment and payment reform, including CalAIM implementation, though exciting in its promise, also presented a challenge as providers continue to adapt to the changes in service provision, reporting, and reimbursement.

Several client success stories were reported by providers. ACT team worked with one client for over two years, beginning when the client was still in IMD and under conservatorship, then successfully discharging into outpatient ACT program. The treatment team found housing for the client, supported the client in independent living and through the process of getting off conservatorship. The team provided education in social skills, nutrition, healthy lifestyle, financial management, and helped search for employment. Another client has been in ACT services for 18 months. During this entire time the client struggled with substance use. The team continued providing services and motivating for change, and the client is now in residential treatment program for substance use on the path to recovery. Yet another client with resent crisis residential admission and IMD stay is successfully living in the community with the support of intensive case management by the ACT team. And finally, just in the first week of July 2023, one ACT provider reported that 3 clients moved into independent housing.

FORENSIC ASSERTIVE COMMUNITY TREATMENT (FACT)

CSS Full Service Partnership (FSP) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Forensic Assertive Community Treatment (FACT) is an evidence-based behavioral health program for justice-involved consumers with severe mental illness who are at risk of or would otherwise be served in institutional settings (e.g. jails/prisons) or experience homelessness. The FACT model is a comprehensive community-based model of treatment, support, and rehabilitation for individuals with severe mental illness who are unwilling or unable to engage in mental health services and who are experiencing frequent and repetitive incarcerations, likely to be homeless, and may suffer from a co-occurring disorder. FACT teams provide community support characterized by:

i. An interdisciplinary team with a low staff to consumer ratio that includes specific positions, including team leader, psychiatrist (1:100) ratio, nurse (1:50), vocational and substance abuse specialists (1:50), and peer counselor.
ii. A team approach to care in which: 1) all FACT team members know and work with all FACT consumers, and 2) a practicing ACT team leader spends more than 50% of their time providing direct services to ACT consumers.
iii. A high frequency and intensity of community-based services with at least four face-to-face contacts per week for a minimum of two hours total per week, where at least 80% of services are provided in the community, not in an office.
iv. Assertive engagement mechanisms that allow for longer periods of outreach prior to treatment admission, including street outreach, working with informal support networks (e.g. family, landlord, employer), and coordination of legal mechanisms such as outpatient commitment and court orders.
v. FACT teams assuming total responsibility for treatment services, including crisis response, so that all service needs can be met by FACT staff members who are available 24 hours per day, 7 days per week, 365 days per year.

When implemented to fidelity, FACT produces reliable results that decrease negative outcomes such as hospitalization, incarceration, and homelessness, and improve psychosocial outcomes. A budget increase was necessary to appropriately execute the program to fidelity.
In the FY24 and FY25 annual plan update, a Division name change will be reflected. The Criminal Justice Services (CJS) Division changed its name to the Forensic, Diversion and Reintegration (FDR) Division. This change was officially announced in the FY23 SLC meetings.

2. Program Goals, Objectives & Outcomes

❖ **Outcomes**

i. Promote recovery and increase quality of life.
ii. Decrease negative outcomes such as incarceration, hospitalization, and homelessness.
iii. Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	**Program Expenditure**	**Cost per Person**
172	S 4,895,548.00	$ 28,501.01

4. Evaluation Activities

The following outcomes and measures are established by Santa Clara County expected of Criminal Justice FACT program:

i. Timeliness and Access

The FACT program shall monitor its compliance with the timeliness and access requirements as set forth in Code of Federal Regulations (CFR) 42, Section 438. The FSP program must adhere to these requirements for all geographic areas within Santa Clara County and adhere to the State standards for time and distance requirements. Based on population density, the FACT program must provide behavioral health services within ten (10) working days. Services must be accessible within fifteen (15) miles or thirty (30) minutes from a beneficiary's residence.

ii. Engagement in Services (Timeliness/Access)

a. Performance Objective: Decrease the number of business days from the date of request to an appointment being offered for mental health services to ten (10) days.
b. Performance Objective: Decrease the percent of open client no shows to 25%.

iii. Successful Discharges (Quality)

a. Performance Objective: Increase the percent of successful discharges to 60%.

iv. Acute Care Readmissions (Quality)

a. Targeted System Performance: No more than 5% of clients receiving inpatient hospital services are readmitted within thirty (30) days.
b. Metric: Number and percentage of clients discharging from acute care services who are readmitted within thirty (30) days for any reason.
c. Improvement Objective: Reduce the percentage of clients receiving inpatient hospital services who are readmitted within thirty (30) days to no more than 7%.

v. Successful Discharges (Quality)

a. Targeted System Performance: At least 60% of discharges are successful, as measured by Milestones of Recovery Scales (MORS).
b. Metric: Number and percentage of clients who discharged successfully from a program (as indicated by change in MORS scores).
c. Improvement Objective: Increase the number of clients who successfully discharge to at least 35%, as indicated by improvement in MORS score at discharge.

The following evidence-based practice standard and promising practice standard are established by Santa Clara County expected of Criminal Justice FACT program. The FACT program shall document that all staff have been trained in accordance with licensing requirements.

i. Criminal Thinking
ii. Thinking for Change
iii. Cognitive Behavioral Therapy (CBT)
iv. Trauma-Focused CBT (TF-CBT)

v. Family Therapy
vi. Motivational Enhancement Therapy (MET)
vii. Dialectical Behavioral Therapy (DBT)
viii. Stages of Change Model

In addition to licensing requirements, the FACT program staff shall have the following additional experience, training and skills:

i. Each FACT CJS team shall have specific expertise in working with their target population.
ii. FACT CJS teams shall reflect the ethnic, cultural, and linguistically diverse target populations.
iii. Desirable staff skills include Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT), Motivational Interviewing, criminal thinking, experience working with adult victims of abuse and trauma, personality disorders, dual diagnosis, and co-occurring disorders.
iv. Use of peer support and/or family/caregiver partners is highly encouraged.
v. Confidentiality
vi. Crisis Assessment and Intervention
vii. Understanding of Wellness and Recovery Principles
viii. Knowledge of local community resources available to the client population, including self-help centers and ethnic community resources
ix. Understanding of the BHSD System of Care
x. Capability to collaborate and coordinate with local providers of health and human services.
xi. Mental health treatment (including comprehensive and individualized assessments and care/treatment plans, individual and group therapy, and psychiatric services)
xii. Risk assessments that assess the likelihood for re-offending/re-arrest
xiii. Chemical dependency/substance use treatment (individual and group treatment) including 12-step programs.
xiv. Medication management and education
xv. 24-hour crisis intervention services and immediate support
xvi. Assertive community-based outreach and engagement services
xvii. Support and advocacy while incarcerated or hospitalized.
xviii. Self-management and skills training (includes symptom management)
xix. Physical health screenings and care coordination for other medical needs
xx. Immediate linkage to necessary basic needs, such as food and clothing
xxi. Immediate assistance with securing appropriate supported housing arrangements, including linking to safe and permanent housing upon graduation from the program.
xxii. Assistance with applying and gaining access to Medi-Cal and an income source (e.g., General Assistance [GA], Supplemental Security Income [SSI], etc.)
xxiii. Vocational/educational support and linkages (e.g., community colleges, technical/trade schools, universities, etc.) that shall contribute to long-term employment and community stability.
xxiv. Community integration through social activities and outings that shall assist in building pro-social skills
xxv. Peer support services
xxvi. Transition planning that begins at assessment, with step down planning as part of the client's overall plan; and
xxvii. Housing support services for Incompetent to Stand Trial (IST) clients and non-IST clients.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**

0 – 15 years		
16 -25 years	19	9%
26- 59 years	175	83%
60+ years	17	8%
Prefer not to answer		
Unknown		
Unduplicated Total	211	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native		
Asian	24	11.4%
Black or African American	36	17.1%
Native Hawaiian or Other Pacific Islander	1	0.5%
White/ Caucasian	68	32.2%
Other	68	32.2%
More than one race		
Prefer not to answer	3	1.4%
Unknown	11	5.2%
Unduplicated Total	211	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano	17	8.1%
Puerto Rican		
South American	1	0.5%
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino	54	25.6%
Hispanic or Latino Subtotal	72	

Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian	4	1.9%
Cambodian		
Chinese	2	0.9%
Eastern European		
European		
Filipino	4	1.9%
Japanese	1	0.5%
Korean		
Middle Eastern		
Vietnamese	7	3.3%
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	109	51.7%
Non-Hispanic or Non-Latino Subtotal	127	
More than one ethnicity		
Prefer not to answer	2	0.9%
Unknown	10	4.7%
Unduplicated Total	211	100.0%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	149	70.6%
Female	62	29.4%
Prefer not to answer		
Unknown		
Unduplicated Total	211	100.0%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**

Male	149	70.6%
Female	62	29.4%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	211	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown		
Unduplicated Total	Not Available – Data no required in system	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	205	97.2%
Spanish	4	1.9%
Vietnamese	2	0.9%
Chinese		
Tagalog		

Farsi		
Other		
Prefer not to answer		
Unknown		
Unduplicated Total	211	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran	1	0.5%
Served in Military		
Family of Military		
No Military	19	9.0%
Prefer not to answer		
Unknown	191	90.5%
Unduplicated Total	211	100.0%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability	3	1.4%
No Disability		
Prefer not to answer		
Unknown	208	98.6%
Unduplicated Total	211	100%

*Participants may choose more than one option for Disability.

6. Additional FSP Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Imminent risk of homelessness		
Jail Transitioning Program		
Literally Homeless		
Not Homeless		
Other		
Unknown	211	100.0%
Unduplicated Total	211	100%

	FY 2023	
Educational Status	**# Served**	**% of Served**
Associate degree	11	5.2%
Bachelors Degree	9	4.3%
Elementary School	11	5.2%
GED	7	3.3%
High School	111	52.6%
Masters Degree	3	1.4%
Middle School	7	3.3%
None	2	0.9%
Other	7	3.3%
Unknown	43	20.4%
Unduplicated Total	211	100.0%

	FY 2023	
Employment Status	**# Served**	**% of Served**
Disabled	3	1.4%
Employed Student/Part Time		
Full Time	7	3.3%

Other		
Part Time	7	3.3%
School, Part Time	2	0.9%
Unemployed Looking for Work	3	1.4%
Unemployed/Not Seeking Employment	160	75.8%
Unknown	29	13.7%
Unduplicated Total	211	86.3%

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Not available- system does not collect this level of detail		
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Not available- system does not collect this level of detail		
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Not available- system does not collect this level of detail		
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Not available- system does not collect this level of detail		

Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Not available- system does not collect this level of detail		
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to service (Separate out service that is provided, funded administered, or overseen by county mental health versus service that is not)	**Kind of service to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in service** (for service that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in service (defined as participating at least once in the service to which referred) and standard deviation** (for referrals to service that are provided by or overseen by county mental health)
322	FACT	120	153	15

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
5 per week		10-15 attendees per group

9. Detailed Outcomes

Per FY23 February 2023 Year-To-Date Report, FACT outcomes and performances are as followed:

i. Unduplicated clients overserved by 20 for FACT Track I and 7 for FACT Track II
ii. Units of Service underutilized by 767,524 for FACT Track I and 165,203 for Fact Track II
iii. Annual budget underspent by -81.91% for FACT Track I and -88.15% for FACT Track II
iv. Dosage underutilized by 10.46 hours for FACT Track I and 11.26 hours for FACT Track II

v. Case management services underdelivered by 13.77% for Track I and 10.67% for Track II
vi. Mental health services overdelivered by 13.49% for Track I and 7.77% for Track II

10. Evaluation Summary

In FY2023, Criminal Justice FACT program continued to have underperformed in units of services and dosage utilization. To reflect the program utilization trend, contracted dosage is decreased from 14 to 12 hours for FY2023.

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The County's Criminal Justice FSP program seeks to engage justice involved individuals with severe mental illness into intensive, wraparound services with a low staff to consumer ratio (1:10), and provide a "whatever it takes" approach to:

i. Promote recovery and increased quality of life;
ii. Decrease negative outcomes such as incarceration, hospitalization, and homelessness; and
iii. Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports (e.g., psychosocial outcomes).

For adults, the following criteria must be met for Criminal Justice FSP enrollment:

i. Must be on parole or probation.
ii. Their mental disorder results in substantial functional impairments or symptoms, or they have a psychiatric history that shows that, without treatment, there is an imminent risk of decompensation with substantial impairments or symptoms.
iii. Due to mental functional impairment and circumstances, they are likely to become so disabled as to require public assistance, services, or entitlements; and
iv. They are in one of the following situations:

    a. They are unserved and experiencing one of the following:
        - Homeless or at-risk of becoming homeless.
        - Involved in the criminal justice system; and/or
        - Frequent users of hospital or emergency room services as the primary resource for mental health treatment.
    b. They are underserved and at-risk of one of the following:
        - Homelessness
        - Further involvement in the criminal justice system; and/or
        - Institutionalization

FSP programs provide a collaborative relationship between the County, the consumer, and— when appropriate— the consumer's family. Through this partnership, providers plan for and provide a full spectrum of community services so that the consumer can achieve his/her identified goals and reduce their criminogenic risks and needs.

FSPs provide Justice involved FSP consumers with the full spectrum of community services necessary to attain the goals identified in each person's Individual Services and Supports Plan (ISSP), as well as any services that may be deemed necessary through collaborative planning between the County, the consumer, and/or the consumer's family to address unforeseen circumstances in the consumer's life that could be, but have not yet been included in the ISSP. As a part of this process, a criminogenic risk and needs assessment is performed on

adults enrolled in the Criminal Justice FSP, and consumers are connected with programs to address areas such as criminogenic thinking and antisocial behavior. The services to be provided may also include services that the County, in collaboration with the consumer and when appropriate the consumer's family, believe are necessary to address unforeseen circumstances in the consumer's life that could be, but have not yet been included in the ISSP. The full spectrum of community services that must be available for inclusion in a person's ISSP consists of the following:

i. Mental health services and supports including, but not limited to:

   a. Mental health treatment, including alternative and culturally specific treatments o Peer support
   b. Supportive services to assist the consumer, and when appropriate the consumer's family, in obtaining and maintaining employment, housing, and/or education
   c. Wellness centers
   d. Alternative treatment and culturally specific treatment approaches
   e. Personal service coordination/case management to assist the consumer, and when appropriate the consumer's family, to access needed medical, educational, social, vocational rehabilitative and/or other community services
   f. Needs assessment
   g. ISSP development
   h. Crisis intervention/stabilization services
   i. Family education services
   j. Medication support services
   k. Re-engagement

ii. Non-mental health services and supports including, but not limited to:

   a. Food
   b. Clothing
   c. Housing, including, but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing
   d. Cost of health care treatment
   e. Cost of treatment of co-occurring conditions, such as substance abuse
   f. Respite care
   g. Criminogenic thinking

Service capacity increased by 50 in Fiscal Year 2022 and will be fully functional by Fiscal Year 2023.

In the FY24 and FY25 annual plan update, a Division name change will be reflected. The Criminal Justice Services (CJS) Division changed its name to the Forensic, Diversion and Reintegration (FDR) Division. This change was officially announced in the FY23 SLC meetings.

2. Program Goals, Objectives & Outcomes

❖ **Outcomes**

i. Promote recovery and increase quality of life
ii. Decrease negative outcomes such as hospitalization, incarceration, and homelessness
iii. Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 700		
Number Served	Program Expenditure	Cost per Person
700	$ 6,747,721	$ 9,639.60

4. Evaluation Activities

The following outcomes and measures are established by Santa Clara County expected of Criminal Justice FSP program:

i. Timeliness and Access

The FSP program shall monitor its compliance with the timeliness and access requirements as set forth in Code of Federal Regulations (CFR) 42, Section 438. The FSP program must adhere to these requirements for all geographic areas within Santa Clara County and adhere to the State standards for time and distance requirements. Based on population density, the FSP program must provide behavioral health services within ten (10) working days. Services must be accessible within fifteen (15) miles or thirty (30) minutes from a beneficiary's residence.

ii. Engagement in Services (Timeliness/Access)

a. Performance Objective: Decrease the number of business days from the date of request to an appointment being offered for mental health services to ten (10) days.
b. Performance Objective: Decrease the percent of open client no shows to 25%.

iii. Successful Discharges (Quality)

a. Performance Objective: Increase the percent of successful discharges to 60%.

iv. Acute Care Readmissions (Quality)

a. Targeted System Performance: No more than 5% of clients receiving inpatient hospital services are readmitted within thirty (30) days.
b. Metric: Number and percentage of clients discharging from acute care services who are readmitted within thirty (30) days for any reason.
c. Improvement Objective: Reduce the percentage of clients receiving inpatient hospital services who are readmitted within thirty (30) days to no more than 7%.

v. Successful Discharges (Quality)

a. Targeted System Performance: At least 60% of discharges are successful, as measured by Milestones of Recovery Scales (MORS).
b. Metric: Number and percentage of clients who discharged successfully from a program (as indicated by change in MORS scores).
c. Improvement Objective: Increase the number of clients who successfully discharge to at least 35%, as indicated by improvement in MORS score at discharge.

The following evidence-based practice standard and promising practice standard are established by Santa Clara County expected of Criminal Justice FSP program. The FSP program shall document that all staff have been trained in accordance with licensing requirements. In addition to licensing requirements, the FSP program staff shall have the following additional experience, training and skills:

a. Each FSP CJS team shall have specific expertise in working with their target population.
b. FSP CJS teams shall reflect the ethnic, cultural, and linguistically diverse target populations.

c. Desirable staff skills include Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT), Motivational Interviewing, criminal thinking, experience working with adult victims of abuse and trauma, personality disorders, dual diagnosis, and co-occurring disorders.
d. Use of peer support and/or family/caregiver partners is highly encouraged.
e. Confidentiality
f. Crisis Assessment and Intervention
g. Understanding of Wellness and Recovery Principles
h. Knowledge of local community resources available to the client population, including self-help centers and ethnic community resources
i. Understanding of the BHSD System of Care
j. Capability to collaborate and coordinate with local providers of health and human services.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	1	0.1%
16 -25 years	56	8.0%
26- 59 years	601	85.9%
60+ years	42	6.0%
Prefer not to answer		
Unknown		
Unduplicated Total	700	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	12	1.7%
Asian	69	9.9%
Black or African American	79	11.3%
Native Hawaiian or Other Pacific Islander	6	0.9%
White/ Caucasian	181	25.9%
Other	281	40.1%
More than one race		
Prefer not to answer	8	1.1%

Unknown	64	9.1%
Unduplicated Total	700	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano	102	14.6%
Puerto Rican	1	0.1%
South American	11	1.6%
Hispanic/ Latino (undefined)	186	26.6%
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	300	
African		
Asian Indian/ South Asian	6	0.9%
Cambodian	4	0.6%
Chinese	4	0.6%
Eastern European		
European	2	0.3%
Filipino	13	1.9%
Japanese	1	0.1%
Korean		
Middle Eastern	3	0.4%
Vietnamese	26	3.7%
Non-Hispanic/ Non-Latino (undefined)	10	1.4%
Other Non-Hispanic/ Non-Latino	262	37.4%
Non-Hispanic or Non-Latino Subtotal	335	

More than one ethnicity		
Prefer not to answer	6	0.9%
Unknown	59	8.4%
Unduplicated Total	700	100.0%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	521	74.4%
Female	179	25.6%
Prefer not to answer		
Unknown		
Unduplicated Total	700	100.0%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	521	74.4%
Female	179	25.6%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	700	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**

Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown		
Unduplicated Total	Not Available – Not a required field in system	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	642	91.7%
Spanish	36	5.1%
Vietnamese	6	0.9%
Chinese	1	0.1%
Tagalog	2	0.3%
Farsi		
Other	9	1.3%
Prefer not to answer		
Unknown	4	0.6%
Unduplicated Total	700	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran	6	0.9%
Served in Military		
Family of Military		
No Military	303	43.3%

Prefer not to answer		
Unknown	391	55.9%
Unduplicated Total	700	100.0%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability	48	6.9%
No Disability		
Prefer not to answer		
Unknown	652	93.1%
Unduplicated Total	700	100%

*Participants may choose more than one option for Disability.

6. Additional FSP Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Imminent risk of homelessness	8	1.1%
In a Homeless Shelter		
Jail Transitioning Program		
Literally Homeless	11	1.6%
Not Homeless	58	8.3%
On the Streets	3	0.4%
Other	14	2.0%
Shelter/Motel	3	0.4%
Street, bus, Car. Camping	1	0.1%

Transitional Housing	3	0.4%
Unknown	599	85.6%
Unduplicated Total	700	100%

	FY 2023	
Educational Status	**# Served**	**% of Served**
Associate degree	36	5.1%
Bachelors Degree	26	3.7%
Doctorate Degree	6	0.9%
Elementary School	16	2.3%
GED	54	7.7%
High School	387	55.3%
Masters Degree	2	0.3%
Middle School	30	4.3%
None	2	0.3%
Other	58	8.3%
Unknown	83	11.9%
Unduplicated Total	700	100.0%

	FY 2023	
Employment Status	**# Served**	**% of Served**
Disabled	48	6.9%
FT homemaker		
Employed Student/Part Time	3	0.4%
Full Time	24	3.4%

Other	2	0.3%
Part Time	82	11.7%
School, Full Time	4	0.6%
School, Part Time	1	0.1%
Unemployed Looking For Work	155	22.1%
Unemployed/Not Seeking Employment	343	49.0%
Unknown	38	5.4%
Unduplicated Total	700	94.6%

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Not Available- system does not collect this data		
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Not Available- system does not collect this data		
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Not Available- system does not collect this data		
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Not Available- system does not collect this data		
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Not Available- system does not collect this data		
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to service (Separate out service that is provided, funded administered, or overseen by county mental health versus service that is not)	**Kind of service to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in service** (for service that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in service (defined as participating at least once in the service to which referred) and standard deviation** (for referrals to service that are provided by or overseen by county mental health)
664	FSP	373	93 days	13 days

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	**Attendance**	**Average Attendance per Group**

Gardner: 7 groups per week Community Solutions: 11 groups	Gardner: 60 attendees per week	Community Solutions: 5-16 attendees per group

9. Detailed Outcomes

Per FY23 February 2023 Year-To-Date Report, FSP outcomes and performances are as followed:

i. Unduplicated clients overserved by 122 for Community Solutions and 183 for Gardner
ii. Units of Service underutilized by 637,573 for Community Solutions and 239,905 for Gardner
iii. Annual budget underspent by an average of -61.4% for Community Solutions and -30% for Gardner.
iv. Dosage underutilized by 4.73 hours for Community Solutions and 3.18 hours for Gardner.
v. Case management services underdelivered by 31.52% for Community Solutions and on target for Gardner
vi. Mental health services overdelivered by 28.56 % for Community Solutions and on target for Gardner

10. Evaluation Summary

In FY2023, Criminal Justice FSP program continued to have overserved and performed on target. To meet the needs of our justice involved population, an increase of $982,265 was approved by the MHSA stakeholders and Board of Supervisor to support the service capacity increase by 50 slots, effective of FY2023. Service dosage will remain the same on average of 8 hours per month per client.

OLDER ADULT FULL-SERVICE PARTNERSHIP (OAFSP)

CSS Full-Service Partnership (FSP) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The County's Older Adult (60 and older) Full Services Partnership (OAFSP) program is a Community Contract Provider (CCP)operated program with services provided by one CCP: Community Solutions. OAFSP provides intensive wraparound services to Older Adult's with severe mental illness in a low staff to consumer ratio (1:10) through a "whatever it takes" approach, to:

- Promote recovery and increased quality of life.
- Decrease negative outcomes such as Mental Health stigma, incarceration, hospitalization, and homelessness; and
- Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports (e.g., psychosocial outcomes). This program offers intensive services designed to meet the unique biopsychosocial needs of older adults ages 60 and above. OAFSP services are client- and family-driven and designed for older adults at risk of inappropriate or premature out-of-home placement due to a serious mental illness and— in many instances— co-occurring medical conditions that impact their ability to remain in their home and community environments. OAFSP services are client- and family-driven and designed for older adults at risk of inappropriate or premature out-of-home placement due to a serious mental illness and— in many instances—co-occurring medical conditions that impact their ability to remain in their home and community environments.

Additionally, the program was designed to provide full spectrum of community services necessary to attain each consumer's quality of life goals that reflect their cultural values, which may include living arrangements, social supports, education, and employment.

2. Program Goals, Objectives & Outcomes

❖ **Goals**

i. The program was designed to reduce homelessness and increase safe and permanent housing:
ii. Increase access to substance abuse treatment.
iii. Increase natural networks of supportive relationships
iv. Increase self-help and client/family involvement.

❖ **Objectives**

The OAFSP program provides services that align with Adult FSP but directed at the isolated Older Adults who are homebound. The program was created to engage underserved consumers who have not benefitted from traditional outpatient mental health services due to complex risk factors including substance abuse; community violence; interpersonal family violence; general neglect and exposure to trauma; social and emotional isolation; and physical decline and losses by providing culturally and linguistically proficient services 24/7. Also, Older Adults may experience increase recovery and improvement to their quality of life.

❖ **Outcomes**

Based on the number of clients served for this period, the program has been functioning above and beyond

expectations regarding the number of consumers contracted and served.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 29		
Number Served	**Program Expenditure**	**Cost per Person**
43	$392,629	$9,130.91

4. Evaluation Activities

The following outcomes and measures are established by Santa Clara County expected of OAFSP program:

v. Timeliness and Access

The OAFSP program shall monitor its compliance with the timeliness and access requirements as set forth in Code of Federal Regulations (CFR) 42, Section 438. The OAFSP program must adhere to these requirements for all geographic areas within Santa Clara County and adhere to the State standards for time and distance requirements. Based on population density, the OAFSP program must provide behavioral health services within ten (10) working days. Services must be accessible within fifteen (15) miles or thirty (30) minutes from a beneficiary's residence.

vi. Engagement in Services (Timeliness/Access)

a. Performance Objective: Decrease the number of business days from the date of request to an appointment being offered for mental health services to ten (10) days.
b. Performance Objective: Decrease the percent of open client no shows to 25%.

vii. Successful Discharges (Quality)

Performance Objective: Increase the percent of successful discharges to 60%.

viii. Acute Care Readmissions (Quality)

a. Targeted System Performance: No more than 5% of clients receiving inpatient hospital services are readmitted within thirty (30) days.
b. Metric: Number and percentage of clients discharging from acute care services who are readmitted within thirty (30) days for any reason.
c. Improvement Objective: Reduce the percentage of clients receiving inpatient hospital services who are readmitted within thirty (30) days to no more than 7%.

The following evidence-based practice standard and promising practice standard are established by Santa Clara County expected of the OAFSP program. The OAFSP program shall document that all staff have been trained in accordance with licensing requirements. In addition to licensing requirements, the OAFSP program staff shall have the following additional experience, training and skills:

i. Each OAFSP team shall have specific expertise in working with their target population
ii. OAFSP teams shall reflect the ethnic, cultural, and linguistically diverse target populations
iii. Desirable staff skills include Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT), Motivational Interviewing, experience working with adult victims of abuse and trauma, dual diagnosis, and co-occurring disorders
iv. Use of peer support and/or family/caregiver partners is highly encouraged

v. Confidentiality
vi. Crisis Assessment and Intervention
vii. Understanding of Wellness and Recovery Principles
viii. Knowledge of local community resources available to the client population, including self-help centers and ethnic community resources
ix. Understanding of the BHSD System of Care
x. Capability to collaborate and coordinate with local providers of health and human services

5. Demographic Data

The demographics in section 5 were reported by BHSD Analytics and Reporting Unit. The data came from two electronic records systems Unicare and myAvatar, as contract providers were still being onboarded into myAvatar throughout FY23. Care was taken to remove any duplicates, however, some inconsistencies between county level data and provider-reported data remained. This should be resolved in the next FY when all programs' data will be sourced from myAvatar.

	FY 2023	
Age Group	**# Served**	**% of Served**
60+ years	29	100%
Unduplicated Total	29	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	1	3%
Asian	3	10%
Black or African American	3	10%
White/ Caucasian	13	45%
Other	7	24%
Unknown	2	7%
Unduplicated Total	29	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Caribbean	1	3%
Central American	1	3%
Other Hispanic/ Latino	4	14%
Other Non-Hispanic/ Non-Latino	20	69%
Unknown	3	10%

Unduplicated Total	29	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Female	17	59%
Male	12	41%
Unduplicated Total	29	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Female	17	59%
Male	12	41%
Unduplicated Total	29	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Heterosexual/ Straight	18	62%
Prefer not to answer	3	10%
Unknown	8	28%
Unduplicated Total	29	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
Chinese	1	3%
English	24	83%
Other	1	3%
Spanish	3	10%
Unduplicated Total	29	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Unknown	29	100%
Unduplicated Total	29%	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
No Disability	1	3%
Other	5	17%
Other non-communication disability	23	79%
Unduplicated Total	29	100%

*Participants may choose more than one option for Disability.

6. Additional FSP Data Collection Requirements

Below data is not available due to CCPs not currently tracking this in their EHRs. In the future, BHSD A&R Division is working on tracking this data set for the following year when they are available in myAvatar. Additionally, BHSD needs support from MHSA to clarify and standardize the data definition in order for the BHSD A&R Division to report on.

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unknown	29	100%
Unduplicated Total	29	100%

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unknown	29	100%
Unduplicated Total	29	100%

	FY 2023	
Employment Status	**# Served**	**% of Served**

Unknown	29	100%
Unduplicated Total	29	100%

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unknown	29	100%
Unduplicated Total	29	100%

	FY 2023	
Health Status	**# Served**	**% of Served**
Unknown	29	100%
Unduplicated Total	29	100%

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unknown	29	100%
Unduplicated Total	29	100%

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unknown	29	100%
Unduplicated Total	29	100%

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**

Unknown	29	100%
Unduplicated Total	29	100%

7. Referrals

FY 2023				
Unduplicated N = 29				
Number of individuals with serious mental illness referred to service (Separate out service that is provided, funded administered, or overseen by county mental health versus service that is not)	**Kind of service to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in service** (for service that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in service (defined as participating at least once in the service to which referred) and standard deviation** (for referrals to service that are provided by or overseen by county mental health)
Per BHSD QM, a total of 12 referrals were received.	OAFSP Adult provides Mental Health services including case management to link clients to community resources, individual rehabilitation to educate clients on life functioning skills, therapy to allow clients to process underlying issues and learn healthy coping skills, collateral to educate client's support persons on their mental health condition and teach supportive skills, and psychiatric support services to provide medication management and education from a psychiatrist and psychiatric nurse	Per BHSD QM, out of 12 referrals received 5 of them were opened and followed through on the referral.	Prior to OAFSP, clients have either engaged in Emergency services or came from another level of care and had been triaged prior to intake.	4 – 6 days

8. Group Services Delivered

Below data is collected and provided by Community Solutions who is the only CCP providing OAFSP. Community Solutions offers one group per week with an average attendance per group around 9. Since the group is open to all FSP, OAFSP, and IFSP clients, the total attendance may not be representative for OAFSP.

FY 2023
Unduplicated N = 29

Number of Groups	Attendance	Average Attendance per Group
1	468	9

9. Detailed Outcomes

Due to ongoing transition into myAvatar during FY 23, there are some discrepancies between county records and provider-reports on charges for services, admissions, discharges, and timeliness. The outcomes indicators data are affected by these discrepancies, and we are working on resolving the issues for the future reports. The following is based on the data available in county records per FY23 MHSA Outcomes July22-Jun23 provided BHSD Quality Management and Unduplicated Client Count Data provided by BHSD A&R Division. OAFSP outcomes and performances are as followed:

i. Out of 25 contracted capacity, 29 unduplicated clients were served. Unduplicated clients overserved by 4 or 16%.
ii. Number of referrals received is 12 and out of which 5 were opened. Conversion rate is 42%.
iii. Percentage of Clients Received Assessment Appointment within 10 Business Days is on average 25%.
iv. Average Days to First Offered Assessment Appointment is 17.17 days.
v. Number of discharges is 11 and out of which 5 were successful. Successful discharge rate is 45%.

10. Evaluation Summary

In FY23 the OAFSP program has been able has had an improvement in client “productivity” and “housing stability” within the first 180 days of treatment. Staff have been modeling the “whatever it takes” approach by being in the community and wrapping clients with whole person support and continue to benefit from MHSA funding. Program goals such as reducing hospitalizations have seen success as well.
OAFSP program staff continued to use Evidence-Based Practices and work diligently to provide the support to the target population. While CalAIMs was presented mid-year, OAFSP provider learned to quickly adapt to the CalAIMs expectations and has been succeeding in the implementation.

GENERAL SYSTEM DEVELOPMENT PROGRAMS

Permanent Supportive Housing Program

The Permanent Supportive Housing program in Santa Clara County covers 2 different programs.

1. Permanent Supportive Housing Program
2. Abode HEAT (Homeless Engagement and Access Team)

The total cost per person, across all programs in this category can be found below. The following pages are detailed reports for each individual program in this category.

FY 2023		
Number Served	Program Expenditure	Cost per Person
875	$ 3,660,503	$4,183.43

PERMANENT SUPPORTIVE HOUSING (PSH)

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Permanent Supportive Housing (PSH) –
Care Connection combines low-barrier affordable housing, health care, and supportive services to help individuals with mental illness and their families to lead more stable lives. The PSH model incorporates mobile care teams and peer case managers to support individuals with mental illness who need intensive outpatient treatment, and who are not currently enrolled in a Full-Service Partnership or other PSH program, with the goal of enabling them to successfully obtain and maintain housing as a part of their recovery. The program uses "whatever it takes" approach to help individuals who experience mental health issues and are homeless or otherwise unstably housed; experience multiple barriers to housing; and are unable to maintain housing stability without supportive services. Key components of PSH-Care Connection that facilitate successful housing tenure include:

i. Individually tailored and flexible supportive services that are voluntary, can be accessed 24 hours a 7 day a week, and are not a condition of ongoing tenancy;
ii. Leases that are held by the tenants without limits on length of stay; and
iii. Ongoing collaboration between service providers, property managers, and tenants to preserve tenancy and resolve crisis situations that may arise.

This model has been shown to not only impact housing status, but also result in cost savings to various public service systems, including health care.

2. Program Goals, Objectives & Outcomes

❖ Goals

O&E will use KPIs or expand on current methodology: Point of greatest challenge and most recent scores DLA-20 scores are reported based on n= 70 matched pairs of clients for point of greatest challenge and most recent scores.

i. Reduce subjective suffering from mental illness
    a. DLA-20 Overall Score, combined Improved and Maintained WNL: 47 (43.52%) clients from n=108 clients with at least one or more DAL-20 total score. Different sample size (n) is based on there being an allowable tolerance for missing items producing a valid overall score.
ii. Increase meaningful use of time and capabilities in school, work, and activity
    a. DLA-20 Productive Domain, combined Improved and Maintained WNL: 16 (22.86%) clients
iii. Reduce homelessness and increase safe and permanent housing
    a. DLA-20 Housing Item, combined Improved and Maintained WNL: 19 (27.14%) clients 120
    b. Program housed clients: 92.86% of clients housed at end of FY21-22
    c. The number of clients housed (130) vs unhoused (10) at end of FY21-22
iv. Increase access to substance use treatment

a. The program does not currently track substance use treatment access, but will develop a way to track this data in the next FY.

v. Increase natural networks of supportive relationships

a. DLA-20 Item #13 re: supportive relationships: 13 (18.57%) clients increased supportive relationships

vi. Reduce incarceration/criminal justice involvement

a. DLA-20 Behavioral Norms Item, combined Improved and Maintained WNL: 20 (28.57%) clients improved behavioral norms and stayed within normal limits

vii. Increase self-help and client/family involvement

a. The data gathered from the DLA-20 does not clearly answer this question.

❖ Objectives

i. 80% of clients enrolled in Intensive Case Management (ICM) shall work with the Intensive Case Manager aggressively to obtain housing within sixty (60) days of Enrollment.

a. Program housed clients: 92.86% of clients housed at end of FY21-22
b. The number of clients housed (130) vs unhoused (10) at end of FY21-22
c. Unable to pull data to determine how quickly individuals were housed.

ii. 75% of clients enrolled in ICM shall have access to sufficient resources to meet their basic needs.

a. DLA-20 Item 8: Problem Solve 11 (15.71%) clients

iii. 75% of clients shall have incomes equal to or greater than $850 per month within one hundred eighty (180) days of enrollment in ICM.

a. The number of clients who have > 850$ (44) vs those below (96)
b. 31% of clients have an income of $850 or greater

iv. 100% of clients enrolled in ICM shall be connected to a medical home within sixty (60) Days.

a. 109 ICM clients connected to a medical home
b. 77% of ICM clients are currently connected to a medical home

v. 75% of clients in need of behavioral health services shall be referred to and/or assisted to utilize behavioral health services within ninety (90) days of being housed. –

a. 17 not connected to BH due to client declining services, 123 total clients connected to ICM case
b. 87% of ICM clients are connected to BH services.

vi. Reduce stigma and discrimination

a. Please see below answer

vii. Reduce and/or prevent suicide risk

a. Program does not currently have a data set that would accurately indicate the reduction of suicide risk.

viii. Increase the quality of services, including better outcomes

a. Please see outcomes data above

ix. Increase the ability of families being able to provide safe, stable, loving, and stimulating Homes

a. Program housed clients: 92.86% of clients housed at end of FY21-22
b. The number of clients housed (130) vs unhoused (10) at end of FY21-22
c. O&E: (Research & Pull-in/Analysis) DLA-20 Item #13 re: supportive family: 13 (18.57%) clients

❖ **Outcomes**

i. Remove barriers for obtaining and maintain housing as a part of recovery

   a. Program housed clients: 92.86% of clients housed at end of FY21-22
   b. The number of clients housed (130) vs unhoused (10) at end of FY21-22

ii. Decrease homelessness

   a. Program housed clients: 92.86% of clients housed at end of FY21-22
   b. The number of clients housed (130) vs unhoused (10) at end of FY21-22

iii. Increase stability and quality of life

   a. Please see other data measures above

iv. Reduce costs to various public service agencies, including health care (e.g., emergency room visits, inpatient hospital services)

   a. N/A, program does not currently have a system to track this.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 146 Clients (122 Households)		
Number Served	Program Expenditure	Cost per Person
146	See cover page	See cover page

4. Evaluation Activities

i. Access and Linkage

   a. The ICM programs support access to linkage through eligibility criteria VI-SPDAT which assesses client acuity, thereby helping to inform the type of support and housing intervention that may be most beneficial to improve long term housing outcomes. It also helps inform the order - or priority - in which people should be served. In addition to assessing for homelessness and acuity, ICM serves the highest percentage of clients with a high frequency of emergency psychiatric admissions and serious mental illness. Linkage to housing, a medical home, basic needs, income, and mental health services are all provided.

ii. Providing one or more mental health services and supports specified in 9 CCR § 3630

   a. All clients have access to obtaining mental health services directly through their case managers in ICM at Community Solutions. Currently we have ____ out of ___ clients enrolled in mental health services. The mental health services provided include case management, rehabilitation counseling services, group counseling, medication support services, collateral natural support services, treatment plan development and psychosocial and daily functioning assessment.

iii. Improving the county mental health service delivery system for all clients and their families

   a. The mental health services are imbedded in this program which combines housing case management and mental health services including include case management, rehabilitation counseling services, group counseling, medication support services, collateral natural support services, treatment plan development and psychosocial and daily functioning assessment. All clients are eligible to receive these services from Community Solutions through the ICM program.

iv. Developing and implementing strategies for reducing ethnic/racial disparities

a. Our program holds an awareness that homelessness impacts people of color at a disproportionate rate and therefore aims to serve our clients with ethnic and racial disparities. Strategies include housing rights training and awareness to reduce discrimination in housing. Furthermore, we aim to hire staff that reflect our client population and link clients with the appropriate provider to improve advocacy. The population of black and Hispanic clients we serve is disproportionately higher than the census population for black and Hispanic identifying residents in Santa Clara County.
b. ICM population 15.97% black, 2019 census for Santa Clara County 2.9% black
c. ICM population 44.54% Hispanic, 2019 census for Santa Clara County 17.4 % Hispanic
d. https://www.santaclaraca.gov/our-city/about-santa-clara/demographics#:~:text=White%20alone%2C%20not%20Hispanic%20or,or%20African%20American%20alone%3A%202.9%25

v. Peer support and family education support services

a. Collateral services are supported through the ICM program model which aims to educate and train family and other natural supports on our client's mental health symptoms, accompanying behaviors, and family approaches to interventions with our clients. ICM hires peer support staff who have lived experience similar to our population of focus. Additionally, clients are linked to AA and other peer-led community resources.

vi. Food, clothing, and shelter to engage unserved individuals, and when appropriate their families

a. Our population of underserved individuals have access to housing through their subsidized vouchers in PSH, we support them in accessing units that best fit their needs. We also work towards supporting our clients in having an income higher than $850 dollars or more monthly to allow them to have self-sufficiency in obtaining food and clothing. Additionally, our program is partnered with Saint Josephs in Morgan Hill to provide food boxes to our clients on a weekly basis, which our clients get linked to through our case managers. Donations and flex funds are utilized throughout the year to support our clients in meeting their basic needs.

In order to assess for client needs and challenge areas Community Solutions uses a system of assessments: These include MORS scores, DLA-20 assessments, and psychosocial mental health assessments.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	17	12%
16 -25 years	3	2%
26- 59 years	73	50%
60+ years	53	36%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	146	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	2	1%
Asian	0	0%
Black or African American	22	15%
Native Hawaiian or Other Pacific Islander	2	1%
White/ Caucasian	106	73%
Other	2	1%
More than one race	10	7%
Prefer not to answer	0	0%
Unknown	2	1%
Unduplicated Total	146	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	67	46%

Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal	79	54%
More than one ethnicity		
Prefer not to answer		
Unknown		
Unduplicated Total	146	

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	78	53%
Female	66	45%
Prefer not to answer		

Unknown	2	2%
Unduplicated Total	146	

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	78	53%
Female	66	45%
Transgender (Male to Female)		
Transgender (Female to Male)	1	1%
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity	1	1%
Prefer not to answer		
Unknown		
Unduplicated Total	146	

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	Not available	
Heterosexual/ Straight	Not available	
Bisexual	Not available	
Questioning/ Unsure	Not available	
Queer	Not available	
Another sexual orientation	Not available	
Prefer not to answer	Not available	
Unknown	Not available	
Unduplicated Total	Not available	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	132	90%
Spanish	4	3%
Vietnamese		
Chinese		
Tagalog		
Farsi		
Other	8	5%
Prefer not to answer		
Unknown	2	1%
Unduplicated Total	146	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran	3	2%
Served in Military		
Family of Military		
No Military	143	98%
Prefer not to answer		
Unknown		
Unduplicated Total	146	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive (Developmental)	17	12%
Physical/ Mobility	45	31%
Chronic Health Condition	49	34%
Other non-communication disability		
No Disability	19	13%

Prefer not to answer		
Unknown		
Unduplicated Total	146	100%

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Employment Status	**# Served**	**% of Served**
(Clients who reported earned income)	7	5%
Unduplicated Total		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Earned Income	7	7%
Social Security Retirement Income	4	4%
Unemployment Income	4	4%

Supplemental Security Income (SSI)	54	56%
General Assistance	26	27%
TANF	1	1%
Unduplicated Total	96	100%

	FY 2023	
Health Status	**# Served**	**% of Served**
Mental Health Disorder	118	81%
	28	19%
Unduplicated Total	146	100%

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Alcohol, Drug or Both	82	56%
	64	44%
Unduplicated Total	146	100%

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total	Not available	

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
N/A not tracked				

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
N/A not tracked		

9. Detailed Outcomes

In FY2023, 146 clients were served across 122 households. Please see above.

10. Evaluation Summary

The barriers to success that the ICM program face are client engagement challenges, staff retention, housing resource availability, rehousing clients who have had many placements, hoarding, substance use, and aging clients with high level health care needs. Additionally, clients have challenges obtaining SSI, due to long waiting times including the denial and appeal processes.
Some areas of system improvement we suggest are further assessment of referrals to determine readiness for self-sufficiency and independent living. More evaluation on the client's willingness to engage in behavioral health supports would benefit the program. Additionally, ICM would benefit from more of a continuum of care including higher levels of care and support (i.e.. Residential support, SLE, board and care, SNF) and adding more stability resources for clients on the HMIS queue who are awaiting permanent supportive housing.
As a result of these suggestions, we believe the client impact will be that clients will have more longevity remaining housed, decreased symptoms and high-risk behaviors with accessing higher levels of care temporarily. Additionally, we foresee improvement in client outcomes of independence and the decrease use of emergency medical systems and jails.

The program intends to develop measurement of substance use access and other demographic information not assessable for this report.

ABODE - HEAT

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Homeless Engagement and Access Team (HEAT)

The HEAT program is primarily aimed at improving behavioral health access and outcomes for homeless individuals. The strategies include prolonged outreach to reach a historically difficult to engage homeless population and linking people to the treatment they need early on in the onset to prevent negative consequences that can occur if mental illness is undiagnosed and/or untreated.

Abode is the contracted agency that provides HEAT Outreach services. This team of 5 (consisting of Rehabilitation counselors and MH Community Workers) will partner with the BHSD to try address a person's mental health, substance use disorder, and/or medical needs by building trust between the individual and the service teams and identifying opportunities through which other services can be provided. This specialized outreach team's primary role is to work with various stakeholders (e.g., emergency rooms, law enforcement, etc.) to identify unsheltered homeless individuals (or families) who are unable to accept or utilize services – even permanent housing – due to an untreated physical, cognitive, behavioral, or emotional impairment. While many of these individuals may have a serious mental illness and other disorders, their conditions may not rise to a level where they can be considered gravely disabled, a danger to themselves, or a danger to others. The team's responsibility is to try to build some level of rapport with the individuals over a period of time, help the individuals seek services that, at a minimum, would address their basic needs and reduce their impact on nearby businesses and residences. The team augments existing case-finding efforts by identifying and building rapport with 250 or more individuals who are or would be eligible for Permanent Supportive Housing (PSH) or Rapid Rehousing (RRH) programs. During a crisis, the HEAT program could utilize the services of the BHSD's Mobile Crisis Teams or Law Enforcement Liaisons.

2. Program Goals, Objectives & Outcomes

❖ **Outcome**

i. Remove barriers for obtaining and maintain housing as a part of recovery
ii. Decrease homelessness
iii. Increase stability and quality of life
iv. Reduce costs to various public service agencies, including health care (e.g., emergency room visits, inpatient hospital services)

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 146 Clients (122 Households)		
Number Served 729	Program Expenditure See cover page	Cost per Person See cover page

4. Evaluation Activities

HEAT outreach activities are entered into the Santa Clara County (SCC) Homeless Management Information System (HMIS). An HMIS is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families. Each Continuum of Care (CoC) is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards. SCC CoC has selected Bit Focus by Clarity as our HMIS. Client's data is input into HMIS upon intake once consents are obtained.

The HEAT team also utilizes the Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT) to determine individuals' eligibility for housing interventions. Use of a VI-SPDAT assessment tool is also a HUD requirement for all Coordinated Entry programs.

Coordinated entry is a consistent, community-wide intake process to match people experiencing homelessness to existing community resources that are best fit for their situation. In Santa Clara County's coordinated entry system, all homeless people complete a standard assessment tool (the VI-SPDAT) that considers the household's situation and identifies the best type of housing intervention to address their situation. A community queue of eligible households is generated from the standard assessment. The community queue is used to fill spaces in the various housing programs, including permanent supportive housing and rapid rehousing. Use of a coordinated assessment maximizes the use of available resources and minimizes the time and frustration people spend while trying to find assistance. It also identifies and quantifies housing and service gaps and thereby enables effective and efficient systems planning.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	4	1%
16 -25 years	38	5%
26- 59 years	628	86%
60+ years	59	8%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	729	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	9	

Asian	28	
Black or African American	132	
Native Hawaiian or Other Pacific Islander	8	
White/ Caucasian	162	
Other	0	
More than one race	327	
Prefer not to answer	5	
Unknown	7	
Unduplicated Total	729	

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	358	
Other Hispanic/ Latino		
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		

Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal	358	
More than one ethnicity		
Prefer not to answer	4	
Unknown	6	
Unduplicated Total	726	

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	338	
Female	386	
Prefer not to answer		
Unknown		
Unduplicated Total	724	

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	338	
Female	386	
Transgender (Male to Female)	1	
Transgender (Female to Male)		
Transgender (Undefined)	2	
Genderqueer		
Questioning or Unsure	1	
Another gender identity	1	
Prefer not to answer		
Unknown		
Unduplicated Total	729	

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	Not available	
Heterosexual/ Straight	Not available	
Bisexual	Not available	
Questioning/ Unsure	Not available	
Queer	Not available	
Another sexual orientation	Not available	
Prefer not to answer	Not available	
Unknown	Not available	
Unduplicated Total		

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	706	
Spanish	14	

Vietnamese	2	
Chinese		
Tagalog		
Farsi		
Other	1	
Prefer not to answer		
Unknown	2	
Unduplicated Total	725	

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran	15	
Served in Military		
Family of Military		
No Military	704	
Prefer not to answer	4	
Unknown		
Unduplicated Total	723	

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive (Developmental)	272	
Physical/ Mobility	316	
Chronic Health Condition	421	
Other non-communication disability		
No Disability	19	
Prefer not to answer		
Unknown		
Unduplicated Total	729	

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

Not tracked

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Employment Status	**# Served**	**% of Served**
(Clients who reported earned income)	158	
Unduplicated Total		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Earned Income	158	
Social Security Retirement Income	8	
Unemployment Income	9	
Supplemental Security Income (SSI)	148	
General Assistance	121	

TANF	16	
Unduplicated Total	96	100%

	FY 2023	
Health Status	**# Served**	**% of Served**
Mental Health Disorder	660	
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Alcohol, Drug or Both	517	
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
Not a collected data point in HMIS (Homeless Management Information System)				

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
N/A	N/A	

9. Detailed Outcomes

In FY2023, 729 clients were served. Please see above.

10. Evaluation Summary

Abode Services, HEAT program, has been successful in carrying out its intended purpose by connecting unhoused clients with serious mental illness to supportive housing interventions throughout Santa Clara County. The team consisted of Mental Health Outreach Clinicians and Outreach Wellness specialists, in collaboration with licensed clinicians from the Office of Supportive Housing, to render outreach services and linkage to acute mental health services.

Throughout the year, the HEAT program successfully collaborated with external stakeholders to concentrate outreach efforts to address the homelessness in the cities of Milpitas and Cupertino. Also, in collaboration with

local police departments in the County of Santa Clara, the team was able to support the unhoused with improving their living situation and minimizing rate of recidivism in those communities.

Throughout the year, Abode's HEAT staff provided informational materials about waste disposal, safe parking, emergency shelters and continued to coordinate care with the Office of Supportive Housing to support participants with obtaining necessary documentation for housing acquisition purposes. In conclusion, the team employed motivational interviewing techniques when engaging with the unhoused to foster healthy life change in participants and also utilized housing problem solving techniques to support the unhoused with exploring sustainable housing options outside of the emergency shelter system.

Children & Family Behavioral Health Outpatient Program

The Children & Family Behavioral Health Outpatient program in Santa Clara County covers 3 different programs.

1. Family & Children Behavioral Health Outpatient / Intensive Outpatient
2. Family & Children Behavioral Health Integrated Outpatient Services
3. Family & Children Ethnic Outpatient Services

The total cost per person, across all programs in this category can be found below. The following pages are detailed reports for each individual program in this category.

FY 2023		
Number Served	Program Expenditure	Cost per Person
5,490	$33,459,252	$6,094.58

FAMILY AND CHILDREN BEHAVIORAL HEALTH OUTPATIENT/ INTENSIVE OUTPATIENT SERVICES

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Family and Children's (F&C) Outpatient Continuum (OPC) program serves children and youth to help address mental health symptoms and associated functional impairments. The program provides a range of services that includes Intensive, Outpatient, and Wellness levels of service offering flexibility in service levels to meet the needs of the youth and family at the given time.

Intensive level of service provides a higher frequency of support to address symptoms, conditions, and/or risk factors that are impacting their ability to maintain themselves in community settings. Services include crisis response services as needed. Outpatient services provide support to address behavioral health challenges that impact life domains including, education, living situation, personal wellbeing, interpersonal relationships, and community functioning. Wellness services provide support to youth who may need short term medication management and light case management or lower frequency of support to sustain their wellness and recovery as the program is actively working on linking to long term medication support.

County of Santa Clara contracts with various community-based organizations that provide an array of F&C OPC support services for children and youth. OPC program serves children and youth ages 6 through 20, particularly those from unserved and underserved ethnic and cultural populations.

F&C OPC services include:

i. Individual, family, and/or group therapy
ii. Case management services
iii. Dual-diagnosis treatment
iv. Screening
v. Psychological assessment
vi. Service linkages
vii. Crisis intervention

2. Program Goals, Objectives & Outcomes

❖ **Outcome**

i. Reduce the need for a higher level of care for consumers.
ii. Reduce symptoms and impacts of mental illness for consumers who qualify for specialty mental health services.

3. Clients Served & Annual Cost per Client Data

FY 2023
Unduplicated N =4954

Number Served	Program Expenditure	Cost per Person
4954	See cover page	See cover page

**Data Sources: MHSA Unduplicated Client Count Data Report as of 8/18/23, and FY23 JUN YTD Finance Report (08-22-23)*

4. Evaluation Activities

F&C OPC Focus Areas & Evaluation Activities include:

During FY23 the F&C Outpatient and Intensive Outpatient program was combined into the F&C OPC program to help promote better access to care, more flexibility for when clients need higher and lower levels of service, and reduction of administrative burden. This program change was made in collaboration with County Contracted Providers (CCPs) to improve the service delivery for the County's Children, Youth and Family outpatient programming.

Evaluation occurs on a monthly and quarterly basis through reports and dashboards that show how many clients are referred to services and how many access in a timely manner. Feedback and discussion occur with CCPs regarding their performance. While conducting a qualitative review with 14 F&C OPC programs regarding which service level their F&C OPC youth were accessing 74% of youth were in the Outpatient service level, 17% in the Intensive service level, and 9% in their Wellness service level. When asked if the F&C CCPs receive referrals requesting for Same Day Access to services, seven CCPs reported that this is not a common request. Ten agencies stated that if same day access is requested by a family that they should be able to accommodate the request.

Youth and families that engage in F&C OPC services are provided assessment, Individual, family, and/or group therapy, case management, crisis intervention, and other linkage supports that may be warranted to meet the needs of the youth and family. As of June 2023, 58% of referred individuals accessed services and service providers retained an active caseload that was 92% full on average. F&C OPC services continue to evaluate the needs for increasing peer support and family education support services. Many contracted providers have employed more peer support staff to help families and provide alternative services that promotes health and well-being.

Service Providers utilize various evidence-based practices to support the needs of their youth and families. During assessment, every 6 months, and at discharge, service providers utilize the Child and Adolescent Needs and Strengths (CANS) to enhance their assessments and to help track client outcomes. The CANS also highlights the client's strengths, needs and progress over time. In evaluation of the CANS outcomes to identify performance of services, F&C OPC demonstrated improvement in all three evaluated domains, Behavioral Emotional Needs, Risk Behaviors, and Life Functioning: with the greatest positive change in a youth's Risk Behaviors. The providers also administer the Pediatric Symptom Checklist (PSC-35) for youth 18 and under at the same frequency as the CANS. Clients are also asked to participant in a yearly Satisfaction Survey, which help inform system change and improvement.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**

0 – 15 years	3204	65%
16 -25 years	1739	35%
26- 59 years	11	0%
60+ years		
Prefer not to answer		
Unknown		
Unduplicated Total	4954	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	17	0%
Asian	356	7%
Black or African American	104	2%
Native Hawaiian or Other Pacific Islander	14	0%
White/ Caucasian	454	9%
Other	2444	49%
More than one race	5	0%
Prefer not to answer	32	1%
Unknown	1528	31%
Unduplicated Total	4954	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		

Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	2829	57%
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	2829	57%
Non-Hispanic or Non-Latino as follows:		
African	1	0%
Asian Indian/ South Asian		
Cambodian		
Chinese	1	0%
Eastern European		
European		
Filipino		
Japanese		
Korean		
Mien	2	0%
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	723	15%
Non-Hispanic or Non-Latino Subtotal	727	15%
More than one ethnicity		

Prefer not to answer		
Unknown	1398	28%
Unduplicated Total	4954	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	2125	43%
Female	2790	56%
Prefer not to answer		
Unknown	39	1%
Unduplicated Total	4954	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male		
Female		
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	4954	100%
Unduplicated Total		

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		

Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	4954	100%
Unduplicated Total		

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	2764	56%
Spanish	1287	26%
Vietnamese	59	1%
Cantonese	6	0%
Chinese	5	0%
Mandarin	18	0%
Tagalog	2	0%
Farsi	7	0%
American Sign Language	7	0%
Other (Arabic 1, Croatian 1, Italian 1, Korean 2, Portuguese 5, Russian 3 & Turkish 2, 9)	24	0%
Prefer not to answer		
Unknown	775	16%
Unduplicated Total	4954	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran	4	0%
Served in Military		

Family of Military		
No Military	1219	25%
Prefer not to answer		
Unknown	3731	75%
Unduplicated Total	4954	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	7	0%
Difficulty hearing or speaking	12	0%
Other communication disability		
Cognitive	451	9%
Physical/ Mobility	3	0%
Chronic Health Condition		
Other non-communication disability	490	10%
No Disability	3991	81%
Prefer not to answer		
Unknown		
Unduplicated Total	4954	100%

*Participants may choose more than one option for Disability. *Data source for this section was the MHSA Unduplicated Client Count Data Report as of 8/18/23 report.*
Sexual orientation and Gender Identity data was not provided for this report.

6. Additional Data Collection Requirements

Data not available for FY23. The program is exploring ways to collect and report this data in future reporting

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Health Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total	Not Available	

7. Referrals

FY 2023

Unduplicated N =3206				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
3206	Outpatient Mental Health Treatment, EBPs & PPs	1861	12 days	8 to 17 days (F&C OPC Programs)

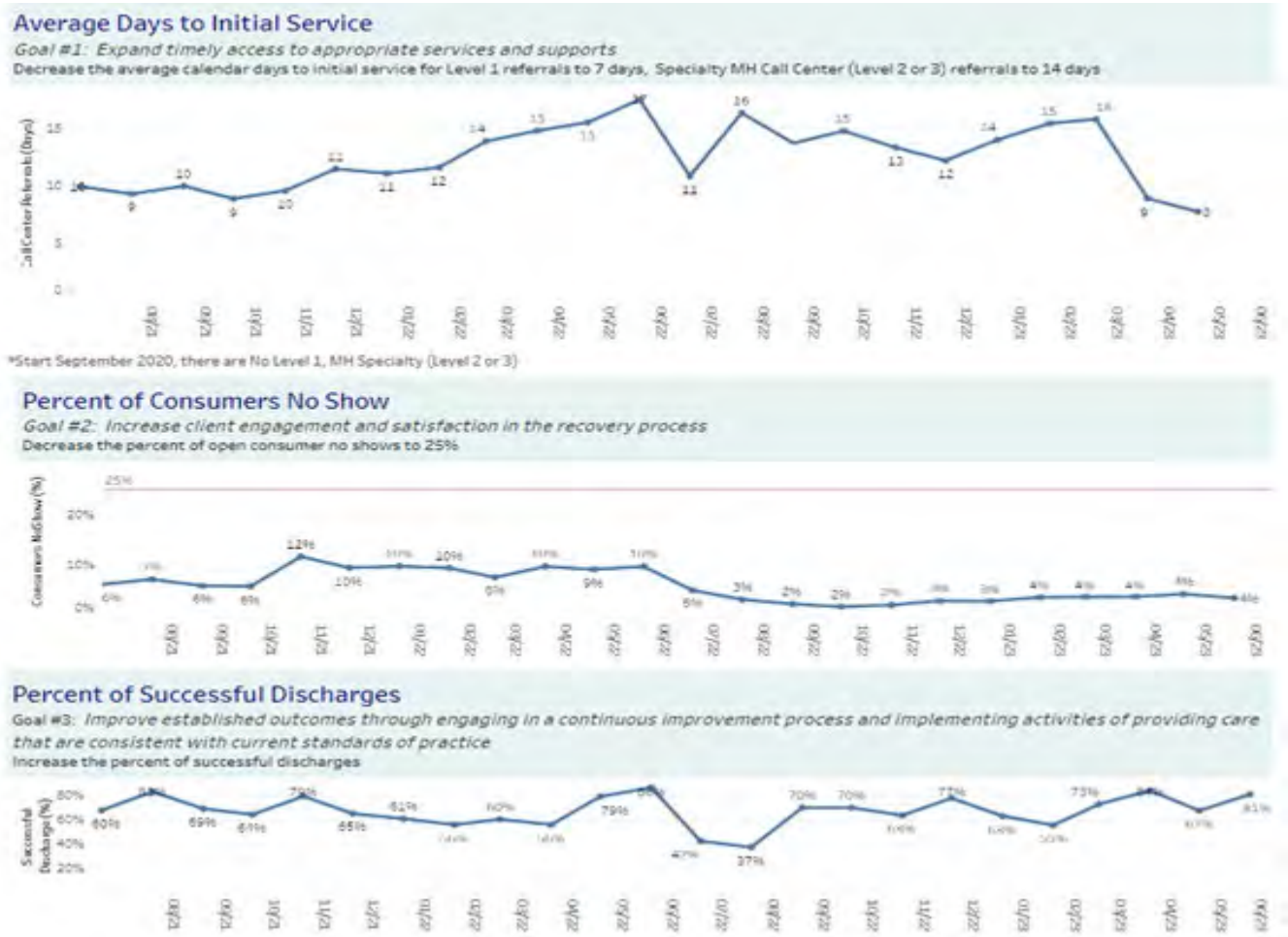
Data Source: MHSA- Outcomes July22-June23 (08-18-23) and PLM Dashboard

8. Group Services Delivered

Contracted providers provide various types of groups for clients and families that include social skills, treatment
orientation, child sexual abuse survivors' groups, support groups, wellness groups, social anxiety groups, and telehealth groups. Detail of group services are not currently captured.

FY 2023		
Unduplicated N =		
Number of Groups	**Attendance**	**Average Attendance per Group**
Not available		

9. Detailed Outcomes



The PLM Dashboard chart above shows some of the performance learning measures that are tracked for our F&C OPC programs by our Analytics & Reporting Division. This data comes from our EHR. Contracted agencies are required to send in data to our system regularly. This chart indicates that these programs were meeting contracted expectations on average most of FY23. In regard to Timeliness (Average Data to Initial Service), once clients were open in an F&C OPC program, they began services within 8 to 16 calendar days on average. For Client Engagement (% of Consumer No Show), clients were engaged in services most of the time. No shows only happened for 2% to 5% of clients in F&C OPC programs during FY23. Regarding Successful Discharges, for FY23 the overall Successful Discharge Rate, not including administrative discharges, was 78% (1332/1701) through June 2023, which exceeds the current contract requirement for these programs. When including administrative discharges, the Successful Discharge rate is 64% (1214/1911) through June 2023, which also exceeds the current contract requirement for these programs.

Service Providers utilize various evidence-based practices to support the needs of their youth and families. In evaluation of the CANS outcomes to identify performance of services, F&C OPC programs demonstrated client improvement in all three evaluated domains, Behavioral Emotional Needs (23%), Risk Behaviors (28%), and Life Functioning (16%): with the greatest positive change in a youth's Risk Behaviors (28% positive change).

10. Evaluation Summary

As stated above, BHSD Contracted F&C OPC Programs performed well in FY23 regarding Timeliness, Engagement, Successful discharges, program utilization, and affecting Child and Adolescent Needs and Strengths (CANS) over time. Clients showed the most improvement in the Risk Behaviors domain during FY23. The F&C OPC Programs serve a very diverse client population, with varying levels of need. Providers have

described providing more case management, collateral, rehabilitative services; and working with clients to meet the many additional needs that continue to be exacerbated by the pandemic. Providers are also usually responsive to care coordination requests, trouble shooting and work well together when trying to support clients at the individual level.

CCPs have continued to express challenges regarding the pandemic, hiring, high client demand, strain on staff, and transitions between in person and telehealth. F&C OPC programs continued to use strategies related to the workforce shortage, which helped a lot of programs increase their staffing and retain staff.

FAMILY AND CHILDREN BEHAVIORAL HEALTH INTEGRATED OUTPATIENT SERVICES

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Family and Children's (F&C) Integrated Outpatient (IntOP) services programs serve children and youth to help address mental health symptoms, co-occurring substance use disorders, and associated functional impairments. County of Santa Clara contracts with various community-based organizations that provide an array of F&C IntOP support services for children and youth. IntOP programs serve children and youth ages 6 through 20, particularly those from unserved and underserved ethnic and cultural populations. Services consist of culturally relevant outpatient mental health and substance use treatment services to help children and their families who are experiencing difficulty functioning personally and, in their relationships, and environments. Children and youth who meet medical necessity can access integrated outpatient services.

Integrated behavioral health service programs work with children and their families to support and address co-occurring mental health and substance abuse needs. BHSD has recognized the need to provide such services both for adolescents as well as for younger children who are beginning to struggle with co-occurring disorders. Children and youth who qualify—based on individual need and Medi-Cal eligibility— receive comprehensive biopsychosocial assessments to determine the appropriate level of care for issues related to trauma, substance abuse, mental health, and family challenges. Integrated mental health/substance abuse providers work together in care planning efforts with other child-serving agencies to ensure a comprehensive continuum of care.

i. F&C IntOP services include:
ii. Individual, family, and/or group therapy
iii. Case management services
iv. Dual-diagnosis treatment
v. Screening
vi. ASAM and Psychological assessments
vii. Service linkages
viii. Crisis intervention

2. Program Goals, Objectives & Outcomes

❖ **Outcomes**

i. Treat and ameliorate the behavioral health symptoms and dysfunction of children and adolescents, and their families, in the least restrictive manner.
ii. Improve the quality of life for children and families dealing with co-occurring disorders.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =187		
Number Served	**Program Expenditure**	**Cost per Person**

187	See cover page	See cover page

**Data Sources: MHSA Unduplicated Client Count Data Report as of 8/18/23, and FY23 JUN YTD Finance Report (08-22-23)*

4. Evaluation Activities

F&C IntOP Focus Areas & Evaluation Activities include:

Evaluation occurs on a monthly and quarterly basis through reports and dashboards that show how many clients are referred to services and how many access in a timely manner. Feedback and discussion occur with the contracted agencies regarding their performance. For F&C IntOP services, 68% of referred clients accessed services as of June 2023. F&C IntOPC services retained an active caseload that was 77% full on average as of June 2023 compared with the expected contracted F&C IntOP caseload. When asked if the F&C CCPs get clients who want Same Day Access to services, 2 CCPs reported that this is not a common client request. Two agencies stated that if same day access is requested by a client that they should be able to accommodate the request.

Client and families that engage in F&C IntOP services are provided assessment, Individual, family, and/or group therapy, case management, crisis intervention, and other linkage supports that may be warranted to meet the needs of the client and family. Frequent check-in meetings with contracted providers are held to discuss service delivery and how the needs of their clients are met, specifically related to reducing ethnic minority and racial disparities. F&C IntOP services continue to evaluate the needs for increasing peer support and family education support services. Many contracted providers have employed more peer support staff to help families and provide alternative services that promotes health and well-being.

Contracted providers utilize various evidence-based practices to support the needs of their clients. During assessment, every 6 months, and at discharge, service providers utilize the Child and Adolescent Needs and Strengths (CANS) to enhance their assessments and to help track client outcomes. The CANS also highlights the client's strengths, needs and progress over time. In evaluation of the CANS outcomes to identify performance of services, F&C IntOP demonstrated improvement in all three evaluated domains, Behavioral Emotional Needs, Risk Behaviors, and Life Functioning: with the greatest positive change in a client's Risk Behaviors. The providers also administer the Pediatric Symptom Checklist (PSC-35) for youth 18 and under at the same frequency as the CANS. Clients are also asked to participant in a yearly Satisfaction Survey, which help inform system change and improvement.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	72	39%
16 -25 years	115	61%
26- 59 years		
60+ years		

Prefer not to answer		
Unknown		
Unduplicated Total	187	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	1	1%
Asian	5	3%
Black or African American	12	6%
Native Hawaiian or Other Pacific Islander		
White/ Caucasian	21	11%
Other	110	59%
More than one race		
Prefer not to answer	1	1%
Unknown	37	20%
Unduplicated Total	187	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		

Hispanic/ Latino (undefined)	116	62%
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	116	62%
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Mien		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)	33	18%
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal	33	18%
More than one ethnicity		
Prefer not to answer		
Unknown	38	20%
Unduplicated Total	187	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	82	44%
Female	101	54%
Prefer not to answer		
Unknown	4	2%
Unduplicated Total	187	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male		
Female		
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	Not Available	

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		

Another sexual orientation		
Prefer not to answer		
Unknown		
Unduplicated Total	Not Available	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	118	63%
Spanish	53	28%
Vietnamese	2	1%
Cambodian		
Cantonese		
Chinese		
Mandarin		
Tagalog		
Farsi		
American Sign Language		
Other (Portuguese)		
Prefer not to answer		
Unknown	14	7%
Unduplicated Total	187	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military	58	31%
Prefer not to answer		
Unknown	129	69%
Unduplicated Total	187	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive	58	31%
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability	10	5%
No Disability		
Prefer not to answer		
Unknown	119	64%
Unduplicated Total	187	100%

*Participants may choose more than one option for Disability. *Data source for this section was the MHSA Unduplicated Client Count Data Report as of 8/18/23 report.*
Sexual orientation and Gender Identity data was not provided for this report.

6. Additional Data Collection Requirements

Data not available for FY23. The program is exploring ways to collect and report this data in future reporting.

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Health Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total	Not Available	

7. Referrals

FY 2023				
Unduplicated N =57				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
Not available	Outpatient Mental Health Treatment, EBPs & PPs	39	11 days average	5 to 17 days (F&C IntOP Programs)

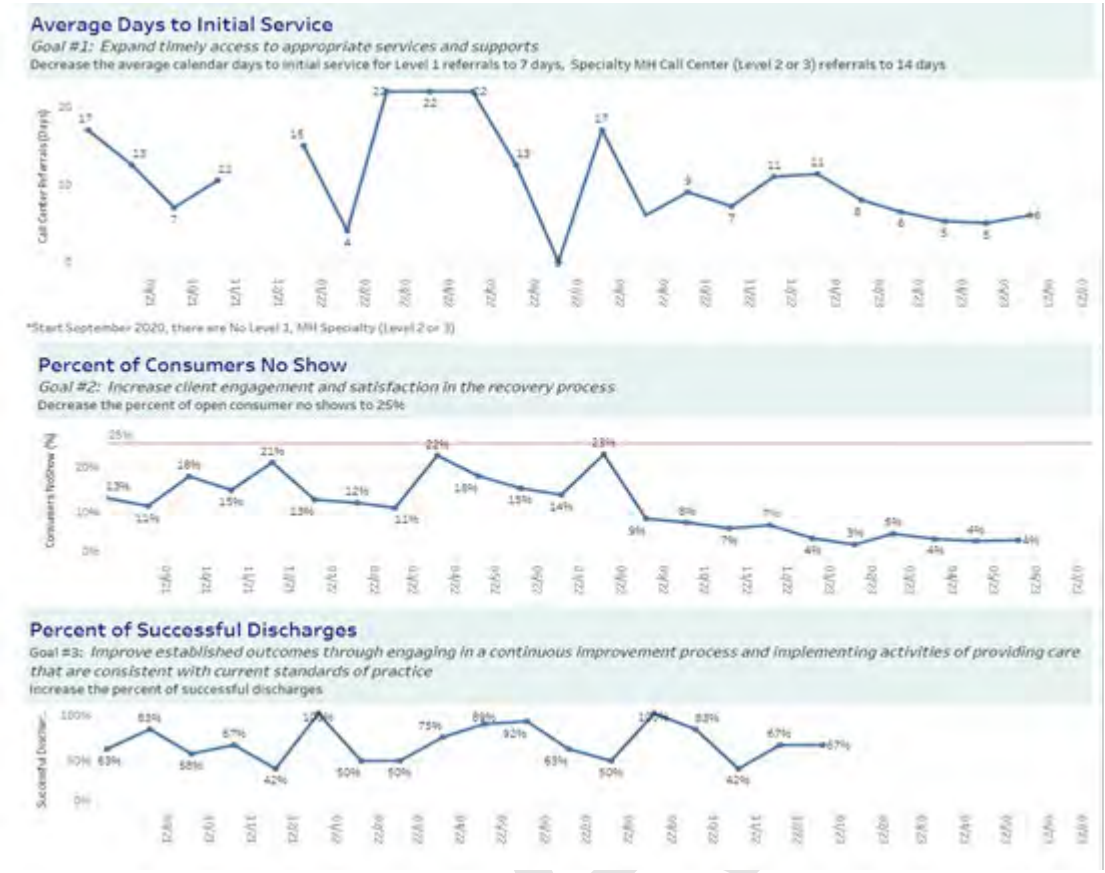
Data Source: MHSA- Outcomes July22-June23 (08-18-23) and PLM Dashboard

8. Group Services Delivered

F&C OPC contracted providers provided various types of groups for clients and families that include social skills, treatment orientation, child sexual abuse survivors' groups, support groups, wellness groups, social anxiety groups, and telehealth groups. Clients in the F&C IntOP programs had access to these groups on an as needed basis. Detail of group services are not currently captured.

FY 2023		
Unduplicated N =		
Number of Groups	**Attendance**	**Average Attendance per Group**
Not available		

9. Detailed Outcomes



The PLM Dashboard chart above shows some of the performance learning measures that are tracked for our F&C IntOP programs by our Analytics & Reporting Division. This data comes from our EHR. Contracted agencies are required to send in data to our system regularly. This chart indicates that these programs were meeting contracted expectations on average most of FY23. In regard to Timeliness (Average Data to Initial Service), once clients were open in an F&C IntOP program, they began services within 5 to 17 calendar days on average. For Client Engagement (% of Consumer No Show), clients were engaged in services most of the time. No shows only happened for 3% to 23% of clients in F&C IntOP programs during FY23. Regarding Successful Discharges, for FY23 the overall Successful Discharge Rate, not including administrative discharges, was 66% (29/44) through June 2023, which exceeds the current contract requirement for these programs. When including administrative discharges, the Successful Discharge rate is 67% (39/57) through June 2023, which also exceeds the current contract requirement for these programs.

Service Providers utilize various evidence-based practices to support the needs of their youth and families. In evaluation of the CANS outcomes to identify performance of services, F&C IntOP programs demonstrated client improvement in all three evaluated domains, Behavioral Emotional Needs (19%), Risk Behaviors (40%), and Life Functioning (0%): with the greatest positive change in a youth's Risk Behaviors (40% positive change). 0% change in the Life Functioning domain demonstrates that there was no regression this area during the time period of evaluation which may be interpreted as a strength, as services are supporting other areas of functioning that may impact Life Functioning.

10. Evaluation Summary

As stated above, BHSD Contracted F&C IntOP Programs performed well in FY23 regarding Timeliness, Engagement, Successful discharges, program utilization, and affecting Child and Adolescent Needs and Strengths (CANS) over time. Clients showed the most improvement in the Risk Behaviors domain during FY23.

The F&C IntOP Programs serve a very diverse client population, with levels of need ranging from mild to severe. F&C IntOP substance use needs typically range from mild to moderate. Clients who have severe substance use needs are usually referred to the Substance Use Treatment Services (SUTS) for targeted SUTS services. Providers have described providing more case management, collateral, rehabilitative services; and working with clients to meet the many additional needs that continue to be exacerbated by the pandemic. Providers are also responsive to care coordination requests, trouble shooting, and work well together when trying to support clients at the individual level.

Our contracted F&C IntOP Programs have been working very hard during the COVID-19 pandemic to meet the needs of as many clients as possible. The agencies have expressed challenges regarding the pandemic, hiring, high client demand, strain on staff, and transitions between in person and telehealth. During FY23 staffing improve. About 90% of the BHSD Contracted F&C IntOP programs were fully staffed. F&C IntOP programs continued to use strategies related to the workforce shortage, which helped a lot of programs increase and retain their staff.

FAMILY AND CHILDREN ETHNIC OUTPATIENT SERVICES

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Family and Children's (F&C) Ethnic Outpatient Continuum (EOPC) mental health programs serve children and youth to help address mental health symptoms and associated functional impairments. The program provides a range of services that includes Intensive, Outpatient, and Wellness levels of service offering flexibility in service levels to meet the needs of the youth and family at the given time. County of Santa Clara contracts with various community-based organizations that provide F&C EOPC support services for children and youth. EOPC program serve children and youth ages 6 through 20, providing services for unserved and underserved children and youth from targeted cultural/ethnic backgrounds who may be justice or child welfare involved.

Intensive level of service provides a higher frequency of support to address symptoms, conditions, and/or risk factors that are impacting their ability to maintain themselves in community settings. Services include crisis response services as needed. Outpatient services provide support to address behavioral health challenges that impact life domains including, education, living situation, personal wellbeing, interpersonal relationships, and community functioning. Wellness services provide support to youth who may need short term medication management and light case management or lower frequency of support to sustain their wellness and recovery as the program is actively working on linking to long term medication support.
To ensure quality accessible services for underserved/unserved populations, F&C OPC providers specialize in providing culture-specific services. F&C EOPC services are culturally and linguistically proficient to meet the needs of their populations, which may include African/African Ancestry, Southeast Asian refugees/immigrants, Asian Americans, American Indian/ Native Americans, and Latinos.

F&C EOPC services include:

i. Individual, family, and/or group therapy
ii. Case management services
iii. Dual-diagnosis treatment
iv. Screening
v. Psychological assessment
vi. Service linkages
vii. Crisis intervention

2. Program Goals, Objectives & Outcomes

❖ **Outcome**

i. Reduce the need for a higher level of care for consumers.
ii. Reduce symptoms and impacts of mental illness for consumers who qualify for specialty mental health services.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =349		
Number Served	Program Expenditure	Cost per Person
349	See cover page	See cover page

**Data Sources: MHSA Unduplicated Client Count Data Report as of 8/18/23, and FY23 JUN YTD Finance Report (08-23-23)*

4. Evaluation Activities

F&C EOPC Focus Areas & Evaluation Activities include:

Evaluation occurs on a monthly and quarterly basis through reports and dashboards that show how many clients are referred to services and how many access in a timely manner. Feedback and discussion occur with the contracted agencies regarding their performance. For F&C EOPC services, 52% of referred clients accessed services as of June 2023. F&C EOPC services retained an active caseload that was 101% full on average as of June 2023 compared with the expected contracted F&C EOPC caseload.

During FY23 the F&C Ethnic Outpatient and Intensive Outpatient programs were combined into the F&C EOPC program to help promote better access to care, more flexibility for when clients need higher and lower levels of care, and reduction of administrative burden related to client intakes and discharges. This program change was made in collaboration with CCPs. While reviewing with 6 CCPs on how the program design change was going F&C EOPC agencies reported that most clients were in the Ethnic OP level of care (2), F&C EOPC has been following the new program design before it was implemented (1), and program referrals have been coming from initial assessment evaluations from their F&C OPC program and not from the Call Center. While conducting a qualitative review with 6 F&C EOPC programs regarding which level of care (LOC) their F&C EOPC clients were accessing 61% of clients were in the Ethnic Outpatient LOC, 30% in the Intensive Ethnic Outpatient LOC, and 9% in their Ethnic Wellness LOC. When asked if the F&C CCPs get clients who want Same Day Access to services, 4 CCPs reported that this is not a common client request. Two agencies stated that if same day access is requested by a client that they should be able to accommodate the request.

Client and families that engage in F&C EOPC services are provided assessment, Individual, family, and/or group therapy, case management, crisis intervention, and other linkage supports that may be warranted to meet the needs of the client and family. Frequent check-in meetings with contracted providers are held to discuss service delivery and how the needs of their clients are met, specifically related to reducing ethnic minority and racial disparities. F&C EOPC services continue to evaluate the needs for increasing peer support and family education support services. Many contracted providers have employed more peer support staff to help families and provide alternative services that promotes health and well-being.

Contracted providers utilize various evidence-based practices to support the needs of their clients. During assessment, every 6 months, and at discharge, service providers utilize the Child and Adolescent Needs and Strengths (CANS) to enhance their assessments and to help track client outcomes. The CANS also highlights the client's strengths, needs and progress over time. In evaluation of the CANS outcomes to identify performance of services, F&C EOPC demonstrated improvement in all three evaluated domains, Behavioral Emotional Needs, Risk Behaviors, and Life Functioning: with the greatest positive change in a client's Risk Behaviors. The providers also administer the Pediatric Symptom Checklist (PSC-35) for youth 18 and under at

the same frequency as the CANS. Clients are also asked to participant in a yearly Satisfaction Survey, which help inform system change and improvement.

F&C EOP programs were developed to provide culturally efficient behavioral and mental health intervention services offered to youth who are exhibiting functional impairments in self-care, school/employment, mood regulation, relationships, trauma, family functioning, and cultural adjustments. Feedback and discussion occur with the contracted agencies regarding their work with clients to address this area.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	223	64%
16 -25 years	124	36%
26- 59 years	2	1%
60+ years		
Prefer not to answer		
Unknown		
Unduplicated Total	349	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	4	1%
Asian	150	43%
Black or African American	74	21%
Native Hawaiian or Other Pacific Islander		
White/ Caucasian	3	1%
Other	62	18%
More than one race		
Prefer not to answer	3	1%

Unknown	53	15%
Unduplicated Total	349	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	109	31%
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	109	31%
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		

Mien		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	187	54%
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer		
Unknown	53	15%
Unduplicated Total	349	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	167	48%
Female	182	52%
Prefer not to answer		
Unknown		
Unduplicated Total	349	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male		
Female		
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		

Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	Not Available	

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown		
Unduplicated Total	Not Available	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	187	54%
Spanish	31	9%
Vietnamese	66	19%
Cambodian	3	1%
Cantonese	1	0%
Chinese	1	0%
Mandarin	3	1%
Tagalog		
Farsi	1	0%
American Sign Language		
Other (Portuguese)	3	1%
Prefer not to answer		

Unknown	53	15%
Unduplicated Total	349	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military	122	35%
Prefer not to answer		
Unknown	227	65%
Unduplicated Total	349	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive	126	36%
Physical/ Mobility	2	1%
Chronic Health Condition		
Other non-communication disability	29	8%
No Disability		
Prefer not to answer		
Unknown	192	55%
Unduplicated Total	349	100%

*Participants may choose more than one option for Disability. *Data source for this section was the MHSA Unduplicated Client Count Data Report as of 8/18/23 report.*
Sexual orientation and Gender Identity data was not provided for this report.

6. Additional Data Collection Requirements

Data not available for FY23. The program is exploring ways to collect and report this data in future reporting

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Health Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**

Unduplicated Total	Not Available	

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total	Not Available	

7. Referrals

FY 2023				
Unduplicated N =83				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
83	Outpatient Mental Health Treatment, EBPs & PPs	43	13 day average	8 to 18 days (F&C EOPC Programs)

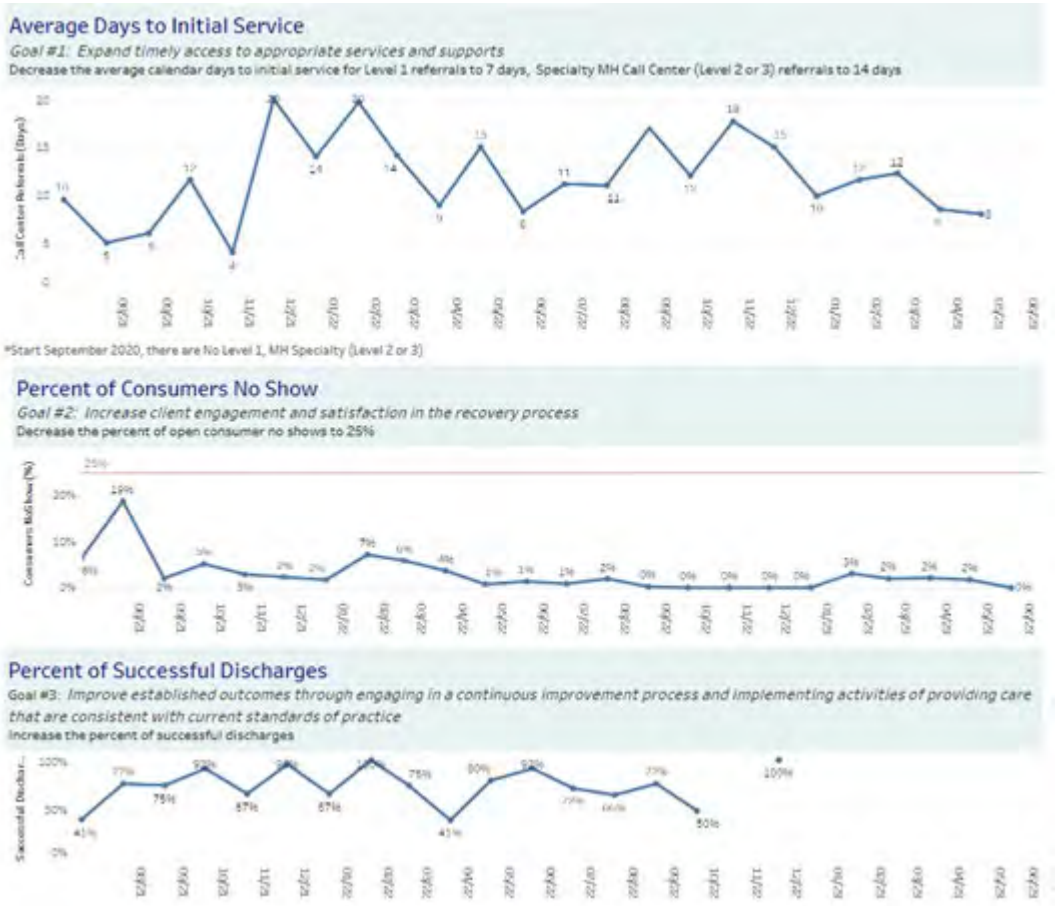
Data Source: MHSA- Outcomes July22-June23 (08-18-23) and PLM Dashboard

8. Group Services Delivered

F&C OPC contracted providers provided various types of groups for clients and families that include social skills, treatment orientation, child sexual abuse survivors' groups, support groups, wellness groups, social anxiety groups, and telehealth groups. Clients in the F&C EOPC had access to these groups on an as needed basis. Detail of group services are not currently captured.

FY 2023		
Unduplicated N =		
Number of Groups	**Attendance**	**Average Attendance per Group**
Not available		

9. Detailed Outcomes



The PLM Dashboard chart above shows some of the performance learning measures that are tracked for our F&C EOPC programs by our Analytics & Reporting Division. This data comes from our EHR. Contracted agencies are required to send in data to our system regularly. This chart indicates that these programs were meeting contracted expectations on average most of FY23. In regard to Timeliness (Average time to Initial Service), once clients were open in an F&C EOPC program, they began services within 8 to 18 calendar days. For Client Engagement (% of Consumer No Show), clients were engaged in services most of the time. No shows only happened for 0% to 3% of clients in F&C EOPC programs during FY23. Regarding Successful Discharges, for FY23 the overall Successful Discharge Rate, not including administrative discharges, was 81% (26/32) through June 2023, which exceeds the current contract requirement for these programs. When including administrative discharges, the Successful Discharge rate is 68% (43/63) through June 2023, which also exceeds the current contract requirement for these programs.

Service Providers utilize various evidence-based practices to support the needs of their youth and families. In evaluation of the CANS outcomes to identify performance of services, F&C EOPC programs demonstrated client improvement in all three evaluated domains, Behavioral Emotional Needs (29%), Risk Behaviors (60%), and Life Functioning (28%): with the greatest positive change in a youth's Risk Behaviors (60% positive change).

10. Evaluation Summary

As stated above, BHSD Contracted F&C EOPC Programs performed well in FY23 regarding Timeliness, Engagement, Successful discharges, program utilization, and affecting change over time based on CANS outcomes. Clients showed the most improvement in the Risk Behaviors domain during FY23. The F&C EOPC Program serve a very diverse client population, including African/African Ancestry, Southeast Asian refugees/immigrants, Asian Americans, American Indian/ Native Americans, and Latinx clients. Providers have

described providing more case management, collateral, rehabilitative services; and working with clients to meet the many additional needs that continue to be exacerbated by the pandemic. Providers are also usually responsive to care coordination requests, trouble shooting, and work well together when trying to support clients at the individual level.

Our contracted F&C EOPC Programs have been working very hard during the COVID-19 pandemic to meet the needs of as many clients as possible. The agencies have expressed challenges regarding the pandemic, hiring, high client demand, strain on staff, and transitions between in person and telehealth. F&C EOPC programs continued to use strategies related to the workforce shortage, which helped a lot of programs increase and retain their staff.

SPECIALTY SERVICES: EATING DISORDERS

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Eating disorder services are offered to youth and adults ages 10 to 65. The youth or adult must reside in Santa Clara County and be a Medi-Cal beneficiary or unsponsored. There are currently six contracted providers, and four levels of services are provided: residential, partial hospitalization, intensive outpatient, and outpatient. Services are in the cities of San Jose, Los Altos, Cupertino, Dublin, Fremont, Sunol, La Fayette, and Menlo Park, and some services are available via telehealth.

Youth and adults with eating disorders often struggle with body dysmorphia and become overly concerned with a sociocultural idealization of thinness. This concern can endure through life without treatment and there is a high degree of relapse during the recovery journey. Treatment of co-morbid health and mental health conditions which are often needed and require treatment teams than include mental health clinicians, dieticians, nurses, and physicians, including psychiatrists.

2. Program Goals, Objectives & Outcomes

- **Outpatient (OP)**
  i. Programming is typically 1-3 times a week and may be virtual or in person.
  ii. Treatment is individualized and may include individual sessions, group sessions, nutritionist, and psychiatry.
  iii. Length of treatment is based on clinical needs
  iv. May be a step-down from more intensive services, or first line of treatment for individuals with less acute eating disorder symptomology
  v. This level of care was newly developed in FY23, with a focus on planning and implementation. Services began in FY24.
- **Intensive Outpatient (IOP)**
  i. Programming is Monday-Friday 11:30am-3-3:30pm or 4pm-7pm (3 hours per treatment day)
  ii. Treatment includes individual, family and group therapy, nutritionist sessions (meal planning and psychoeducation), and weight and vitals checks
  iii. Average length of treatment is 30 days, 5 days a week and can be titrated down/up based on need
  iv. Treatment modalities can include exposure therapy, cognitive behavioral therapy, experiential therapies, family systems therapy and skills-based therapies, including mindfulness and dialectical behavioral therapy
- **Partial Hospitalization**
  i. Programming is Monday-Friday, 11am to 7pm 5 days per week (6 hours per treatment day)
  ii. Treatment includes individual, family and group therapy, nutritionist sessions (meal planning and psychoeducation), and weight and vitals checks
  iii. Treatment modalities can include exposure therapy, cognitive behavioral therapy, experiential therapies, family systems therapy and skills-based therapies, including mindfulness and dialectical behavioral therapy
  iv. Average length of treatment is 45 treatment, 5 days a week is titrated up/down based on a need.
- **Residential Treatment**

i. Program is 7 days a week and youth or adult reside in the treatment facility. Programs offered 6-8 hours per day.
ii. Treatment includes individual, family and group therapy, nutritionist sessions (meal planning and preparation, psychoeducation), and weight and vitals checks
iii. Average length of treatment is 30 days and can be extended if indicated
iv. Treatment modalities can include exposure therapy, cognitive behavioral therapy, experiential therapies, family systems therapy and skills-based therapies, including mindfulness and dialectical behavioral therapy
v. Passes home are encouraged when transitioning to a lower level of care

3. Clients Served & Annual Cost per Client Data

FY 2023		
Number Served	Program Expenditure	Cost per Person
45	$955,724	$21,238.31

4. Evaluation Activities

❖ **MHSA CSS-GSD Eating Disorders Outcomes**

i. Services provided are culturally responsive and linguistically competent to address racial and ethnic diverse population
ii. Improve care coordination between providers and linkage to needed services
iii. Improve access to services
iv. Improve referral pathway for physicians and community
v. Reduce need for acute medical inpatient admission

❖ **County Outcomes**

i. Adults or youth will discharge successfully.
ii. Adults or youth will be admitted into services and/or provided behavioral health services within 7 business days to improve timely access.
iii. Improve readmission rates

❖ **Additional Program Specific Outcomes**

i. Increase knowledge and awareness of eating disorders
ii. Increase access to services by increasing capacity
iii. Support family involvement and engagement in services

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	27	60%
16 -25 years	12	27%
26- 59 years	6	13%

60+ years	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	**45**	**100%**

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:	0	0%
Caribbean	0	0%
Central American	0	0%
Mexican/ Mexican-American/ Chicano	0	0%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	28	62%
Other Hispanic/ Latino	0	0%
Hispanic or Latino Subtotal	28	62%
Non-Hispanic or Non-Latino as follows:		
African	0	0%
Asian Indian/ South Asian	1	2%
Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%
European	7	16%
Filipino	0	0%
Japanese	0	0%

Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Non-Hispanic/ Non-Latino (undefined)	0	0%
Other Non-Hispanic/ Non-Latino	0	0%
Non-Hispanic or Non-Latino Subtotal	8	18%
More than one ethnicity	0	0%
Prefer not to answer	0	0%
Unknown	9	20%
Unduplicated Total	**45**	**100%**

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	9	20%
Female	32	71%
Prefer not to answer	0	0%
Unknown	4	9%
Unduplicated Total	**45**	**100%**

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	9	20%
Female	32	71%
Transgender (Male to Female)	3	7%
Transgender (Female to Male)	1	2%
Transgender (Undefined)	0	0%
Genderqueer	0	0%
Questioning or Unsure	0	0%

Another gender identity	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	45	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Information about Sexual Orientation was not collected in FY23. Efforts are being made to capture this information in FY24.		

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	13	29%
Spanish	23	51%
Vietnamese	0	0%
Chinese	0	0%
Tagalog	0	0%
Farsi	0	0%
Other	2	4%
Prefer not to answer	0	0%
Unknown	7	16%
Unduplicated Total	**45**	**100%**

	FY 2023	
Military Status	**# Served**	**% of Served**
Information about military status was not collected in FY23. Efforts are being made to capture this information in FY24.		

	FY 2023	
Disability*	**# Served**	**% of Served**

Information about disabilities was not collected in FY23. Efforts are being made to capture this information in FY24.

6. Additional Data Collection Requirements

N/A

7. Referrals

FY 2023				
Unduplicated N =45				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
72 youth (duplicated) under age 18; 28 adults (duplicated) over age 18	Residential; Partial Hospitalization; IOP Eating Disorder services. Note: All but six of the referred beneficiaries had another mental health team in place at the time of the referral	45 individuals engaged in Eating Disorder treatment services (10 adults and 35 youth under age 18) Some individuals had more than one referral into services (51 treatment episodes).	Unknown	Unknown

8. Group Services Delivered

FY 2023
Intensive Outpatient treatment, Partial Hospitalization services, and residential treatment for eating disorders services provides group treatment often with two groups a day. Participants are required to participate in group treatment. Focus of groups vary. Meal planning, experiential treatment (music and art), cognitive behavioral and skills-based groups for mindfulness practices and dialectical behavioral treatment are provided. Each participant in ED services participated in groups while in treatment which averages 30 days for each level of care and varies from 4-7 days per week. Specific data was not collected in FY23. Efforts are underway to collect this data in FY24.

9. Detailed Outcomes

Engagement data: Of all referrals, 49% engaged in treatment at the time of referral. The vast majority of those receiving eating disorder treatment services were young people under age 25.
Additional, aggregate outcome data will be available for FY24. Various tools are used by the providers to assess clients, determine a treatment plan, and measure outcomes to support the individual and curate their treatment plan.
For one of our primary providers, Cielo House, the following outcome tools are utilized to look at success at an individual level:

i. EDE-Q (measures client's thoughts, feelings, behaviors, meal compliance)
ii. Recovery Record (measures client's thoughts, feelings, behaviors, meal compliance)
iii. Outcome tool worksheet for eating out
iv. Level of care assessment (nutrition, physical and psychological outcomes)

Moving forward to FY24, the following positive outcome metrics have been identified for our providers to collect and report at an aggregate level:

i. Family involvement in treatment (for youth)
ii. Reduction in eating disorder behaviors (restriction, avoidance, purging, etc.)
iii. Improvement in psychological recovery (decrease in symptoms, improvement in thinking)
iv. Improvement in physical health (weight, vitals)
v. Achievement of treatment goals

10. Evaluation Summary

FY23 successes notably include adding an outpatient level of care for our eating disorder continuum. Contracts for outpatient services were finalized late in the FY23 and the continuum of care for treatment is now a more robust continuum from an outpatient level of care, to intensive, to partial hospitalization and residential for the most intensive level of care.
Our bilingual Eating Disorder coordinator for youth provides support and psychoeducation for the families of youth referred by their pediatricians. The coordinator serves as a vital liaison between the medical primary care physician, the family, and the eating disorder provider. Our Eating Disorder coordinator for adults helps bridge between the primary mental health provider and the Eating Disorder treatment provider.
Our Eating Disorder coordinator for adults helps bridge the gap between the primary mental health provider and the Eating Disorder treatment provider. For our adult and older adult patients, one of the benefits of having multiple providers is that they are located in different cities, and some of our patients prefer to access treatment in cities that are not necessarily in San Jose. In conjunction with that, one of our adult patients attempted to access services with one of our providers, and after further assessment, they recommended a higher level of care. Because we have multiple providers, another provider assessed the patient and provided that patient an opportunity for treatment. That specific patient reached out to our adult Eating Disorder coordinator and said the following, "I just wanted to reach out and extend a big thank you for all your help while I was in the hospital. I began my stay, and I couldn't be more grateful for the assistance". Another benefit for our youth and adult patients is that the eating disorder programs also offer virtual services within the PHP, IOP, and OP levels of care.
An additional challenge is the individual's and family's readiness for change, which fuels engagement in the treatment that will match the acuity of clinical and medical risk. The programs can be intensive and may disrupt other life events (travel, family or school activities, etc.) in order to provide the level of treatment clinical indicated and at times there is not the readiness at the time the referral is made. For children and youth, the referral is often made by the PCP or mental health provider, and at times there is a difference between the perceived seriousness of the condition by provider than perceived by the family/ youth. Services are voluntary. For the

individuals who choose not to participate in the services offered, they are still offered psychoeducation and information about how to engage in services when they are ready. The relationship built between the Eating Disorder coordinator and the family helps to fulfill this purpose, as families have called back to request services when they are ready to engage.

Similar to recovery from addiction, eating disorder recovery may not be linear, and there may be relapses along the way. With a robust continuum of care to address needs, and increased capacity, it is hoped that as we move forward in FY24 we will be well-positioned to provide timely access to services to promote the engagement and treatment of individuals at the time they are ready to engage.

Transitional Age Youth (TAY) Outpatient Program

The Transition Age Youth program in Santa Clara County covers 2 different programs.

1. TAY Outpatient Program
2. TAY LGBTQ

The total cost per person, across all programs in this category can be found below. The following pages are detailed reports for each individual program in this category.

FY 2023		
Number Served	Program Expenditure	Cost per Person
794	$ 5,703,377	$7,183.09

TRANSITONAL AGE YOUTH (TAY) OUTPATIENT SERVICES

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Outpatient programs for TAY ages 16-24 aim to prevent chronic mental illness while improving quality of life for TAY. Outpatient programs for TAY focuses on treatment for co-occurring disorders and trauma-informed care. Programs are focused on preventing or improving symptoms that may lead to chronic mental illness while keeping TAY on track developmentally.

Specific services include:

i. Assessments
ii. Treatment planning
iii. Referral hotline
iv. Brief crisis intervention
v. Case Management
vi. Self-help and peer support
vii. Outreach and engagement activities

2. Program Goals, Objectives & Outcomes

❖ **Outcome**

i. Improve functioning and quality of life for TAY
ii. Reduce symptoms and impacts of mental illness for TAY
iii. Reduce the need for a higher level of care for TAY

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
710	See cover sheet	See cover sheet

**Data Sources: MHSA Unduplicated Client Count Data Report as of 8/18/23, and FY23 JUN YTD Finance Report (08-22-23)*

4. Evaluation Activities

The TAY Program focuses on mental health treatment, including alternative and culturally specific treatments using peer support, individual services and support plan development. Service providers supported Transitional Aged Youth, young adults aged 16-25, with age specific services to help them transition smoothly into adulthood. TAY programming is a high utilized program as it crosses age populations with adult programming.

Access and linkage for TAY and their family have been closely monitored to ensure system capacity is available to support timely access of appropriate services.
Service Providers use Evidence Based Practice Standards or Promising Practice Standards. The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool created to support communication with the individual and identify needs and strengths to determine treatment focus and monitor outcomes. The CANS is completed in collaboration with the youth/young adult and their family to discuss needs and strengths during initial assessment, at six month intervals and at discharge from services. For youth 18 and under, the Pediatric Symptom Checklist (PSC-35) is utilized to screen for general concerns in youth, from the caregiver's perspective. If a caregiver is not involved with the individual, the youth has the ability to answer on their behalf. Both these tools are entered into a County database. Information from the tools is used for individualized program planning to support treatment goals but also used to evaluate program outcomes an identify any needs in service delivery to support continuous quality improvement. Lastly, an annual Client Satisfaction Survey is distributed to beneficiaries receiving behavioral health services. These surveys are collected and used for system changes and improvement.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	3	0%
16 -25 years	682	96%
26- 59 years	25	4%
60+ years	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	710	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	4	1%
Asian	74	10%
Black or African American	38	5%
Native Hawaiian or Other Pacific Islander	2	0%

White/ Caucasian	97	14%
Other	304	43%
More than one race	0	0%
Prefer not to answer	4	1%
Unknown	187	26%
Unduplicated Total	710	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino		
Caribbean	0	0%
Central American	0	0%
Mexican/ Mexican-American/ Chicano	0	0%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	334	47%
Other Hispanic/ Latino	0	0%
Hispanic or Latino Subtotal	334	47%
Non-Hispanic or Non-Latino as follows:		
African	0	0%
Asian Indian/ South Asian	0	0%

Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%
European	0	0%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Non-Hispanic/ Non-Latino (undefined)	0	0%
Other Non-Hispanic/ Non-Latino	187	26%
Non-Hispanic or Non-Latino Subtotal	187	26%
More than one ethnicity	0	0%
Prefer not to answer	0	0%
Unknown	189	27%
Unduplicated Total	710	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	222	31%
Female	482	68%
Prefer not to answer	0	0%
Unknown	6	1%

Unduplicated Total	710	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male		
Female		
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	710	100%
Unduplicated Total	710	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	710	100%
Unduplicated Total	710	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	566	80%

Spanish	74	10%
Vietnamese	4	1%
Cantonese	1	0%
Chinese	2	0%
Madeiran	1	0%
Tagalog	1	0%
Farsi	1	0%
Other (Korean, Portuguese, Other)	4	1%
Prefer not to answer	0	0%
Unknown	56	8%
Unduplicated Total	710	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	0	0%
Veteran	1	0%
Served in Military	0	0%
Family of Military	0	0%
No Military	213	30%
Prefer not to answer	0	0%
Unknown	496	70%
Unduplicated Total	710	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	1	0%
Difficulty hearing or speaking	1	0%
Other communication disability	0	0%
Cognitive	184	26%
Physical/ Mobility	1	0%
Chronic Health Condition	0	0%
Other non-communication disability	53	7%
No Disability	0	0%
Prefer not to answer	0	0%

Unknown	470	66%
Unduplicated Total	710	100%

*Participants may choose more than one option for Disability. *Data source for this section was the MHSA Unduplicated Client Count Data Report as of 8/18/23 report.*
Sexual orientation and Gender Identity data was not provided for this report.

6. Additional Data Collection Requirements

Data not available for FY23. The program is exploring ways to collect and report this data in future reporting

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N = 572				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
490	TAY Outpatient Treatment Services including individual/group therapy, case management, medication assessment/management, etc.	340	11 Days	5 to 19 days

**Data Source: MHSA- Outcomes July22-June23 (08-18-23) and PLM Dashboard*

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
N/A	N/A	N/A

9. Detailed Outcomes

There were four (4) County Contracted Providers (CCP's) who provide TAY Outpatient Services. Data from all FY23 (7/1/22 through 6/30/23) was used to inform this report. New referrals to the TAY outpatient program accessed their first appointment between 5 to 19 days. The program had 156 discharges and 54% of these beneficiaries had a successful discharge from services. CANS Outcome Data indicate a 15% positive change in Behavioral and Emotional Needs domain, 57% positive change in risk factors domain, and 21% positive change in life functioning domain.

Every month there was a meeting with CCP's to discuss program challenges and improvements. One challenge that may have contributed to the lower successful discharge rate was continued busyness of life. As the masking and quarantine mandates ended this year, everything fully reopened and TAY went back to everything: school, work, and handling additional family responsibilities. Balancing these priorities continued to be difficult and some of these young adults left behavioral health services even though they continued to express needing support. Another challenge that continues to remain is the difficulty in hiring and maintaining clinical staff. During Fiscal Year 2023, the TAY outpatient programs were not fully staffed, most programs only had about 50% to 75% half of the clinical staff needed. This staffing shortage directly contributed to the longer wait times to access services. Similar to last fiscal year, as new staff on-boarded there was likely not enough training time to teach the granular details of discharge definitions which likely lead to inconsistent capturing of discharge reasons and lower successful discharge data. CCP's utilized triaging and created intake specialists to help support beneficiaries while they were waiting for services to begin. Consistent communication and contact were also provided and if an urgent situation emerged, the beneficiary had the ability to contact the CCP for immediate support.

10. Evaluation Summary

Fiscal Year 2023 had many challenges as well as successes. Staff shortage remained a challenge for the program throughout the year. Program outcomes demonstrated improvement for youth and young adults that participated in services with programs noting success of beneficiaries re-entering vocational schools and returned to higher education since the start of the pandemic. CCP's realized how important flexibility was to meet the needs of the beneficiaries in ways that had not happened prior to the pandemic. This year, innovation continued to meet the needs of beneficiaries all while trying to continuing to balance the staff hiring and managing the continued staff shortage.

TRANSITIONAL AGE YOUTH (TAY) LGBTQ

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The TAY LGBTQ Outpatient program supports individuals ages 16-24 and aims to prevent chronic mental illness while improving quality of life for youth and young adults who identify as part of the LGBTQ+ community or are questioning. Outpatient programs for TAY LGBTQ place a particular emphasis on treatment for co-occurring disorders and trauma-informed care.

Specific Services Include:

i. Assessments
ii. Treatment planning
iii. Referral hotline
iv. Brief crisis intervention
v. Case Management
vi. Self-help and peer support
vii. Outreach and engagement services
viii. Confidential counseling
ix. Medication Services

2. Program Goals, Objectives & Outcomes

TAY LGBTQ Outpatient Services Outcomes

i. Improve functioning and quality of life for youth
ii. Reduce symptoms and impacts of mental illness for youth
iii. Reduce the need for a higher level of care for youth

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 112		
Number Served	Program Expenditure	Cost per Person
84	See cover sheet	See cover sheet

4. Evaluation Activities

The LGBTQ TAY Outpatient program is geared towards providing mental health supports, including alternative and culturally specific treatments to support the County's mental health service delivery system for all clients and their families who may identify with the LGBTQ+ community. Service Providers have expertise in engaging LGBTQ+ identified youth and young adults with additional training specifically to support the needs of the LGBTQ+ TAY population. Some examples are being able to write a letter in support of seeking medical transitions, helping a youth advocate for hormone blockers or support in resolving access to gender neutral bathrooms at school.

Both the TAY LGBTQ Outpatient and TAY IST programs utilize standardized functional assessment tools to support determination of treatment needs, goals and monitoring of outcomes. The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool created to support communication with the individual and identify needs and strengths to determine treatment focus and monitor outcomes. The CANS is completed in collaboration with the youth/young adult and their family to discuss needs and strengths during initial assessment, at six month intervals and at discharge from services. For youth 18 and under, the Pediatric

Symptom Checklist (PSC-35) is utilized to screen for general concerns in youth, from the caregiver's perspective. If a caregiver is not involved with the individual, the youth has the ability to answer on their behalf. Both these tools are entered into a County database. Information from the tools is used for individualized program planning to support treatment goals but also used to evaluate program outcomes an identify any needs in service delivery to support continuous quality improvement. Lastly, an annual Client Satisfaction Survey is distributed to beneficiaries receiving behavioral health services. These surveys are collected and used for system changes and improvement.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years	82	98%
26- 59 years	2	2%
60+ years		
Prefer not to answer		
Unknown		
Unduplicated Total	84	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	1	1%
Asian	13	15%
Black or African American	3	4%
Native Hawaiian or Other Pacific Islander	0	0%
White/ Caucasian	17	20%
Other	38	45%

More than one race	0	0%
Prefer not to answer	1	1%
Unknown	11	13%
Unduplicated Total	84	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	49	58%
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	49	58%
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	29	35%
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer		
Unknown	6	7%
Unduplicated Total	84	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	31	37%
Female	53	63%
Prefer not to answer		
Unknown		
Unduplicated Total	84	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male		
Female		
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	84	100%
Unduplicated Total	84	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		

Prefer not to answer		
Unknown	TAY LGBTQ = 84	TAY LGBTQ = 100%
Unduplicated Total	TAY LGBTQ = 84	TAY LGBTQ = 100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	78	93%
Spanish	3	4%
Vietnamese	0	0%
Chinese		
Mandarin	0	0%
Tagalog		
Farsi		
Other (*American Sign Language and Cambodian)*	2	2%
Prefer not to answer		
Unknown	1	1%
Unduplicated Total	84	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	0	0%
Veteran		
Served in Military		
Family of Military		
No Military	18	21%
Prefer not to answer		
Unknown	66	79%
Unduplicated Total	84	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	1	1%
Difficulty hearing or speaking		
Other communication disability		

Cognitive	4	5%
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability	12	14%
No Disability		
Prefer not to answer		
Unknown	67	80%
Unduplicated Total	84	100%

*Participants may choose more than one option for Disability. *Data source for this section was the MHSA Unduplicated Client Count Data Report as of 8/18/23 report.*

Sexual orientation and Gender Identity data was not provided for this report.

6. Additional Data Collection Requirements

Data not available for FY23. The program is exploring ways to collect and report this data in future reporting

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N = 49				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
TAY LGBTQ = 32	TAY LGBTQ Outpatient services including individual/group therapy, casement, peer support, etc.	TAY LGBTQ = 24	TAY LGBTQ = 16 Days	TAY LGBTQ = 8 to 23 days

8. Group Services Delivered

FY 2023
Unduplicated N =

Number of Groups	Attendance	Average Attendance per Group
N/A	n/a	

9. Detailed Outcomes

There were two (2) County Contracted Provider (CCP) who provided Transitional Age Youth LGBTQ Outpatient Services, one funded by MHSA. On average, it took 16 days for a client to receive their first assessment appointment. There were 19 discharges and 31% of these beneficiaries had a successful discharge from services. CANS outcomes for the program were not available, as submission completion was an identified challenge for the program and will continue to be addressed with service providers.

Every month there was a meeting with service providers to discuss program challenges and improvements. Challenges that were consistently shared amongst the programs was the difficulty of the staffing shortage and the impact on their workforce. Strategies were implemented to address the challenges around staffing, such as triaging and creating the position of an intake specialist that could help support youth/young adults with consistent check ins or resource linkage, while they were waiting for services to begin. This helped to support engagement as wait times for initial appointments may be delayed.

One positive impact from the pandemic mentioned by a youth is that they were on-line a lot more than normal and as a result was more active on social media sites and this information helped them to identify feelings they were having and recognizing that they are queer.

10. Evaluation Summary

The number of LGBTQ TAY identified referrals received in Fiscal Year 23 confirmed that the expansion of services was needed. Staffing for this program stabilized in January and this directly impacted the days to receive services which decreased from 24 days to 16 days. The two LGBTQ programs have continued to be fully staffed which will make a difference in this upcoming fiscal year as the outpatient program will expand to include both a wellness level and an intensive outpatient level so that there is flexibility in the outpatient program to support youth at whatever level they need support.

COMMERCIALLY, SEXUALLY EXPLOITED CHILDREN (CSEC)

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The Commercially Sexually Exploited Children (CSEC) program provides integrated behavioral health treatment for young people ages 10-21 who have experience or are at risk of commercial sexual exploitation to help them recover from emotional, physical, and sexual trauma. Treatment services place special emphasis on healing-oriented individual therapy and family involvement through collateral support and family therapy. Medication support, crisis intervention, and targeted case management are additional components of the program. Once a referral is received youth are connected to an advocate who helps maximize their safety from exploitation. Additional services include financial support and connection to primary and secondary school or other education programs. The multidisciplinary treatment teams that support youth consist of case managers and clinical therapists and works in partnership with Child Welfare, Juvenile Probation, and Community Based Organizations.

2. Program Goals, Objectives & Outcomes

❖ Goals

Program goals focus on:

i. Reducing subjective suffering from mental illness
ii. Increase meaningful use of time and capabilities in school, work, and activity
iii. Increase access to substance use treatment
iv. Increase natural networks of supportive relationships
v. Reduce multiple foster care placements
vi. Reduce incarceration/juvenile justice involvement
vii. Reduce disparities in service access
viii. Increase self-help and client/family involvement
ix. Reduce psycho-social impact of trauma

❖ Objectives

i. Access for new clients
ii. Engagement in services
iii. Successful discharges
iv. Maintain service delivery/capacity that meets the needs of the referral flow

❖ Outcomes

i. Improved behavioral and emotional functioning, including addressing needs related to depression, impulsivity, oppositional/conduct needs, anxiety, and the impact of trauma/adversity.
ii. Attend school and prevent school failure or dropout.
iii. Decreased needs in substance use, including severity/duration of use and peer, parent, and environmental influences.
iv. Minimize risk related to juvenile justice involvement and incarceration.
v. Address needs related to the impact of trauma
vi. Reduce risk and/or prevent suicide risk 259

vii. Reduce or prevent commercially sexually exploited risk factors and behaviors
viii. Improved functioning in key life domains, such as legal, social functioning, and decision making.
ix. Increase supportive relationships, including relationship permanence and natural supports.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N 27		
Number Served	**Program Expenditure**	**Cost per Person**
30	$556,341 CSEC	$61,033
	$1,274,649 Foster Care Development funds supporting CSEC	
	$1,830,990 Total	

** Program expenditure includes all funds, not only MHSA funds.

4. Evaluation Activities

The CSEC program utilized the following evidence based or promising practices: Motivation Interviewing (MI), Trauma-Focused Cognitive-Behavioral Therapy, Harm Reduction, and CSEC specific interventions. Fidelity to the models occurs through supervision and fidelity reviews as recommended by the EBP.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	8	30%
16 -25 years	19	70%
26- 59 years	0	0%
60+ years	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	27	100%

	FY 2023	
Race	**# Served**	**% of Served**

American Indian or Alaska Native	0	0%
Asian	2	7%
Black or African American	1	4%
Native Hawaiian or Other Pacific Islander	0	0%
White/ Caucasian	4	15%
Other	16	59%
More than one race	0	0%
Prefer not to answer	0	0%
Unknown	4	15%
Unduplicated Total	27	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	0	0%
Central American	0	0%
Mexican/ Mexican-American/ Chicano	0	0%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	0	0%
Other Hispanic/ Latino	0	0%
Hispanic or Latino Subtotal	12	45%
Non-Hispanic or Non-Latino as follows:		
African	0	0%

Asian Indian/ South Asian	0	0%
Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%
European	0	0%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Non-Hispanic/ Non-Latino (undefined)	0	0%
Other Non-Hispanic/ Non-Latino	5	19%
Non-Hispanic or Non-Latino Subtotal	0	0%
More than one ethnicity	0	0%
Prefer not to answer	0	0%
Unknown	10	37%
Unduplicated Total	27	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	2	7%
Female	25	93%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	27	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	2	7%
Female	25	93%
Transgender (Male to Female)	0	0%
Transgender (Female to Male)	0	0%
Transgender (Undefined)	0	0%
Genderqueer	0	0%
Questioning or Unsure	0	0%
Another gender identity	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	27	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	0	0%
Heterosexual/ Straight	0	0%
Bisexual	0	0%
Questioning/ Unsure	0	0%
Queer	0	0%
Another sexual orientation	0	0%
Prefer not to answer	0	0%
Unknown	27	100%
Unduplicated Total	27	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	18	67%
Spanish	4	15%

Vietnamese	0	0%
Chinese	0	0%
Tagalog	0	0%
Farsi	0	0%
Other	0	0%
Prefer not to answer	0	0%
Unknown	5	18%
Unduplicated Total	27	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	0	0%
Veteran	0	0%
Served in Military	0	0%
Family of Military	0	0%
No Military	27	100%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	27	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	0	0%
Difficulty hearing or speaking	0	0%
Other communication disability	0	0%
Cognitive	0	0%
Physical/ Mobility	0	0%
Chronic Health Condition	0	0%
Other non-communication disability	0	0%
No Disability	0	0%
Prefer not to answer	0	0%
Unknown	27	100%
Unduplicated Total	27	100%

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

CCR § 3620.10 data is not collected for this program.

	FY 2023	
Residential Status	**# Served**	**% of Served**
Not available		
Unduplicated Total		

	FY 2023	
Educational Status	**# Served**	**% of Served**
Not Available		
Unduplicated Total		

	FY 2023	
Employment Status	**# Served**	**% of Served**
Not Available		
Unduplicated Total		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Not Available		
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Not Available		
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Not Available		
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Not Available		
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Not Available		
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N =27				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
27	Integrated Behavioral Health Services that include individual, family and group therapy, case management, medication	27	Not Available	Not Available

	support, and crisis intervention.			

8. Group Services Delivered

This program did not offer group services during this reporting period

FY 2023		
Unduplicated N =0		
Number of Groups	Attendance	Average Attendance per Group

9. Detailed Outcomes

FY23 CANS Outcome Measures and Successful Discharge Rate

i. Youth leaving the program had a 29% successful discharge rate. Many of the youth were referred to higher levels of care, thus reflecting the lower successful discharge rate.
ii. Youth had a slight decrease in need with regards to their behavioral and emotional well-being as evidenced by a -25% in the CANS Behavioral and Emotional domain score.
iii. Youth risk factors increased as evidenced by a 100% in the CANS. This reflects the intense needs of youth referred to the program and referral to higher levels of care.
iv. Youth maintained their Life Domain Functioning Score as evidenced by a 0% change in the CANS Life Functioning domain score, which reflects

10. Evaluation Summary

Program Successes Include:

i. Engagement of youth participation in the program
ii. Providing integrated treatment using model of co-occurring standards
iii. Continued to provide in-person services or hybrid support for youth despite COVID-19 limitations.
iv. Program served as a no-wrong door entry point and as needed; youth received supports to higher levels of care.
v. Use of virtual platforms for care coordination and multidisciplinary team meeting created higher levels of engagement and participation. Program Challenges Include:
vi. Providing in person, face-to-face services during Covid-19 during quarantine/isolation periods.
vii. Staff turnover/retention is low and youth are not needing to experience changes in their primary provider.

Program Challenges include:

i. Youth needs often outweighed the level of care of the CSEC program.

JUVENILE JUSTICE DEVELOPMENT

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Juvenile Justice Development (JJD) funds positions that focus on the wellness and recovery of youth returning to their communities through transition planning in a strength-based, client centered, and healing oriented manner. JJD alongside families to support youth in developing life skills that allow them to thrive, engage in school or vocational settings as well as meaningful daily activities. After an assessment of needs youth are supported in co-creating a care plan that identifies appropriate interventions and resources to help youth develop functional skills around self-care, self-regulation, and address other functional impairments through decreasing or replacing non-functional behavior. Gender specific programming is available as needed.

2. Program Goals, Objectives & Outcomes

❖ **Goals**

i. Reducing subjective suffering from mental illness
ii. Increase meaningful use of time and capabilities in school, work, and activity
iii. Increase access to substance use treatment
iv. Increase natural networks of supportive relationships
v. Reduce incarceration/juvenile justice involvement
vi. Reduce disparities in service access
vii. Increase self-help and client/family involvement

❖ **Objectives**

i. Support juvenile justice involved youth as they return to their communities.
ii. Reduce recidivism for juvenile justice involved youth.
iii. Increase service connectedness.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 645		
Number Served	Program Expenditure	Cost per Person
665	$ 1,540,909	$2,317.16

**Program expenditure includes all funds, not only MHSA funds.

4. Evaluation Activities

The program utilized the following evidence based or promising practices: Motivation Interviewing (MI), Trauma-Focused Cognitive-Behavioral Therapy, Seeking Safety and the Neurosequential Model of Therapeutics. Fidelity to the models occurs through supervision and fidelity reviews as recommended by the EBP.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	84	13%
16 -25 years	561	87%
26- 59 years	0	0%
60+ years	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	645	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	0	0%
Asian	0	0%
Black or African American	0	0%
Native Hawaiian or Other Pacific Islander	0	0%
White/ Caucasian	0	0%
Other	0	0%
More than one race	0	0%
Prefer not to answer	0	0%
Unknown	100	100%
Unduplicated Total	645	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	0	0%
Central American	0	0%
Mexican/ Mexican-American/ Chicano	0	0%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	561	87%
Other Hispanic/ Latino	0	0%
Hispanic or Latino Subtotal	0	0%
Non-Hispanic or Non-Latino as follows:		
0African	0	0%
Asian Indian/ South Asian	0	0%
Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%
European	0	0%
Filipino	0	0%
Japanese	0	0%

Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Non-Hispanic/ Non-Latino (undefined)	0	0%
Other Non-Hispanic/ Non-Latino	84	13%
Non-Hispanic or Non-Latino Subtotal	0	0%
More than one ethnicity	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	645	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	635	98%
Female	10	2%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	645	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	0	0%
Female	0	0%
Transgender (Male to Female)	0	0%
Transgender (Female to Male)	0	0%

Transgender (Undefined)	0	0%
Genderqueer	0	0%
Questioning or Unsure	0	0%
Another gender identity	0	0%
Prefer not to answer	0	0%
Unknown	645	100%
Unduplicated Total	645	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	0	0%
Heterosexual/ Straight	0	0%
Bisexual	0	0%
Questioning/ Unsure	0	0%
Queer	0	0%
Another sexual orientation	0	0%
Prefer not to answer	0	0%
Unknown	645	100%
Unduplicated Total	645	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	630	98%
Spanish	6	.95%
Vietnamese	5	.78%
Chinese	0	0%
Tagalog	0	0%
Farsi	1	.15%
Other	3	.46%
Prefer not to answer	0	0%
Unknown	0	0%

Unduplicated Total	645	

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	0	0%
Veteran	0	0%
Served in Military	0	0%
Family of Military	0	0%
No Military	0	0%
Prefer not to answer	0	0%
Unknown	645	100%
Unduplicated Total	645	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	0	0%
Difficulty hearing or speaking	0	0%
Other communication disability	0	0%
Cognitive	0	0%
Physical/ Mobility	0	0%
Chronic Health Condition	0	0%
Other non-communication disability	0	0%
No Disability	0	0%
Prefer not to answer	0	0%
Unknown	645	100%
Unduplicated Total	645	100%

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

CCR § 3620.10 data is not collected for this program.

	FY 2023	
Residential Status	**# Served**	**% of Served**
Not available		

Unduplicated Total		

	FY 2023	
Educational Status	**# Served**	**% of Served**
Not available		
Unduplicated Total		

	FY 2023	
Employment Status	**# Served**	**% of Served**
Not available		
Unduplicated Total		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Not available		
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Not available		
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Not available		
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Not available		
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Not available		
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N =645				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
645	Integrated Behavioral Health Services that include individual, family and group therapy, case management, medication support, and crisis intervention.	645	Not available	Not available

8. Group Services Delivered

FY 2023		
Unduplicated N = 645		
Number of Groups	**Attendance**	**Average Attendance per Group**
0	0	0

9. Detailed Outcomes

FY23 Outcome Measures

i. The program length of stay is generally less than 6-months.
ii. 100% of youth were referred and connected to post-program supports.

10. Evaluation Summary

Program Successes Include:

iii. Engagement of youth participation in the program
iv. Providing integrated treatment using model of co-occurring standards
v. Continued to provide in-person support for youth despite COVID-19 limitations.
vi. Use of virtual platforms for care coordination and multidisciplinary team meeting created higher levels of engagement and participation.

Program Challenges Include:

i. Providing in person, face-to-face services during Covid-19 during quarantine/isolation periods.

Mobile Response and Stabilization Services

The Mobile Response and Stabilization Services program in Santa Clara County covers 2 different programs.

1. Mobile Response and Stabilization Services
2. Post-Crisis Stabilization Services

The total cost per person, across all programs in this category can be found below. The following pages are detailed reports for each individual program in this category.

FY 2023		
Number Served	Program Expenditure	Cost per Person
1,143	$6,943,273	$ 6,074.60

MOBILE RESPONSE & STABILIZATION SERVICES

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Mobile Response and Stabilization Services (MRSS) program is operated by Pacific Clinics. The services are available 24/7 and services include stabilization and support services to children, youth, and families in the community who are depressed, experiencing thoughts of suicide and/or a potential danger to others, or in some other form of acute psychological crisis. Services include a 5150 assessment, safety planning, and referrals to community-based mental health services. All children and youth in the County can receive services regardless of living situation or funding. Children and youth are typically referred to mobile crisis from parents, family members, caregivers, friends, schools, police officers, community service providers, or health professionals. Length of service is two to four hours. Pacific Clinics Mobile Crisis therapeutic teams consult, assess for risk and safety, and intervene with the hope of promoting community stabilization. Through a family-centered, strengths-based approach, clinicians utilize the least intrusive and restrictive means to work with children and families on finding tools that promote ongoing health and growth and help maintain children in their homes and communities. These tools consist of practical strategies to stabilize current and future crises, improve communication, and facilitate positive outcomes; youth-specific referrals; and access to information for ongoing treatment and other supports. The Pacific Clinics staff is diverse, multi-lingual, and multi-disciplinary. All Pacific Clinics clinicians are authorized 5150 evaluators and can place youth on 72-hour holds. Crisis response includes:

i. Diagnostic interview, assessment of mental and emotional status, risk assessment
ii. Strengths-based family evaluation
iii. Safety planning
iv. Facilitation of emergency hospitalizations
v. Crisis counseling, therapeutic supports
vi. Youth -specific referrals for follow-up or access to services.

2. Program Goals, Objectives & Outcomes

❖ Goal

The goal for MRSS is to provide timely response to children and youth in Santa Clara County who are experiencing an emotional/psychiatric crisis and providing services to stabilize youth in community or assess for a psychiatric inpatient hospitalization.

❖ Outcomes

i. Improve the overall crisis response in the community
ii. Reduce the trauma and stigma of crisis experience for children, youth, and families
iii. Reduce unnecessary utilization of law enforcement resources
iv. Improve acute hospital diversion rate

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =785		
Number Served	Program Expenditure	Cost per Person
1014	$3,181,655	$3,137.73

4. Evaluation Activities

❖ **MHSA CSS-GSD (MRSS) Outcomes**

i. Services provided are culturally responsive and linguistically competent to address racial and ethnic diverse population
ii. Improve care coordination and linkage to needed services
iii. Improve access by provision of services 24/7 in the community at the time needed
iv. Improve parent education and skills with parent coaching and support to address urgent/crisis need
v. Reduce need for inpatient hospitalizations

❖ **County Outcomes**

i. Children and youth will discharge successfully
ii. Children and youth will be admitted into program within 7 business days to improve timely access
iii. Improve readmission rates

❖ **Additional Program Specific Outcomes**

i. Increase knowledge and awareness of suicide prevention
ii. Increase access to services by increasing capacity
iii. Support learning and knowledge of stressors that impact emotional wellness

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	559	71%
16 -25 years	226	29%
26- 59 years	0	0%
60+ years	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	785	100%

	FY 2023	
Race	**# Served**	**% of Served**

American Indian or Alaska Native	6	1%
Asian	138	18%
Black or African American	27	3%
Native Hawaiian or Other Pacific Islander	2	<1%
White/ Caucasian	147	19%
Other	391	50%
More than one race	70	9%
Prefer not to answer	1	<1%
Unknown	3	<1%
Unduplicated Total	785	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	0	0%
Central American	12	2%
Mexican/ Mexican-American/ Chicano	101	13%
Puerto Rican	3	<1%
South American	14	2%
Hispanic/ Latino (undefined)	245	31%
Other Hispanic/ Latino	0	0%
Hispanic or Latino Subtotal	375	48%
Non-Hispanic or Non-Latino as follows:		
African	27	3%

Asian Indian/ South Asian	21	3%
Cambodian	1	0%
Chinese	31	4%
Eastern European	0	0%
European	0	0%
Filipino	28	4%
Japanese	7	1%
Korean	4	1%
Middle Eastern	0	0%
Vietnamese	40	5%
Non-Hispanic/ Non-Latino (undefined)	161	21%
Other Non-Hispanic/ Non-Latino	16	2%
Non-Hispanic or Non-Latino Subtotal	336	43%
More than one ethnicity	70	9%
Prefer not to answer	1	<1%
Unknown	3	<1%
Unduplicated Total	785	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	286	37%
Female	497	63%
Prefer not to answer	0	0%
Unknown	2	<1%
Unduplicated Total	785	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	233	30%
Female	351	45%
Transgender (Male to Female)	6	1%
Transgender (Female to Male)	27	3%
Transgender (Undefined)	0	0%
Genderqueer	8	1%
Questioning or Unsure	9	1%
Another gender identity	5	1%
Prefer not to answer	141	18%
Unknown	5	1%
Unduplicated Total	785	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	22	3%
Heterosexual/ Straight	196	25%
Bisexual	67	9%
Questioning/ Unsure	28	4%
Queer	3	<1%
Another sexual orientation	37	5%
Prefer not to answer	10	1%
Unknown	422	54%
Unduplicated Total	785	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	632	81%
Spanish	113	14%

Vietnamese	18	2%
Chinese	2	<1%
Tagalog	1	<1%
Farsi	1	<1%
Other	15	2%
Prefer not to answer	0	0%
Unknown	3	<1%
Unduplicated Total	785	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
The program is a brief same day in-person crisis response program for youth under age 21. Due to the nature of brief crisis contacts, there has been limited opportunity to collect demographic information on military status, and military status will have low data due to the target age of this program. The program will work to collect additional information on this metric in FY24 when possible.		

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	1	<1%
Difficulty hearing or speaking	2	<1%
Other communication disability	0	0%
Cognitive/ Mental	46	6%
Physical/ Mobility	0	0%
Chronic Health Condition	0	0%
Other disability	159	20%
No Disability	0	0%
Prefer not to answer	0	0%
Unknown/ None	577	74%
Unduplicated Total	785	100%

6. Additional Data Collection Requirements

Data regarding Residential Status, Educational Status, Employment Status, Sources of Financial Support, Health Status, Substance abuse issues, and ADLs were not collected in FY23. The program is moving to collect additional information on these data points in FY24. Due to the nature of the program being very brief crisis response, it is not always possible to collect this data.

	FY 2023

Emergency Interventions	# Served	% of Served
Crisis Responses	785	100%
Unduplicated Total	785	100%

7. Referrals

FY 2023				
Unduplicated N = 785				
Number of individuals with serious mental illness referred to treatment	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
Of the 785 individuals served, referrals were made to all individuals for either a hotline if further support is needed and/or to ongoing mental health services, as clinically indicated. A total of 1,323 referrals were made.	Short Term Community Based Stabilization Program (Post Crisis Stabilization Services): 53, 5% Crisis Stabilization Unit: 250, 25% Other Pacific Clinics Programs: 45, 4% Hotlines: 298, 29% Outside Provider (other BH): 676, 67%	Unknown/Not Identified: See Detailed outcomes for more information	Unknown/Not Identified due to short-term nature of the program	Unknown/Not Identified due to short-term nature of the program

8. Group Services Delivered

N/A: This program does not provide group services.

9. Detailed Outcomes

❖ **Safety Plans vs 5150**

MRSS successfully stabilized 72% of the time they were dispatched to provide support in the community, avoiding the need for a youth to be placed on an involuntary hold. This provided a trauma -informed approach in helping build a safety network within the youth's home and family, allowing the youth to remain in their community rather than being involuntarily detained for their safety.

❖ **Hospital Diversion**

i. 248 (duplicated) referred to CSU (Criss Stabilization Unit), of that 89 were safety-planned.
ii. 53 referred to PCSS (Post-Crisis Stabilization Services), of that 38 were served, and 26 of them met/partially met treatment goals.

❖ **Access**

MRSS has completed their soft launch for South County, and now has a permanent team out stationed during school hours in the area to improve their response time moving forward. In mid FY23, MRSS also increased their available staffing during every shift to better meet the demand of the community. Having staff stationed throughout the county is anticipated to support timely response times. MRSS has also partnered with other county mobile response teams to increase access and timeliness to services. Since the launch of Salesforce in February 2023, the average response time is 39.51 minutes.

❖ **Outreach**

i. Law Enforcement: 14
ii. County 5150 Trainings: 5
iii. Schools/Community mtgs: 7
iv. BH Partners: 7

❖ **Successful discharges**

i. 72% MRSS successfully (safety planned)

The CAT (Crisis Assessment Tool) has been ruled out as an effective measure for tracking outcomes due to the length of time need for assessment and data collection. The program outcomes will continue to be measured on outreach, hospital and 5150 diversion, timeliness of response and access, and successful discharges.

10. Evaluation Summary

MRSS continues to provide a valued and integral service to children and youth in Santa Clara County. The program has grown to expand capacity to serve youth throughout the county and respond at the time needed. MRSS has multiple teams which have helped divert youth from requiring an involuntary hold and helped link to necessary services and resources in the community.

MRSS has also launched the youth of a data and dispatch system, Salesforce, which allows their call center to view where teams are located to improve their response time. Additionally, this platform will allow the team to track and monitor trends, monitor data, so the program can flex and expand to areas most needed as trends may shift over time or seasonally. The Salesforce platform supported by a CCMU grant, launched in early Spring 2023, and will be an added resource to the program to improve coordination, response time, track trends, and assess gaps as the program continues to strive for excellence.

MRSS has also been a valued partner with the Access and Unplanned Services Division and has heavily partnered with the 988 rollout and other mobile response teams in the county to provide services in a coordinated and seamless manner. MRSS has been an integral part of the 988 roll-out in Santa Clara County, and has participated in county workgroups, meetings, and data gathering to support access to mobile crisis services for our community and ease access for our community.

MRSS has also continued to partner with law enforcement, child welfare, and schools in the community to provide outreach and education about the services they provide and helped develop strong and collaborative relationships.

MRSS is often able to stabilize children and youth with telephonic support. The data above is inclusive of the in-person responses from the program, and hundreds of others were served with telephonic support. Of those youth that required an in-person response due to the degree to concern with the child, almost three-quarters were able to be stabilized in their community without requiring an involuntary hold.

MRSS is challenged, as are many programs, with hiring and retaining qualified staff. This can impact MRSS's response time to crisis situations due to limited teams available. During these staff shortages, MRSS leverages its supervisors and managers to respond to crisis calls, and teams with other mobile response programs.
MRSS, as a part of a continuum of available crises care services within Pacific Clinics, along with the Crisis Stabilization Unit (CSU) and Post-Crisis Stabilization Services, has dedicated teams with expertise in child development, trauma, and crisis. MRSS continues to be poised to provide an essential service to children, youth, and young adults in Santa Clara County.

POST-CRISIS STABILIZATION SERVICES

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The Post-Crisis Stabilization Program (PCSS) is a program operated as part of the Crisis Continuum at Pacific Clinics. This program offers intensive community-based services to provide stabilization and support to youth in Santa Clara County who may be at risk of hospitalization. Services include teaming with the child and family, intensive home-based services, rehabilitative services, safety planning, psychiatric services, and identification and linkage to longer-term mental health supports when needed. The services are provided by a clinical team, which may include a clinician, family specialist, family partner, and psychiatrist. Services are designed to be short-term, less than 90 days, to support stabilization to prevent a mental health crisis. Services may be implemented after an acute crisis, including post- admission to the Pacific Clinics Crisis Stabilization Unit. They may also be put in place post-psychiatric hospitalization.

2. Program Goals, Objectives & Outcomes

❖ Goal

The goal of PCSS is to provide timely response to children and youth in Santa Clara County who are experiencing an emotional/psychiatric crisis and provide services to stabilize youth in the community to avoid rehospitalization or further destabilization.

❖ Outcomes

i. Improve the overall crisis response in the community
ii. Reduce the trauma and stigma of crisis experience for children, youth, and families
iii. Reduce unnecessary utilization of law enforcement resources
iv. Reduce readmission rate to hospitals and CSU

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 127		
Number Served	**Program Expenditure**	**Cost per Person**
129 (duplicated)	$2,554,197	$19,780

4. Evaluation Activities

❖ MHSA CSS-GSD (MRSS) Outcomes

i. Services provided are culturally responsive and linguistically competent to address racial and ethnic diverse population
ii. Improve care coordination and linkage to needed services
iii. Improve access by provision of services 24/7 in the community at the time needed
iv. Improve parent education and skills with parent coaching and support to address urgent/crisis need
v. Reduce need for inpatient hospitalizations

❖ **County Outcomes**

i. Children and youth will discharge successfully
ii. Children and youth will be admitted into program within 7 business days to improve timely access
iii. Improve readmission rates

❖ **Additional Program Specific Outcomes**

i. Increase knowledge and awareness of suicide prevention
ii. Increase access to services by increasing capacity
iii. Support learning and knowledge of stressors that impact emotional wellness

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	96	76%
16 -25 years	31	31
26- 59 years	0	0%
60+ years	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	127	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	0	0%
Asian	10	8%
Black or African American	6	5%
Native Hawaiian or Other Pacific Islander	0	0%

White/ Caucasian	7	6%
Other	85	67%
More than one race	18	14%
Prefer not to answer	0	0%
Unknown	1	1%
Unduplicated Total	127	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:	0	0%
Caribbean	0	0%
Central American	0	0%
Mexican/ Mexican-American/ Chicano	15	12%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	56	44%
Other Hispanic/ Latino	10	8%
Hispanic or Latino Subtotal	81	64%
Non-Hispanic or Non-Latino as follows:		
African	6	4%
Asian Indian/ South Asian	0	0%

Cambodian	0	0%
Chinese	1	1%
Eastern European	0	0%
European	0	0%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	7	6%
Non-Hispanic/ Non-Latino (undefined)	0	0%
Other Non-Hispanic/ Non-Latino	9	7%
Non-Hispanic or Non-Latino Subtotal	0	0%
More than one ethnicity	19	15%
Prefer not to answer	0	0%
Unknown	4	3%
Unduplicated Total	127	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	36	28%
Female	91	72%
Prefer not to answer	0	0%

Unknown	0	0%
Unduplicated Total	127	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	28	22%
Female	70	55%
Transgender (Male to Female)	1	1%
Transgender (Female to Male)	3	2%
Transgender (Undefined)	0	0%
Genderqueer	0	0%
Questioning or Unsure	0	0%
Another gender identity	0	0%
Prefer not to answer	0	0%
Unknown	25	20%
Unduplicated Total	127	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	2	2%
Heterosexual/ Straight	38	30%
Bisexual	15	12%
Questioning/ Unsure	0	0%
Queer	0	0%
Another sexual orientation	0	0%
Prefer not to answer	6	6%
Unknown	63	50%
Unduplicated Total	127	100%

	FY 2023

Primary Language	# Served	% of Served
English	99	78%
Spanish	26	21%
Vietnamese	1	1%
Chinese	0	0%
Tagalog	0	0%
Farsi	0	0%
Other	0	0%
Prefer not to answer	0	0%
Unknown	1	0%
Unduplicated Total	127	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
This program serves youth under age 18. Data on military status was not collected.		

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	0	0%
Difficulty hearing or speaking	0	0%
Other communication disability	0	0%
Cognitive/ Mental	12	
Physical/ Mobility	0	0%
Chronic Health Condition	0	0%
Other disability	20	
No Disability	0	0%
Prefer not to answer	0	0%
Unknown/ None	106	
Unduplicated Total	127	100%

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**

Housed	127	100%
Unduplicated Total	127	100%

	FY 2023	
Educational Status	**# Served**	**% of Served**
In School	106	98%
Out of school (graduated)	2	2%
Unduplicated Total	108	100%

	FY 2023	
Employment Status	**# Served**	**% of Served**
This program serves youth under age 18. Employment status was not collected in FY23.		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
This program serves youth under age 18 with Medi-Cal benefits or who are unsponsored. Financial support status was not collected in FY23.		

	FY 2023	
Health Status/Chronic Health Condition	**# Served**	**% of Served**
This data was not collected in FY23. The program is beginning to track this data in FY24.		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Yes	10	8%
No	87	68%
Unknown	30	24%

Unduplicated Total	127	100%

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
This data was not collected for FY23. The program is beginning to collect this data in FY24.		

7. Referrals

FY 2023				
Unduplicated N = 127				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
Of 127 individuals served by the program, 107 were referred to ongoing BH services	Therapy, case management, psychiatry, intensive services, substance use treatment services	Unknown/Not Identified	Unknown/Not Identified	Unknown/Not Identified

8. Group Services Delivered

FY 2023
This program does not provide group services.

9. Detailed Outcomes

There were 129 treatment episodes for 127 youth. At closure, 64% met or partially met their treatment goals.
A success story:
11-year-old “Jason” struggled with anxiety, angry outbursts, and thoughts of harming himself and others. Jason's parents were separated, and he felt very disconnected from both parents. Jason's symptoms became so severe that he had to be evaluated by Pacific Clinic's Mobile Response & Stabilization Service program (MRSS). The

MRSS Clinician responded to the community where Jason had a mental health crisis. Jason was assessed and admitted to our Crisis Stabilization Unit (CSU) as a danger to self and others. Once admitted to the CSU, Jason was seen by the psychiatrist, Clinician, and Nurse. Jason's symptoms stabilized, but he was not connected to mental health services. CSU clinician was able to link the youth and family to Pacific Clinic's Post Crisis Stabilization Services program (PCSS), where he and his family received support and care from a Team of a Clinician, Family Partner, and Family Specialist.

When Jason first began PCSS services, he was not engaged and unwilling to participate in the sessions with PCSS Family Specialists. He expressed feeling frustrated due to feeling overwhelmed with his stressors (school and family relationships). He thought services would not be helpful due to his past experiences with service providers. Jason stated that his mother had minimal interest in him, and his father had very little involvement, which was a source of his stress. During the first few weeks of services, it was challenging to connect with Jason because he often ignored staff and became very emotional, evidenced by pounding on the table, crying, and having emotional outbursts.

The PCSS team did not give up on Jason, and they brainstormed ways to improve his level of engagement with his parents. PCSS team remained consistent with being present during the scheduled sessions, with Jason continuously working on trust so that he would participate in the skills-building activities. PCSS normalized Jason's frustration over factors contributing to his angry outbursts at home and assisted him in improving his self-awareness of factors contributing to anger. PCSS supported Jason with developing self-monitoring, self-care, and communication skills when triggered in stress-provoking situations.

The PCSS facilitated Child and Family Team Meetings (CFTs) where both the mother and father participated and assisted the family in developing a Vision of what they wanted to achieve from PCSS services and identifying areas to work on. PCSS provided collateral support to Jason's parents to bring awareness of his symptoms and the antecedents that led to the youth's escalated behaviors. PCSS provided the family with psychoeducation on the youth's anxiety and coached the family on ways to improve their communication with Jason so that he felt understood and supported. PCSS provided family sessions where Jason and his parents practiced the communication skills—provided family-focused interventions (challenging automatic thoughts, improving communication skills, and increasing connection and family bonding) through a strength-based approach. PCSS coordinated a plan with the family to support the youth by sustaining his progress in safety. Jason and his family worked on the plan, and the youth began stabilizing and decreasing his unsafe and escalated behaviors.

Jason improved his symptoms and behaviors as his parents' involvement in PCSS increased and their co-parenting improved. He improved his communication with his mother and connection to his father. Jason's father began to call Jason and participate in supervised visits frequently. Jason's anxiety decreased as he engaged in community outings and youth groups. Jason reported no longer having homicidal ideation and only occasional thoughts of harming himself. Jason's relationship with his family and engagement improved in family activities and outings. The parents were better aware of Jason's low-level cues indicating signs of anxiety. They learned to proactively support the youth with his coping strategies to manage his stress and thoughts of self-harm. Jason reported feeling better and happier, especially at CFT meetings with his parents. Jason stated feeling hopeful because he was able to develop friendships at school during this time with PCSS, and his family expressed much gratitude and appreciation for the support.

Overall, Jason was provided comprehensive services and continuity of care from our Crisis Continuum programs--MRSS, CSU, and PCSS.

10. Evaluation Summary

PCSS is a vital program that can provide same-day access for youth coming out of an acute crisis and is part of the continuum of care at Pacific Clinics, including the mobile response program and the crisis stabilization unit. PCSS has supported 129 youth with stabilization services and support and provided warm hand-offs for children transitioning to a lower level of care.

PCSS has noted a seasonal pattern with referrals, with more youth experiencing crisis in late fall and early spring, which has required flexibility in staffing to meet the demands as they present. More family specialists were hired to support these needs, and promotional opportunities and retention strategies have been implemented to maintain the level of expertise and access on the team. One of the challenges in FY23 was navigating new requirements under CalAIM while providing intensive services to children and youth.

In FY23, 64% of those who received services from the program met or partially met their treatment goals. Several families with very complex needs were able to help their youth stabilize along with the team by working on both individual and caregiving needs. Family partners have provided critical support for coaching sessions with caregivers, and the Child and Family Team process has brought together both natural and professional supports to promote the youth's wellness, daily functioning, and stability.

TAY RESPITE (TAY CRISIS AND DROP IN CENTER)

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The TAY Crisis and Respite provides a safe, welcoming, and inclusive space for youth to receive access to behavioral health resources and engage in wellness supports. The center conducts outreach and engages youth about their mental health and basic needs.

The center provides outpatient mental health services and overnight respite services to youth 18-25 years of age. Respite services can accommodate up to 10 TAY who need respite as a result of crisis or who are at risk of homelessness. Respite services allow TAY to self-manage and remain in their community, which may impede crisis escalation. The centers also offer services to unsponsored/ uninsured youth and allow the TAY homeless population to access needed supports. Additionally, services specifically for LGBTQ TAY are offered.

Specific mental health outpatient service offered include:

i. Assessments
ii. Treatment planning
iii. Brief crisis intervention
iv. Case management
v. Self-help and peer support
vi. Outreach and engagement activities for homeless TAY

2. Program Goals, Objectives & Outcomes

❖ **Outcome**

i. Provide a safe and inclusive environment for TAY
ii. Increase service connectedness to behavioral health resources
iii. Reduce the need for a higher level of care for youth

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
135	$ 575,809	$4,265.25

4. Evaluation Activities

The Transitional Age Youth Respite program is focused on providing brief crisis and drop-in center services consisting of outreach, engagement, and support for TAY clients to address their psychological and developmental needs to improve functional outcomes. The service model shall include an outpatient Behavioral Health component which is culturally and linguistically responsive and with an emphasis of treatment for co-

occurring disorders and use of trauma informed care. Services focus also on wellness and recovery goals to include supports that prepare and facilitate self-sufficiency and successful achievement of individual transition goals. Transitional life domains include employment, education, living situation, personal wellbeing, interpersonal relationships, and community-life functioning. Beneficiaries are provided with treatment methods which may include assessments, medication evaluation and support services, crisis intervention, individual, group, collateral and family therapy, rehabilitation, and case management/brokerage services.

This is the second year that data has been gathered specifically on the youth who use Respite Services. Some youth come to spend one night and do not engage in other services while other youth stay multiple nights and begin to engage with staff and use multiple services. Data points can be refined and collected to better understand the amount and frequency of services each youth receives.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	0	0%
16 -25 years	135	100%
26- 59 years	0	0%
60+ years	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	135	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	9	6.67%
Asian	7	5.18%
Black or African American	32	23.70%
Native Hawaiian or Other Pacific Islander	1	0.74%
White/ Caucasian	63	46.67%

Other	0	0%
More than one race	14	10.37%
Prefer not to answer	2	1.48%
Unknown	7	5.19%
Unduplicated Total	135	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	0	0%
Central American	0	0%
Mexican/ Mexican-American/ Chicano	0	0%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	67	49.62%
Other Hispanic/ Latino	1	0.74%
Hispanic or Latino Subtotal	68	50.37%
Non-Hispanic or Non-Latino as follows:		
African	0	0%
Asian Indian/ South Asian	0	0%
Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%

European	0	0%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Non-Hispanic/ Non-Latino (undefined)	67	49.62%
Other Non-Hispanic/ Non-Latino	0	0%
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	67	49.62%

	FY 2023	
Gender (Assigned at Birth)*	**# Served**	**% of Served**
Male		
Female		
Prefer not to answer		
Unknown		
Unduplicated Total		

*Data not available

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	86	63.70%
Female	42	31.11%
Transgender (Male to Female)	1	0.74%

Transgender (Female to Male)	3	2.22%
Transgender (Undefined)	1	0.74%
Genderqueer	0	0%
Questioning or Unsure	0	0%
Another gender identity	2	1.48%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	135	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	3	2.22%
Heterosexual/ Straight	109	80.74%
Bisexual	12	8.88%
Questioning/ Unsure*	4	2.96%
Queer	0	0%
Another sexual orientation	0	0%
Prefer not to answer	3	2.22%
Unknown	4	2.96%
Unduplicated Total	135	100%

*Includes A-sexual, Nonlabel, pansexual, and unsure

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	124	91.85%
Spanish	8	5.93%
Vietnamese	1	0.74%
Chinese	0	0%
Tagalog	0	0%
Farsi	0	0%
Other	3	2.22%
Prefer not to answer	0	0%

Unknown	0	0%
Unduplicated Total	135	100%

	FY 2023	
Military Status*	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military		
Prefer not to answer		
Unknown		
Unduplicated Total		

*Data not available

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	0	0%
Difficulty hearing or speaking	0	0%
Other communication disability	0	0%
Cognitive**	45	33.33%
Physical/ Mobility	10	7.41%
Chronic Health Condition	14	10.37%
Other non-communication disability	0	0%
No Disability	118	87.41%
Prefer not to answer	0	0%
Unknown	1	0.74%
Unduplicated Total	0	0%

*Participants may choose more than one option for Disability.
**Includes developmental disability and Mental Health Disorder

6. Additional Data Collection Requirements

Data not available for FY23. The program is exploring ways to collect and report this data in future reporting

	FY 2023

Residential Status	# Served	% of Served
Unduplicated Total		

	FY 2023	
Educational Status	# Served	% of Served
Unduplicated Total		

	FY 2023	
Employment Status	# Served	% of Served
Unduplicated Total		

	FY 2023	
Sources of Financial Support	# Served	% of Served
Unduplicated Total		

	FY 2023	
Health Status	# Served	% of Served
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	# Served	% of Served
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	# Served	% of Served
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
112	Mental health services *including individual/group therapy, casement, peer support, etc.*	48	18 days	

8. Group Services Delivered

This year the in-person support at the Drop-In Center increased. Groups were run weekly, with various topics such as Thinking 4 Change, Art of Success (Employment Focused Group) Mens Group, Sister Circle, 7 Challenges Substance Abuse focused class), and Gayme Night/Social Night plus others. In addition to these groups there were also six (6) college/vocational tours that occurred, every quarter this year with approximately five (5) youth attending each tour. Please note, there will be duplication in these group numbers as youth can attend one or several groups weekly.

FY 2023
Unduplicated N =

Number of Groups	Attendance	Average Attendance per Group
17 weekly groups	85 people/week	5/group (attendees can attend one or multiple groups weekly)

9. Detailed Outcomes

This is the second year that data has been gathered specifically on the youth who use Respite Services. Below is a list of services that the 135-youth used while receiving Respite services. However, the "number of times service used" is duplicative, meaning one youth could have utilized the service 100 times.

Service	**# of times service Used**
Respite	2208
Case Management/Follow-Up	1518
Other Services	353
Employment Assistance (job search coaching referral)	557
Group	442
Emotional Support/Counseling	1002
Housing-BWC (THP THP-TAY etc. referral)	135
Transportation (token referral)	167
Motivational Interview	232
Service Plan Development	62
Educational Assistance (enrollment diploma GED Cert.)	128
Substance Abuse Assessment and/or Treatment	117
Housing-Other Agency (search referral)	154
Mental Health (access referral)	60
Job Search Assistance	34
Shelter/Respite/Safe Haven (access referral)	74
Discharge Follow-Up	19
Medical Referral	87

Crisis Intervention	214
Financial/Social Benefits (SSI TANF WIC etc.)	26
Substance Abuse Treatment (access referral)	117
Relocation Assistance	6
CalOES Referral-Other victim programs	9
CalOES Other legal advice and/or counsel	29
CalOES Civil legal assistance in obtaining protection or restraining order	9
Job Retention Support	6
CalOES Info-Criminal justice process	24
CalOES Criminal advocacy/accompaniment	14
CalOES Intervention with employer creditor landlord or academic institution	0
Dental Referral	5
Job Readiness Training	7
CalOES Victim impact statement assistance	1
Parenting Skills (training coaching referral)	6
CalOES Info-Victim rights obtain notifications etc.	1
STDs/HIV/AIDS Services (access referral)	1
CalOES Law enforcement interview advocacy/accompany	7
Grand Total	8600

10. Evaluation Summary

Fiscal Year 2023 had many challenges as well as successes. As the Drop-In Center increased their operating hours, client engagement increased, and in-person use of the facilities became more widely available again. The Drop-In Center which is well known in the community had new staff leadership join this year and youth were able to be housed, received medical treatment, used the drop-in facilities for meals/laundry, were assisted to get linked for financial support, received transportation tokens, plus more services that were noted in the above section. In January, the Respite & Drop-In Center were highlighted through a PowerPoint presentation in both the CYF Leadership meeting and in the TAY System of Care meetings.

A few challenges included difficulty in staffing, they were unable to hire another overnight staff, so youth needed to leave the respite housing early in the mornings. Also, the manager for the Drop-In Center is new and required on-boarding time.

More data points will be collected and refined for next year in hopes of demonstrating the positive outcomes of this program and how youth continue to benefit from these Respite Services.

TAY INTERDISCIPLINARY SERVICE TEAM

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The TAY interdisciplinary Service Team (IST) provides a spectrum of resources to youth and young adults, including those who are homeless, that support their behavioral health and help launch them into adulthood. TAY IST provides clinic-based services that are safe, welcoming, and ensure an inclusive environment for TAY engagement and direct access to behavioral health services. Service teams consist of case managers, clinicians, psychiatrists, substance use treatment youth counselors, and peer support. Youth served are 16-25 years of age.

In addition to a standard range of outpatient mental health services, IST focuses on youth-specific needs to support their independence and transition into adulthood. This includes individual and group interventions, peer support, socialization, access to education and employment services, and medication management.

2. Program Goals, Objectives & Outcomes

❖ **TAY Interdisciplinary Services Team Outcomes**

i. Increase service connectedness
ii. Reduce later need for higher intensity of care

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = TAY IST: 173		
Number Served	Program Expenditure	Cost per Person
173	$713,645	$4,125.12

4. Evaluation Activities

The TAY IST program focuses on ensuring timely access and linkage to needed services and resources for individuals that may need additional supports to maintain their wellness and recovery. Services provided to the community included a range of services, including mental health supports, culturally specific peer support services, family education, and vocational and educational assistance to help individuals obtain employment as well as individual services and support plan development to help them launch smoothly into adulthood. TAY IST was created to provide a safe, welcoming, and inclusive environment for Transitional Aged Youth to sustain progress in their wellness and recovery journey and provide additional skills to support independence in their ability to maintain their wellness and recovery.

Both the TAY LGBTQ Outpatient and TAY IST programs utilize standardized functional assessment tools to support determination of treatment needs, goals and monitoring of outcomes. The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool created to support communication with the individual and identify needs and strengths to determine treatment focus and monitor outcomes. The CANS is completed in

collaboration with the youth/young adult and their family to discuss needs and strengths during initial assessment, at six month intervals and at discharge from services. For youth 18 and under, the Pediatric Symptom Checklist (PSC-35) is utilized to screen for general concerns in youth, from the caregiver's perspective. If a caregiver is not involved with the individual, the youth has the ability to answer on their behalf. Both these tools are entered into a County database. Information from the tools is used for individualized program planning to support treatment goals but also used to evaluate program outcomes an identify any needs in service delivery to support continuous quality improvement. Lastly, an annual Client Satisfaction Survey is distributed to beneficiaries receiving behavioral health services. These surveys are collected and used for system changes and improvement.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years	TAY IST = 168	TAY IST = 97%
26- 59 years	TAY IST =5	TAY IST =3%
60+ years		
Prefer not to answer		
Unknown		
Unduplicated Total	TAY IST = 174	TAY IST = 100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	TAY IST =1	TAY IST =1%
Asian	TAY IST =23	TAY IST = 13%
Black or African American	TAY IST =5	TAY IST = 3%
Native Hawaiian or Other Pacific Islander	TAY IST =2	TAY IST =1%

White/ Caucasian	TAY IST = 10	TAY IST =6%
Other	TAY IST = 58	TAY IST =34%
More than one race	TAY IST = 0	TAY IST =0%
Prefer not to answer	TAY IST = 2	TAY IST =1%
Unknown	TAY IST = 72	TAY IST =42%
Unduplicated Total	TAY IST = 173	TAY IST = 100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	TAY IST = 67	TAY IST = 39%
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	TAY IST = 67	TAY IST = 39%
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		

Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	TAY IST = 38	TAY IST = 22%
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer		
Unknown	TAY IST = 68	TAY IST = 39%
Unduplicated Total	TAY IST = 173	TAY IST = 100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	TAY IST = 51	TAY IST =29%
Female	TAY IST = 121	TAY IST =70%
Prefer not to answer		
Unknown		
Unduplicated Total	TAY IST = 173	TAY IST = 100%

	FY 2023

Gender (Current)	# Served	% of Served
Male		
Female		
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	TAY IST = 173	TAY IST = 100%
Unduplicated Total	TAY IST = 173	TAY IST = 100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	TAY IST = 173	TAY IST = 100%
Unduplicated Total	TAY IST = 173	TAY IST = 100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	TAY IST = 112	TAY IST = 65%
Spanish	TAY IST = 19	TAY IST =11%
Vietnamese	TAY IST = 2	TAY IST =1.25%
Chinese		
Mandarin	TAY IST = 1	TAY IST =1%
Tagalog		
Farsi		
Other (*American Sign Language and Cambodian)*	TAY IST = 0	TAY IST =0%
Prefer not to answer		
Unknown	TAY IST = 39	TAY IST = 23%
Unduplicated Total	TAY IST =173	TAY IST = 100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	TAY IST =0	TAY IST =0%
Veteran		
Served in Military		
Family of Military		
No Military	TAY IST =33	TAY IST =19%
Prefer not to answer		
Unknown	TAY IST =140	TAY IST =81%
Unduplicated Total	TAY IST =173	TAY IST = 100%

	FY 2023	
Disability*	**# Served**	**% of Served**

Difficulty seeing	TAY IST = 0	TAY IST =0%
Difficulty hearing or speaking		
Other communication disability		
Cognitive	TAY IST = 16	TAY IST =9%
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability	TAY IST = 20	TAY IST =12%
No Disability		
Prefer not to answer		
Unknown	TAY IST = 137	TAY IST =79%
Unduplicated Total	TAY IST =173	TAY IST = 100%

*Participants may choose more than one option for Disability. *Data source for this section was the MHSA Unduplicated Client Count Data Report as of 8/18/23 report.*
Sexual orientation and Gender Identity data was not provided for this report.

6. Additional Data Collection Requirements

Data not available for FY23. The program is exploring ways to collect and report this data in future reporting

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N = TAY IST: 87				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment**	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment**

provided, funded administered, or overseen by county mental health versus treatment that is not)		(for treatment that is provided, funded administered, or overseen by county mental health)	overseen by county mental health)	**to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
TAY IST = 75	TAY IST services including individual/group therapy, case management, education/vocational support, peer services, etc.	TAY IST = 35	TAY IST = 9 days	TAY IST = 5 to 13 days

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
TAY IST = 1 weekly group	5 attendees/week	5 attendee/group

9. Detailed Outcomes

There was one (1) County Contracted Provider (CCP) who provided Transitional Age Youth Interdisciplinary Services Team Service. On average, it took 9 days for a client to receive their first assessment appointment. There were 13 discharges and 54% of these beneficiaries had a successful discharge from services. Outcomes from the CANS for the IST program demonstrated a 33% positive change in the Behavioral and Emotional Needs domain, 25% positive change in the life functioning domain and no change in the youth risk factors domain. There were many individual client successes. One client had been struggling with Attention Deficit Hyperactivity Disorder (ADHD) and with therapy, medication and case management, the client has been able to focus in school and obtain employment. Additionally, because they were connected to the TAY IST program, their social isolation was reduced as they were re-connected into community programming and joined a church.

Every month there was a meeting with service providers to discuss program challenges and improvements. Challenges that were consistently shared amongst the programs was the difficulty of the staffing shortage and the impact on their workforce. Strategies were implemented to address the challenges around staffing, such as triaging and creating the position of an intake specialist that could help support youth/young adults with consistent check ins or resource linkage, while they were waiting for services to begin. This helped to support engagement as wait times for initial appointments may be delayed.

One positive impact from the pandemic mentioned by a youth is that they were on-line a lot more than normal and as a result was more active on social media sites and this information helped them to identify feelings they were having and recognizing that they are queer.

10. Evaluation Summary

The second year of operation for the TAY IST program had successes as well as challenges. Referral appropriateness has been a challenge with this program since inception. There was a focused intention during this fiscal year to refer the appropriate level of clients to the program. However, the challenge of maintaining clinical staff made it difficult to fully utilize the program's capacity. Youth and young adults that were provided IST services expressed benefits of the program and CANS outcomes identified positive change for those in services. The TAY IST program was developed to provide a step down from traditional outpatient services to support. There are wellness centers who support youth but these youth may also need a higher level of support, but these clients may be a good fit for the TAY IST program.

Outpatient Services for Adults Program

Due to organizational changes, Adult Outpatient and Older Adult Outpatient services are presented as a combined report on the subsequent pages.

The total cost per person, across both programs can be found below.

FY 2023		
Total Number Served	Program Expenditure	Cost per Person
6,020	$ 35,963,466 (Adult Outpatient)	$ 6,645.51
	$ 4,042,529 (Older Adult Outpatient)	
	$ 40,005,995 Total	

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Santa Clara's contracted outpatient mental health clinics are located throughout the County, where they provide an array of mental health supports, including basic mental health therapy and case management services and medication support. The County's clinics expand access to mental health services by co-locating at health facilities people are likely to go to or be familiar. The goal of Adult/Older Adult Outpatient is to assist individuals within the context of a mutual partnership effort to achieve higher levels of functioning, develop community/family support systems wherever possible, promote self-reliance and self-sufficiency, and encourage individuals to work or to return to work whenever possible. Service teams work with clients suffering from serious mental illness who exhibit severe problems in normal daily functioning, offering a full array of mental health services including case management services, crisis intervention and medication support services. This level of care has full-time service teams operating Monday through Friday, with available after-hours crisis support, and served 6,020 clients. All teams are comprised of therapists, case managers, rehabilitation counselors and psychiatrists. All clinics at this level of care provide a range of from up to 8 hours of service on intake down to about 2 hours per month. This program serves all eligible clients from age 18 years and up and includes the specialty program of the Deaf/Hard of Hearing community. The providers are Asian Americans for Community Involvement (AACI), Bill Wilson Center (BWC) Caminar for Mental Health (CMH), Catholic Charities of Santa Clara County (CCSCC), Community Solutions (CS), Gardner Family Health Network (GFHN), Momentum for Mental Health (MMH).

2. Program Goals, Objectives & Outcomes

❖ Goals

The Program shall accomplish the following goals:

i. Reduce subjective suffering from mental illness
ii. Increase meaningful use of time and capabilities in school, work, and activity
iii. Reduce homelessness and increase safe and permanent housing
iv. Increase access to substance use treatment
v. Increase natural networks of supportive relationships
vi. Increase self-help and client/family involvement
vii. Reduce disparities in access to mental health services
viii. Reduce disparities in service access
ix. Reduce psycho-social impact of trauma

❖ Objectives

The Program is designed to accomplish the following objectives:

i. Engage underserved clients who have not benefitted from traditional outpatient mental health services due to complex risk factors including substance use, community violence, interpersonal family violence, general neglect and exposure to trauma, social and emotional isolation, and physical decline and losses by providing culturally and linguistically proficient services

ii. The program shall address and participate in therapeutic activities, assessments, and/or linkage to services that:

a. Facilitate the reduction of client's psychiatric hospital admissions, including Emergency Psychiatric Services (EPS) episodes.
b. Assist in the prevention/reduction in the rate of incarcerations for the specified target population.
c. Increase client's access to substance use treatment.
d. Increase and strengthen the natural support systems through family engagement in the experience of care, self-help, and other types of support systems.
e. Identify issues including, but not limited to, dual diagnosis, physical disabilities, medications, and connect the client with a Primary Care Physician (PCP) to facilitate treatment of concurrent primary health care and ongoing behavioral health needs.
f. Address and participate in therapeutic activities, assessments and/or linkage services that shall identify physical and psychological conditions specific to target population.
g. The contractor shall initiate coordination and linkage with other providers and institutions including community-based resources that serve adults and/or older adults in Santa Clara County, recognizing that older adults may be less experienced in seeking these resources.
h. The contractor shall encourage clients to actively participate in their recovery and self-monitor milestones and goals towards self-determination, family and vocational education, and recreational services.
i. The contractor shall provide time-limited services for each client through age-appropriate care coordination as the single point of responsibility for services.
j. The contractor shall actively work with the client in their recovery process and assist the client to move towards a lower level of care within the criteria set for the program.
k. The contractor shall utilize Evidence Based Practices (EBPs), Promising Practices (PPs), and/or Community Informed Practices whenever clinically indicated and based on client's diagnoses. The contractor shall report and track both the fidelity and outcomes of any and all practices utilized.

❖ Key Outcomes

Key outcomes shall incorporate and achieve the following target benchmarks:

i. Clients are able to access medication and behavioral health support, including therapy and case management, needed to manage their symptoms and maintain wellness, as well as avoid the need for more intensive interventions such as hospitalization or full service partnership (FSP).
ii. Clients stabilized or experience improved integration in social settings, for the greatest possible opportunities to remain in the community.
iii. Reduce costs to other agencies, including health care (e.g., emergency room visits, inpatient hospital services).

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 6,020		
Number Served	Program Expenditure	Cost per Person
6,020	See cover page	See cover page

4. Evaluation Activities

i. Access & linkage strategy and designed & implemented strategies that are non-stigmatizing, non-discriminatory. Connecting participants to other community-based organizations and creating activities that are both welcoming and inviting for the ethnic specific community.
ii. Method of measuring outcomes is the community-based evidence method. This is being measured through qualitative surveys via verbal surveys and written surveys.
iii. The method of measuring client outcomes for other agencies was determined by a Milestones of Recovery Scale (MORS) score as evaluated by direct service providers monthly.

5. Demographic Data

*Not available, demographic data is not being collected from participants at outreach events or at service activities

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	4	0.07%
16 -25 years	265	4.40%
26- 59 years	4,414	73.32%
60+ years	1,337	22.21%
Prefer not to answer		
Unknown		
Unduplicated Total	6,020	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	67	1.11%
Asian	1162	19.30%
Black or African American	347	5.76%
Native Hawaiian or Other Pacific Islander	23	0.38%
White/ Caucasian	1,854	30.80%

Other	1,811	30.08%
More than one race	1	0.02%
Prefer not to answer	43	0.71%
Unknown	712	11.83%
Unduplicated Total	6,020	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	1,837	30.51%
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	1,837	30.51%
Non-Hispanic or Non-Latino as follows:		
African	1	0.02%

Asian Indian/ South Asian	16	0.27%
Cambodian	45	0.75%
Chinese	6	0.10%
Eastern European	N/A	
European	N/A	
Filipino	16	0.27%
Japanese	1	0.02%
Korean	22	0.37%
Middle Eastern	80	1.33%
Vietnamese	273	4.53%
Non-Hispanic/ Non-Latino (undefined)	N/A	
Other Non-Hispanic/ Non-Latino	N/A	
Non-Hispanic or Non-Latino Subtotal	2	0.04%
More than one ethnicity		
Prefer not to answer		
Unknown	3,723	61.18%
Unduplicated Total	6,020	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	2,333	38.75%

Female	3,687	61.25%
Prefer not to answer		
Unknown		
Unduplicated Total	6,020	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	N/A	N/A
Female	N/A	N/A
Transgender (Male to Female)	N/A	N/A
Transgender (Female to Male)	N/A	N/A
Transgender (Undefined)	N/A	N/A
Genderqueer	N/A	N/A
Questioning or Unsure	N/A	N/A
Another gender identity	N/A	N/A
Prefer not to answer	N/A	N/A
Unknown	6,020	100%
Unduplicated Total	6,020	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	N/A	N/A
Heterosexual/ Straight	N/A	N/A
Bisexual	N/A	N/A
Questioning/ Unsure	N/A	N/A
Queer	N/A	N/A
Another sexual orientation	N/A	N/A
Prefer not to answer	N/A	N/A
Unknown	6,020	100%

Unduplicated Total	6,020	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	4,800	79.73%
Spanish	421	6.99%
Vietnamese	273	4.53%
Chinese	132	2.19%
Tagalog	16	0.27%
Farsi	77	1.28%
Other	299	4.97%
Prefer not to answer	2	0.02%
Unknown	299	4.97%
Unduplicated Total	4,898	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	N/A	
Veteran	N/A	
Served in Military	18	0.30%
Family of Military	N/A	
No Military	1,567	26.03%
Prefer not to answer	N/A	
Unknown	4,435	73.67%
Unduplicated Total	6,020	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	2	0.03%
Difficulty hearing or speaking	6	0.10%
Other communication disability	119	1.98%
Cognitive	1,956	32.49%

Physical/ Mobility	10	0.17%
Chronic Health Condition	N/A	
Other non-communication disability	N/A	
No Disability	3,359	68.58%
Prefer not to answer	N/A	
Unknown	568	0.94%
Unduplicated Total	6,020	100%

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

*Not available, demographic data is not being collected from participants in outpatient treatment, and current database does not permit effective collection of data.

	FY 2023	
Residential Status	**# Served**	**% of Served**
N/A; not tracked		
N/A		
Unduplicated Total	Not available	

	FY 2023	
Educational Status	**# Served**	**% of Served**
N/A		
Unduplicated Total	Not available	

	FY 2023	
Employment Status	**# Served**	**% of Served**
N/A		
Unduplicated Total	Not available	

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
N/A		

Unduplicated Total	Not available	

	FY 2023	
Health Status	**# Served**	**% of Served**
N/A		
Unduplicated Total	Not available	

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
N/A		
Unduplicated Total	Not available	

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
N/A		
Unduplicated Total	Not available	

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
N/A		
Unduplicated Total	Not available	

7. Referrals

FY 2023
Unduplicated N =

Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
2,319	Outpatient	1,564	Unknown	11.88 days SD=3.16

8. Group Services Delivered

Contracted agencies did anecdotally report offering group therapy sessions, especially during surges in referrals and high caseload, but details on this particular service mode is not readily available from the current system.

FY 2023		
Unduplicated N =		
Number of Groups	**Attendance**	**Average Attendance per Group**
N/A, not tracked	N/A	N/A

9. Detailed Outcomes

AOA OP contracted programs opened 1,564 new referrals to services, and discharged 1,769 clients, and so have been able to make headway on the previous very high caseloads caused by the pandemic and societal restrictions and stress. Data provided by BHSD Analytics & Reporting group.
Referrals for Urgent and Emergent Service Need is a maximum of 14 days to initial service. The average number of days to service was 11.83, with a range of 16 days to 7 days, depending on the month.
For No Shows, the expectation is less than 25%; the AOA OP programs far exceeded this goal, with an average of 4.42%, a high of 6%, and a low of 3%, showing a very high level of engagement in services.
For successful discharges, the Milestones of Recovery Scale (MORS) was used; only partial data is available due to current system data capture limitations. However, successful discharges with MORS averaged 10.92%, with a high of 34.00%, and a low of 0.00%, while successful discharges without MORS averaged 41.92%, with a high of 64.00%, and a low of 25.00%.

10. Evaluation Summary

AOA OP contracted programs continue to provide the bulk of mental health services to residents of Santa Clara County. The number of clients being received for services peaked during this year, and eventually began to decline. Maintaining staffing was an ongoing concern, but less than previous fiscal year. Delays in credentialing of staff also contributed to overall program performance, but this issue resolved about in the spring months of 2023.

Success stories: An elderly client with complex clinical and support needs successfully met treatment goals while at Caminar for Mental Health, and successfully transitioned to the Older Adult program at Catholic Charities.
A client was referred to Catholic Charities and was in a Transition Housing Unit (THU), struggling with alcohol use. The treatment team supported her recovery to the point that she obtained a position of Assistant Manager of the THU and is now mentoring and coaching the residents and helping them manage their ADLs.
One of my staff has been working with a 70-year-old monolingual speaking Korean woman with symptoms of paranoia and severe depression. Due to her symptoms and cultural stigma of mental illness, she has been isolated and had impaired relationships with her neighbors due to her paranoid thoughts about her neighbors. Through their collaborative efforts this client has been able to restore family relationships and engage in daily activities such as scheduling medical appointments, handle bank-related transactions, exercise, and healthy eating. She has learned how to communicate more effectively with her neighbors and set boundaries with families.
A male client in his mid-twenties, previously a Gardner client during his childhood, sought assistance due to symptoms of depression and difficulty concentrating. Struggling with family interactions and feeling undervalued in his current job, he also grappled with low self-esteem. Through treatment, he became more adept at articulating his needs to his family, processed his trauma, and exhibited the courage to apply for and secure a management position. His plan entails transitioning his medication to his primary care physician (PCP), given his demonstrated stability and growth in managing his mental health.

Specialty Outpatient Services Program

Specialty Outpatient Services in Santa Clara County covers 2 different programs.

1. Ethnic Specific Outpatient Continuum
2. Gender Affirming Care Clinic (GACC)

The total cost per person, across all programs in this category can be found below. The following pages are detailed reports for each individual program in this category.

FY 2023		
Number Served	Program Expenditure	Cost per Person
248	$1,209,560	$4,877.26

ETHNIC SPECIFIC OUTPATIENT CONTINUUM

CSS General System Development (GSD) Program

Community Services and Support (CSS) 1-Year PROGRAM Report Data: FY2023 (July 1, 2022 – June 30, 2023)

1. Program Description

Ethnic Specific Outpatient is designed to provide culturally relevant intensive mental, emotional, and behavioral services and counseling to adults who have mental health disorders. Services may include individual, family, and group counseling, evaluation/assessment, medication management, plan development, case management/brokerage, rehabilitation and collateral services, referral support, and 24-hour crisis intervention, if needed. Services shall be provided in a variety of settings, including outpatient clinics, the clients' places of residency, and in the community, as appropriate. The clients' cultural views, traditions, and spirituality shall be considered as necessary to contribute to enhanced engagement with treatment. Ethnic Specific Outpatient utilizes EBPs, PPs, and/or trauma informed practices whenever clinically indicated and based on clients' diagnoses. Services will include culture and identify as a part of the dialogue of behavioral health services. It provides a safe place for the client to feel comfortable and understood by their behavioral health professional building an effective therapeutic relationship. Culturally informed services that embrace cultural differences that may impact the diagnosis of a condition. Awareness of biases and ownership of incorporating cultural and linguistic needs and differences into a person's care. Clients under Ethnic Specfic Outpatient may also have significant cultural and linguistic needs that have isolated them and has reduced their access to behavioral health services

2. Program Goals, Objectives & Outcomes

❖ Goals

The Program shall accomplish the following goals:

i. Reduce experiences of homelessness, incarceration, crisis, and hospitalization, as well as substance use, violence, and victimization
ii. Strengthen recovery, self-sufficiency, and other psychosocial outcomes, including housing stability, income and access to entitlement benefits, family relationships, and participation in meaningful activities
iii. Reduce subjective suffering from mental illness
iv. Increase meaningful use of time and capabilities in school, work, and social activities
v. Develop, increase, and strengthen natural networks of supportive relationships
vi. Reduction of psychosocial impact of trauma
vii. Increase use of psychotropic medication and other means of symptom reducing strategies by education of client/family systems; and
viii. Improve access to healthcare and successfully link clients to appropriate lower levels of care as necessary.

❖ Objectives

The Program is designed to accomplish the following objectives:

i. Engage underserved clients who have not benefitted from traditional outpatient mental health services due to complex risk factors including substance use, community violence, interpersonal family violence,

general neglect and exposure to trauma, social and emotional isolation, and physical decline and losses by providing culturally and linguistically proficient services;

ii. Reduce and/or eliminate psychiatric hospitalizations, incarcerations, and homelessness;

iii. Improve culturally and linguistically proficient client-centered services that integrates or directly provide the full range of treatment modalities and rehabilitation services and resources to meet the needs of clients and their families in their recovery process;

iv. Actively work with the clients in their recovery process and assist the clients to move toward a lower level of care within the criteria set for the Program;

v. Encourage clients to actively participate in their recovery and self-monitor milestones and goals towards self-determination, family and vocational education, and recreational services;

vi. Increase clients' understanding pertaining to the importance of their medication adherence and treatment compliance through psychoeducation sessions;

vii. Provide time-limited services for clients through care coordination and utilization of EBPs, PPs, and trauma informed practices; and

viii. Assist clients in learning life skills that allow them to successfully transition to independent living or other residential care facilities.

❖ **Outcomes**

Proposer's key outcomes plan shall incorporate and achieve the following target benchmarks:

i. Improve access for and engagement of adult and older adult clients from unserved or underserved communities who may be previously unknown to the Adult and Older Adult System of Care, but are now experiencing a first mental health episode, into intensive supports and treatment;

ii. Demonstrate ability to successfully transition clients to lower levels of care while maintaining successful recovery process;

iii. Improve functioning as defined through Milestone of Recovery Scale (MORS);

iv. Improve functioning as defined through Daily Living Activities (DLA) 20;

v. Increase in the number of clients engaged in educational and vocational activities;

vi. Positive client service experience;

vii. Decrease in the number of hospital and institution days; and

viii. Increase number of clients reporting satisfaction with services.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =248		
Number Served	Program Expenditure	Cost per Person
248	See cover page	See cover page

4. Evaluation Activities

i. Access & linkage strategy and designed & implemented strategies that are non-stigmatizing, non-discriminatory. Connecting participants to other community-based organizations and creating activities that are both welcoming and inviting for the ethnic specific community.

ii. The method of measuring client outcomes for other agencies was determined by a Milestones of Recovery Scale (MORS) score as evaluated by direct service providers on a monthly basis.

5. Demographic Data

*Not available, demographic data is not being collected from participants at outreach events or at service activities

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	1	1%
16 -25 years	33	14%
26- 59 years	137	55%
60+ years	64	25%
Prefer not to answer		
Unknown	13	5%
Unduplicated Total	248	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	2	1%
Asian	111	45%
Black or African American	86	35%
Native Hawaiian or Other Pacific Islander	1	1%
White/ Caucasian	18	7%
Other	17	6%
More than one race		
Prefer not to answer		
Unknown	13	5%

Unduplicated Total	248	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:	20	8%
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino		
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		

Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer		
Unknown	228	99%
Unduplicated Total	248	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	94	38%
Female	141	57%
Prefer not to answer		
Unknown	13	5%
Unduplicated Total	248	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	94	38%

Female	154	62%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	248	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	248	100%
Unduplicated Total	248	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	115	46%
Spanish	6	2%
Vietnamese	20	8%
Chinese	1	1%
Tagalog	2	1%
Farsi	13	5%

Other		
Prefer not to answer		
Unknown	91	37%
Unduplicated Total	248	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	1	1%
Veteran		
Served in Military		
Family of Military		
No Military	104	42%
Prefer not to answer		
Unknown	143	57%
Unduplicated Total	248	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking	1	1%
Other communication disability		
Cognitive		
Physical/ Mobility	2	1%
Chronic Health Condition		
Other non-communication disability		
No Disability		
Prefer not to answer		
Unknown	245	98%
Unduplicated Total	248	100%

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

*Not available, demographic data is not being collected from participants at outreach events or at service activities

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Health Status	**# Served**	**% of Served**

Unduplicated Total	Not available	

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total	Not available	

7. Referrals

FY 2023				
Unduplicated N =25				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
Unknown	- Community events -behavioral health services -external organizations/ agencies -clinics	6	6 months	2 weeks

8. Group Services Delivered

FY 2023		
Unduplicated N =494		
Number of Groups	Attendance	Average Attendance per Group
102	936	9

9. Detailed Outcomes

The method of measuring client outcomes was determined by a Milestones of Recovery Scale (MORS) score as evaluated by direct service providers on a monthly basis. The score helps determine the client's appropriate level of care .

indicators for successful completion are calculated by the number of successful discharges, both with or without a MORS score. There were a total of 160 discharges.

10. Evaluation Summary

The Adult and Older Adult Ethnic Specific Outpatient Program level of care continued to experience unprecedented increased demand for services, while simultaneously experiencing critical staffing shortages due to experienced staff retiring, leaving the field and/or the area. Even though agencies were eventually able to

replace staff positions, the newly hired staff faced the same stressors and challenges, normally without the benefit of previous experience in mental health work. Supervisors and managers of these programs were often obligated to take on cases in addition to their normal duties, in an attempt to alleviate the overburdened caseload handed to them.

Lessons learned:

Through our experiences, we have learned the importance of active participation in ethnic specific focused events to effectively connect with individuals and promote our workshops and services. Collaborating with dedicated organizations has helped build trust and rapport within the community and provided valuable insights into their unique perspectives and challenges.

Success Stories:

Gardner (African Descent) – In the African American community include organizing with the culturally relevant events such as Black Family Day, Jubilee, and the annual Juneteenth celebrations. These events have become pivotal in our engagement efforts, attracting a diverse range of participants and providing platforms for celebration, education, and empowerment. Collaborations with African American agencies have expanded our reach and allowed us to deliver a broader range of culturally responsive workshops and support groups.

Gardner (Hispanic) - Client Experiences and relevant examples of impact:

One notable success story from our Open Doors program involves a Latino participant who sought help in addressing the trauma associated with immigration and family disruptions. Through the program's specialized workshops and support groups, they were able to process their experiences and find a sense of belonging within a community that understands their unique challenges. This individual reported a noticeable reduction in anxiety and an increased ability to cope with past traumas, demonstrating the program's effectiveness in providing culturally sensitive healing.

Another impactful client experience comes from a young Latina participant who was struggling with academic pressure and familial expectations. The Open Doors program provided her with educational webinars on stress reduction and offered individual counseling sessions to address her specific concerns. As a result, she reported a significant improvement in her academic performance, a strengthened sense of self-esteem, and a newfound enthusiasm for pursuing her goals. This case illustrates how the program's tailored approach can empower young Latinos to overcome obstacles and achieve personal growth.

These client experiences further emphasize the Ethnic Wellness Center's commitment to providing culturally relevant and empowering support to the Latino community. Through a combination of compassionate guidance, targeted workshops, and individualized care, the program continues to make a positive impact on the emotional well-being and resilience of Latino individuals and families. By recognizing the unique needs of this community and fostering a safe and inclusive environment, we remain dedicated to promoting mental health and healing within the Latino community.

GENDER AFFIRMING CARE CLINIC (GACC)

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The County of Santa Clara Behavioral Health Services Department is developing and implementing the new County-run Gender Affirming Care Clinic (GACC). This clinic began program development and hiring processes in 2023, and hopes to start serving clients in early 2024. For this reason, there is no data to present for this reporting period.

The transgender and gender diverse (TGD) community experiences disparities in quality of care, access to affirming support, and over-representation in systems of care and crisis services due to minority stress, anti-transgender bias, and discrimination. Experiences of discrimination and bias are further compounded into multiple minority stress for TGD folks of color. The Valley Medical Center (VMC) Gender Health Center reviewed their panel of patients and determined that several hundred of their patients need specialty mental health services, but do not feel safe receiving services with other providers due to environments not being gender affirming or knowledgeable about supporting TGD clients. According to the Santa Clara County TGNB Employment Survey released in June 2022, 70% of TGD individuals in the county reported experiencing some type of anti-trans bias or discrimination, and 79% reported being diagnosed with a mental health disorder. These are both significant numbers and highlight the need for competent clinical care for this population. Addressing behavioral health disparities among TGD communities requires specialized staff, providers, and programming. This programming must be tailored to different age groups as well (i.e., youth, transitional aged youth (TAY), and adults). While more mental health providers are starting to seek training in gender-affirming care, an overwhelming majority are not contracted with Medi-Cal and do not see clients who are unable to pay out of pocket. The GACC will be filling an important gap here, by serving TGD clients who are Medi-Cal beneficiaries or uninsured.

The Gender Affirming Care Clinic will expand Specialty Outpatient Services, with a focus on serving transgender, non-binary, and gender expansive community members of all ages. The GACC will provide specialty mental health (individual, group, and family therapy), evaluation and assessment, plan development, medication evaluation, rehabilitation, intensive case management, outreach and engagement, peer support, and connection to resources and services for TGD folks who have been unable to receive gender affirming behavioral health services. This program will also work in tandem with BHSD The Q Corner team for outreach and engagement support.

The GACC will provide evidence-based clinical services rooted in the Gender Affirmative Clinical Model, which clearly identifies gender diversity as a normative aspect of human diversity, rather than pathologizing trans and nonbinary identities. The clinic space itself will be a respite for clients who have experienced ongoing discrimination in other behavioral health and healthcare settings. Clients will be supported in processing gender minority stress and compounded trauma that can materialize from ongoing discrimination, as well as other aspects of clinical care. The need for gender-specific clinical services is exploding in the United States, as well as world-wide. The GACC is one of the first county behavioral health clinics that support specifically TGD clients, and will hopefully serve as a template for other counties to replicate as they too strive to increase gender-affirming clinical services for their populations.

A Program Manager II (PM II) started working at the GACC on October 31, 2022, and has been focusing on program development, Medi-Cal site certification, creating the electronic health record system (EHR) in collaboration with TSS, designing the new clinic space, developing clinical protocol and recruitment for the

first three direct service positions. A Licensed Marriage and Family therapist, a Mental Health Peer Support Worker, and a Clinical Supervisor are all in the hiring process and are slated to start early next Fiscal Year (July 2023). The EHR program is set to be up and running and fully functional by early FY 24. Medi-Cal Site Certification is also in process and set to be complete by early FY24. Physical space for the GACC has been identified and is being prepared at 1870 Senter Road, San Jose, CA, 95112. The program anticipates that the initial positions hired will begin serving clients via telehealth within the first 6 months of FY 24, and will begin offering on-site services as soon as the location is ready.

2. Program Goals, Objectives & Outcomes

Tentatively planned program goals, objectives, and outcomes will include some of the following, to be further established as program is designed:

i. Expand access to specialty mental health services for transgender and gender diverse individuals through direct services provided at the Gender Affirming Care Clinic.
ii. Increase comprehensive supports available to families of transgender and gender diverse children, youth, and young adults through collateral work at the Clinic.
iii. Increase collaboration with other County and County contracted mental health providers to improve experience of all Transgender and gender diverse clients throughout all behavioral health services.
iv. Increased collaboration with system partners across other service systems (ie. suicide and crisis prevention and response, health services, housing, criminal justice, etc.) to improve access and linkage to affirming services.
v. Establish community wide Baseline Competency for trans knowledgeable, welcoming, and affirming environments and supports through community-based education and subject matter expertise.
vi. Expand Network of Specialized Services, including Behavioral Health Services through a community of practice of dedicated and individualized training and consultation supports.
vii. Improve workflows for patients navigating changes in levels of care to ensure all clients are paired with trans competent providers at all services (beyond only Clinic)
viii. Reduce behavioral health disparities experienced by population, including feelings of isolation, thoughts of suicide, suicide attempts, disabling mental health challenges, and need for higher level of care interventions.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 0 (not yet operational)		
Number Served	Program Expenditure	Cost per Person
NA	$142,597 **Note: Since program has been in the development phase and not fully operational in FY23, there are no clients served. These expenses are towards the program manager, who has been developing the programmatic structure and hiring staff.	NA

4. Evaluation Activities

N/A The program is not yet operational.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years		
26- 59 years		
60+ years		
Prefer not to answer		
Unknown		
Unduplicated Total	N/A The program is not yet operational	

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native		
Asian		
Black or African American		
Native Hawaiian or Other Pacific Islander		
White/ Caucasian		
Other		
More than one race		
Prefer not to answer		
Unknown		
Unduplicated Total	N/A The program is not yet operational	

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		

Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino		
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer		
Unknown		
Unduplicated Total		

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male		
Female		
Prefer not to answer		
Unknown		
Unduplicated Total	N/A The program is not yet operational	

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male		
Female		
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	N/A The program is not yet operational	

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		

Another sexual orientation		
Prefer not to answer		
Unknown		
Unduplicated Total	N/A The program is not yet operational	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English		
Spanish		
Vietnamese		
Chinese		
Tagalog		
Farsi		
Other		
Prefer not to answer		
Unknown		
Unduplicated Total	N/A The program is not yet operational	

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military		
Prefer not to answer		
Unknown		
Unduplicated Total	N/A The program is not yet operational	

	FY 2023	
Disability*	**# Served**	**% of Served**

Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability		
No Disability		
Prefer not to answer		
Unknown		
Unduplicated Total		

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

N/A The program is not yet operational

7. Referrals

N/A The program is not yet operational

8. Group Services Delivered

N/A The program is not yet operational

9. Detailed Outcomes

N/A The program is not yet operational

10. Evaluation Summary

N/A The program is not yet operational

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The program serves clients with developmental or intellectual disabilities and autism, with an emphasis on behavioral health and co-occurring substance use disorders. Services will support and inspire growth for each individual's social behavior and emotional needs.

2. Program Goals, Objectives & Outcomes

❖ Objectives

i. The program shall engage underserved clients specified in Section III. Target Population who have not benefitted from traditional outpatient mental health services due to complex risk factors including substance use, community violence, interpersonal family violence, general neglect and exposure to trauma, social and emotional isolation, and physical decline and losses by providing culturally and linguistically proficient services.

ii. The program shall address and participate in therapeutic activities, assessments, and/or linkage to services that shall:

   a. Facilitate the reduction of client's psychiatric hospital admissions, including Emergency Psychiatric Services (EPS) episodes
   b. Assist in the prevention/reduction in the rates of incarcerations for the specified target population
   c. Increase and strengthen the natural support systems through family engagement in the experience of care, self-help, and other types of support systems
   d. Identify issues including, but not limited to, dual diagnosis, physical disabilities, and medications, and connect the client with a primary care physician (PCP) to facilitate treatment of concurrent primary health care and ongoing behavioral health needs; and e. Identify physical and psychological conditions specific to the target population.

iii. The program shall initiate coordination and linkage with other providers and institutions including community-based resources that serve adults and/or older adults in Santa Clara County, recognizing that older adults may be less experienced in seeking these resources.

iv. The program shall encourage clients to actively participate in their recovery and self-monitor their milestones and goals towards self-determination, family and vocational education, and recreational services.

v. The program shall provide time-limited services to help client become the single point of responsibility for services through age-appropriate care coordination.

vi. The program shall actively work with clients in their recovery process and assist the client in moving toward a lower level of care using the criteria set for the program.

vii. The program shall utilize Evidence Based Practices (EBPs), Promising Practices (PPs), and/or Community Informed Practices whenever clinically indicated and based on client's diagnoses.

viii. The program shall provide clear details about how they will report and track both the fidelity and outcomes of any and all practices utilized within their services.

a. The program shall provide treatment and services essential for creating positive outcomes for adult (ages 18 to 59) and older adult (60 and older) clients diagnosed with a serious mental illness (SMI) and co-occurring developmental disabilities and/or autism, whose level of functioning, symptoms, and psychiatric history necessitate services intervention to maintain the clients in community settings.
b. Services shall be individualized and consider each client's age, maturational level, culture, family values and structure, educational functioning level, and physical health

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 1,367		
Number Served	Program Expenditure	Cost per Person
1367	$ 8,144,444	$ 5,957.90

4. Evaluation Activities

We provide mental health treatment, including alternative and culturally specific treatments, peer support (through group rehabilitation), supportive services to assist the client, and when appropriate the client's family, in obtaining employment, housing, and/or education, personal service coordination/case management/personal service coordination to assist the client, and when appropriate the client's family, to access needed medical, educational, social, vocational rehabilitative or other community services, needs assessments, individual services and supports plan development, crisis interventions and stabilization services, and family education services.
We help clients access services available to them in the community and link them to these services and collaborate with the county to improve mental health delivery.
We have worked to assist clients in accessing food, clothing, and shelter, and engaged unserved individuals when able to.
We use evidence-based practice standards and promising practices and assess effectiveness by tracking client engagement (through participation in services), using assessment tools (like the MORS), and by tracking successful discharges, hospitalization rates, and needs for higher levels of care. Additionally, we track our number of days to service for level I and level II referrals, to make sure they are within the standards of our contract.
We survey our clients to gauge their satisfaction with the quality of care they receive from us, as well as track the trend of negative client evaluations. We track client reports of symptom improvement over their length of stay with us, as well.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	6	1%
16 -25 years	315	23%

26- 59 years	853	64%
60+ years	163	13%
Prefer not to answer		
Unknown		
Unduplicated Total	1367	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	4	1%
Asian	540	39%
Black or African American	44	3%
Native Hawaiian or Other Pacific Islander	2	1%
White/ Caucasian	348	25%
Other	134	9%
More than one race		
Prefer not to answer	7	1%
Unknown	288	21%
Unduplicated Total	1367	100

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:	324	24%
Central American		
Mexican/ Mexican-American/ Chicano		

Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino		
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	552	41%
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer		

Unknown	491	35%
Unduplicated Total	1367	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	806	60%
Female	531	39%
Prefer not to answer		
Unknown	30	1%
Unduplicated Total	1367	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	806	59%
Female	531	39%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	30	2%
Unduplicated Total	1367	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		

Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown		
Unduplicated Total	1,364	*100%*

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	1118	84%
Spanish	124	8%
Vietnamese	47	4&
Chinese	9	1%
Tagalog		
Farsi		
Other	30	
Prefer not to answer		
Unknown	39	3%
Unduplicated Total	1367	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military	13	1%
Prefer not to answer		
Unknown	1329	99%
Unduplicated Total	1342	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking	1	.05%
Other communication disability		
Cognitive	123	9%
Physical/ Mobility	1	.05%
Chronic Health Condition		
Other non-communication disability		
No Disability		
Prefer not to answer		
Unknown	1242	91%
Unduplicated Total	1367	100%

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	Not Available

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	Not Available

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	Not Available

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**

Unduplicated Total	Not Available	Not Available

	FY 2023	
Health Status	**# Served**	**% of Served**
Unduplicated Total	Not Available	Not Available

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total	Not Available	Not Available

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total	Not Available	

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total	Not Available	Not Available

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)

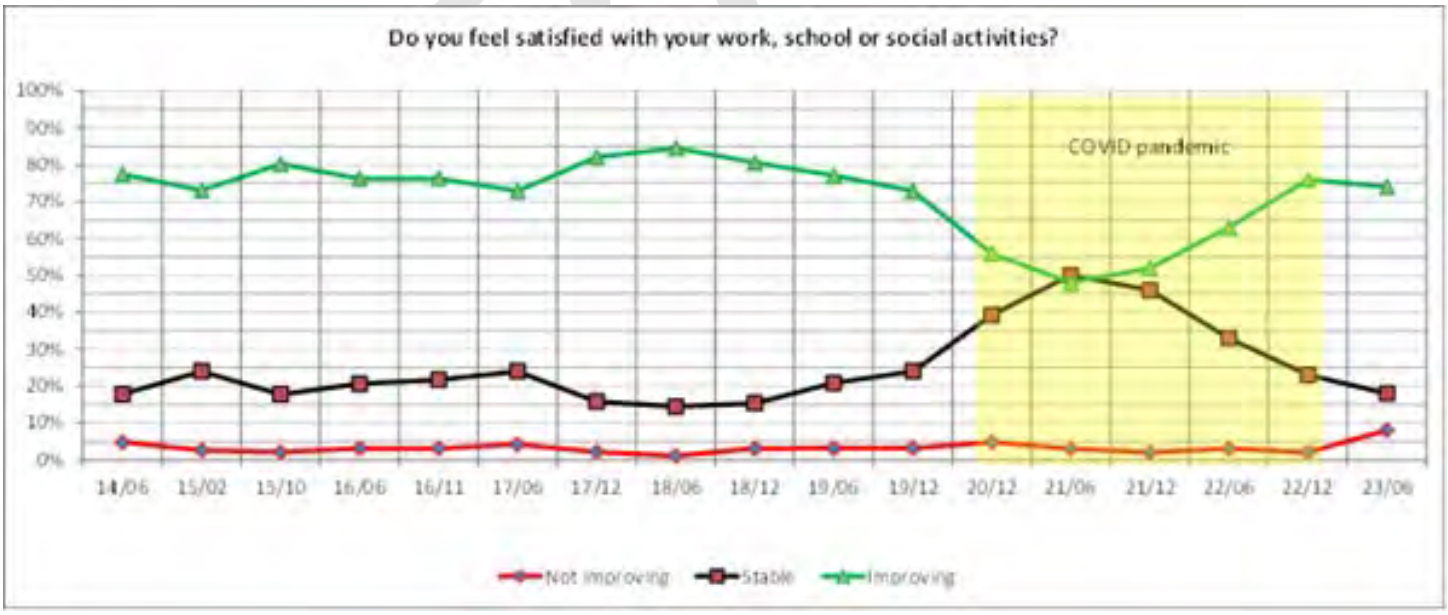
versus treatment that is not)				
129	**Outpatient Mental Health**	**108**	**unknown**	**7**

8. Group Services Delivered

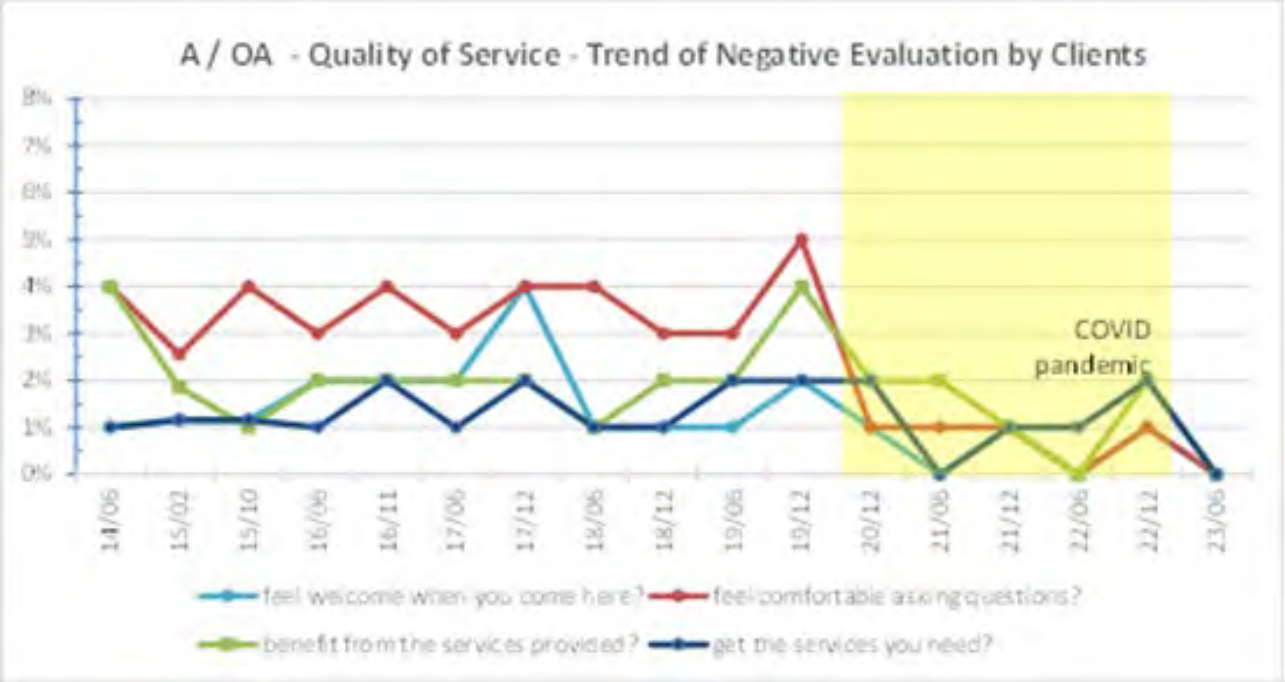
FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
12	**37**	**3**

9. Detailed Outcomes

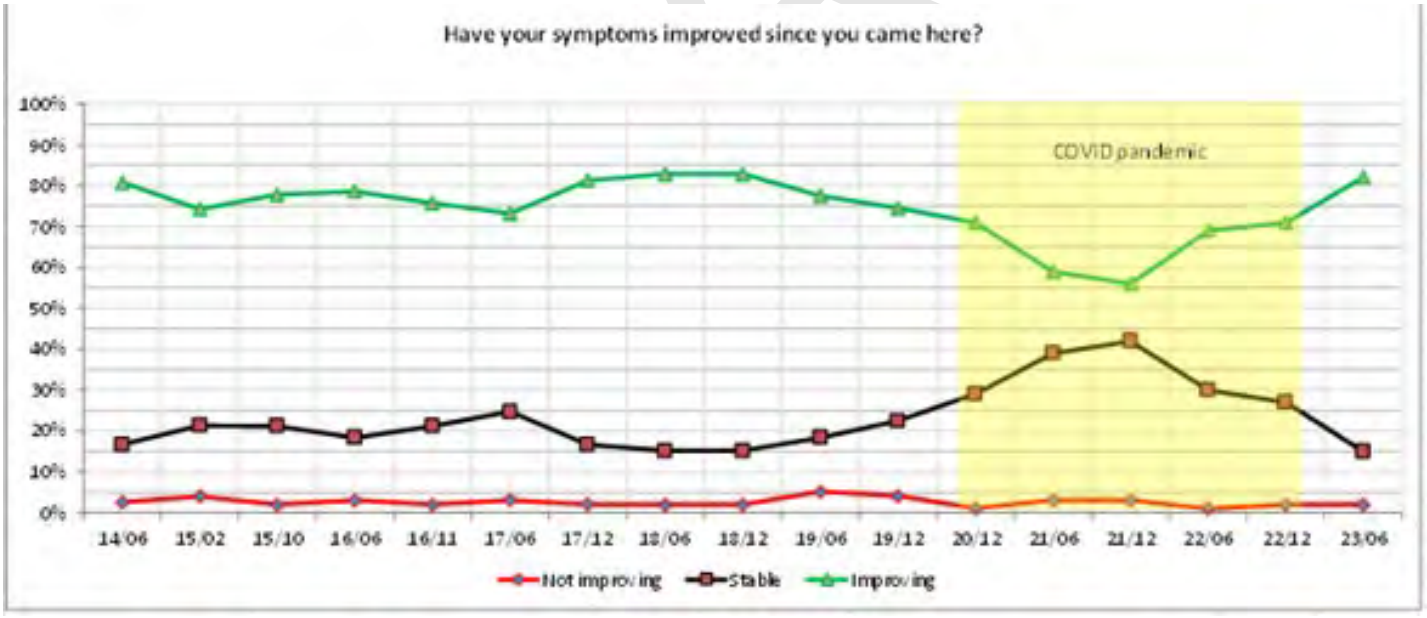
Program Goal 2. Increase meaningful use of time and capabilities in school, work, activities. On average, in the past 8 years, about 3% of the population (range 2% to 4%, up to 50 clients) has had a negative work experience. The plot shows the negative influence of the COVID pandemic on the social net of the population served by the Counseling Center, and the recovery to pre-pandemic levels in the past 18 months.



Indicators of quality of service: negative evaluation. The percentage of people not satisfied has been stable for the past 3 years, between 1% and 2%. For a population of 1321 clients in June 2023 (see Table 1), this means that 13 to 26 clients could complain about the services provided during this fiscal year. Note the sharp decline during the COVID pandemic.



Program Goal 1. Reduction of subjective suffering from mental illness. On average, in the past 9 years, only 3% of the population (range 2% to 4%) has not experienced an improvement in their symptoms. This last trend implies that the clinic should expect 25 to 50 clients requiring emergency services in a year. The plot shows the negative influence of the COVID pandemic on the mental health of the population served by the Counseling Center, and the positive trend in the past 18 months.



10. Evaluation Summary

Most of our work after the COVID pandemic, and the transition to a "new normal", has focused on helping our clients to access the service they need. Data from our bi-annual survey shows that we have been successful in supporting our clients during these challenging times. After a significant decrease in the first stage of the pandemics, probably the effect of social isolation, the two main indicators of the quality of life (mental health and professional satisfaction) are now back to their pre-pandemic level.

COMMUNITY SERVICES AND SUPPORT (CSS)
1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The CalWORKs Community Health Alliance (Health Alliance) provides behavioral health services to adult clients enrolled in the Welfare-to-Work (WTW) Program who experience mental health and substance abuse issues. Health Alliance is a partnership between County of Santa Clara Social Services Agency, Santa Clara Valley Health and Hospital Systems' Department of Alcohol and Drug Services (DADS), and BHSD. The purpose of this partnership is to provide comprehensive behavioral health services for CalWORKs clients and their family members. CalWORKs places mental health services within the employment support program to help address issues that prevent people with mental health issues from obtaining and maintaining employment which can help them transcend poverty. Health Alliance uses a behavioral health model that focuses on the health of the whole person by providing individualized counseling and other services to enhance and support self-sufficiency.
These holistic services include:

i. On-site short-term solution-based therapy/counseling for clients who drop-in or call-in for short-term issues
ii. Long-term off-site therapy/counseling for clients who require services longer than 3-4 visits
iii. Emotional wellbeing
iv. Behavioral issues
v. Substance abuse issues
vi. Relationship issue
vii. Mental health issue
viii. Stress management
ix. Trauma and abuse
x. Psychosocial functioning
xi. Transitional housing services

Health Alliance also partners with community college and adult education programs to provide on-site individual counseling, support groups, and educational forums to clients. Community-based providers leverage Medi-Cal to fund services while the County CalWORKs team is completely funded by CalWORKs funds.

2. Program Goals, Objectives & Outcomes

i. Reduce subjective suffering from mental illness
ii. Increase meaningful use of time and capability in school, work, and activity
iii. Reduce homelessness and increase safe and permanent housing
iv. Increase access to substance abuse treatment
v. Increase natural networks of supportive relationships
vi. Increase self-help and client/family involvement
vii. Reduce incarceration
viii. Reduce of disparities in access to mental health services

ix. Reduce disparities in service access
x. Reduce the psycho-social impact of trauma
xi. Increase access to services

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =292		
Number Served	Program Expenditure	Cost per Person
411	$ 2,253,542	$ 5,483.07

4. Evaluation Activities

Focus Areas including:

i. Access and Linkage- Expand on outreach opportunities in available co-locations to conduct behavioral health screenings for CalWORKs beneficiaries.
ii. Improving the county mental health service delivery system for all clients and their families through therapy, rehabilitative services, collateral, psychiatry, case management and the expansion of peer support services.
iii. Providing mental health treatment using evidence-based practices which may include Motivational Interviewing (MI), Stages of Change, Cognitive Behavioral Therapy (CBT), Trauma-Focused CBT (TF-CBT), Solution-Focused Brief Therapy (SFBT), trauma-informed approaches, and integrated co-occurring disorder practices such as Integrated Dual Disorder Treatment (IDDT), and peer supports such as Wellness Recovery Action Planning. As well, culture and language needs were supported for the six threshold languages for the County, in addition to a myriad of other languages.

The method of measuring client outcomes was determined by a Milestones of Recovery Scale (MORS) score as evaluated by direct service providers monthly. The score help determine the client's appropriate level of care (higher – FSP, IFSP, ACT, lower – graduation, PCP-if requiring ongoing medication). Furthermore, Feedback-informed treatment (FIT) is conducted by clinicians in each session to gather real-time input from clients using structured measures to identify what is and is not working in therapy and then adjust to better meet client's needs. FIT aims to incorporate the client's perspective about the therapeutic relationship.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years	*25*	*6%*
26- 59 years	*386*	*94%*
60+ years		

Prefer not to answer		
Unknown		
Unduplicated Total	*411*	

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	2	*0%*
Asian	22	*5%*
Black or African American	45	*11%*
Native Hawaiian or Other Pacific Islander	4	*1%*
White/ Caucasian	101	*25%*
Other	182	*44%*
More than one race	1	*0%*
Declined to Answer	4	*1%*
Unknown	50	*12%*
Unduplicated Total	411	

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican American/ Chicano		
Puerto Rican		
South American		

Hispanic/ Latino (undefined)		
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	*205*	50%
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal	111	*27%*
More than one ethnicity		
Prefer not to answer		
Unknown	95	*23%*
Unduplicated Total	411	*100%*

	FY 2023

Gender (Assigned at Birth)	# Served	% of Served
Male		
Female		
Prefer not to answer		
Unknown		
Unduplicated Total	N/A	

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	45	11%
Female	366	89%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	411	

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown		
Unduplicated Total	N/A	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	349	*85%*
Spanish	26	*6%*
Vietnamese	5	*1%*
Chinese		
Tagalog		
Farsi		
Other	2	*0%*
Prefer not to answer		
Unknown	29	*7%*
Unduplicated Total	411	

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran	1	0%
Served in Military		
Family of Military		
No Military	256	62%
Prefer not to answer		
Unknown	154	38%
Unduplicated Total	411	

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking	1	*0%*
Other communication disability		
Cognitive	138	*34%*
Physical/ Mobility		
Chronic Health Condition		

Other non-communication disability	26	*6%*
No Disability		
Prefer not to answer		
Unknown	246	*60%*
Unduplicated Total	411	

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total	N/A	

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total	N/A	

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total	N/A	

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total	N/A	

	FY 2023	
Health Status	**# Served**	**% of Served**

Unduplicated Total	N/A	

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total	N/A	

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total	N/A	

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total	N/A	

7. Referrals

FY 2023				
Unduplicated N =N/A				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or

mental health versus treatment that is not)				overseen by county mental health)
1625 screened 357 through OCAT 13 through Call Center	Outpatient	406	Unknown	Unknown

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
N/A		

9. Detailed Outcomes

There were 1625 CalWORKs beneficiaries screened, 357 of whom requested services. Additional referrals were from the Call Center and transfers. There were 406 admissions with 310 discharges with 68% successful discharge rate, which resulted from receiving favorable outcome during treatment.

10. Evaluation Summary

Success Story

This success story is about a client whom I have seen approximately 12 months now. She began counseling as a very scared, traumatized but angry individual who had been living on the streets of a nearby big city as a prostitute for over 3 years approximately. She had a small child and due to her child, she no longer wanted to live the kind of lifestyle that she had been living.

Although she “made money” in her former employment, she was worried about her and her child’s safety long term and knew that this was not sustainable. For this reason, and for some recent “experiences” that she had endured, she knew she had to leave.

When first working with client she did not disclose much of the trauma she had experienced, but as she continued to work with this writer, she began to divulge a lot of the trauma and horrors that she experienced. In counseling and with dedication from the client we have been able to work through some of the trauma she has experienced. This writer has been successful in teaching her some relaxation and self-care techniques and coping skills that has assisted her in being able to move forward and reduce her Sx’s of PTSD.

Through the counseling support and living with a close friend, client has been able to obtain a job, and work and watch her child grow. She is now working towards additional goal of obtaining a more sustainable career type job which will utilize her skills and also provide her the chance and opportunity to develop an actual career that she will be proud of.

Achieved Outcomes

i. Each Behavioral Health provider has been able to successfully transition to providing services through three modalities: in person, telehealth and by telephone. This has maximized the clients access to services.
ii. Behavioral health services has enhanced its training and resources to include racial and gender inclusivity and sensitivity.

Challenges

i. Even with providing in person orientation, referrals to the program still remain low.
ii. Clients are hesitant to go out to appointments and have personal contact following prolonged periods of time in isolation and fear of contracting covid. This lack of flexibility on the part of the CalWORKs beneficiaries has decreased their willingness of seek additional services outside of those mandated by their program.

INDIVIDUALIZED SUPPORTED SERVICES (INDIVIDUALIZED PLACEMENT AND SUPPORT/SUPPORTED EMPLOYMENT -IPS/SE)

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The Client and Consumer Employment project aims to transform how the overall system views employment and promoting employment as a wellness goal for consumers. This project builds on the premise that having a job contributes to a person's overall sense of well-being and can be a significant contributor toward achieving and maintaining recovery from mental illness. Using the consumer-driven Individual Placement and Support (IPS) evidence-based practice, this project integrates employment as a wellness goal for clients/consumers and provides an array of individual supports to help clients and consumers achieve their goals. The Client and Consumer Project was approved by MHSOAC on November 16, 2017. Services commenced on February 2019. The program finished the INN 11 phase of the project, and was converted to CSS, beginning in January 2023. The County currently has three contracted providers: Catholic Charities of Santa Clara County (CCSCC), Fred Finch (FF), and Momentum for Mental Health (MMH).

2. Program Goals, Objectives & Outcomes

❖ Goals

The goal of IPS/SE is for people with serious mental illness (e.g., schizophrenia spectrum disorder, bipolar, depression) to work on their individual barriers to employment; getting and maintaining gainful employment is the treatment goal. IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. Although variations of supported employment exist, IPS refers to the evidence-based practice of supported employment.

❖ Objectives

The objectives are: improve functioning and quality of life, reduce symptoms and impacts of mental illness, reduce the need for a higher level of care, provide additional therapy services. Clients will be supported in working on and coping with barriers to employment in a job of their own choosing, focusing on those that are due to mental health issues.
The model has a “no exclusions” approach. People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.
Department Priorities #2: Promote Wellness & Recovery, #5: Successfully Integrate into the community.

❖ Outcomes

i. Increased income
ii. Improved self-esteem
iii. Increased social and quality of life
iv. Better control of symptoms
v. Reduced substance use
vi. Reduced hospitalization

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 163		
Number Served	Program Expenditure	Cost per Person
163	$ 725,843	$ 4,453.02

4. Evaluation Activities

One of the stronger features of IPS is its fidelity model, which consists of fidelity performance reviews, which are conducted every six months if the program is operating at “Not Supported Employment” or “Fair Fidelity” levels; if a program is operating at “Good Fidelity” or “Exemplary Fidelity”, then performance reviews are conducted only annually. Programs are reviewed across three domains, with 25 total areas of fidelity scored from “1” to “5”, where 5 indicates exemplary fidelity for that item.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	0	0%
16 -25 years	8	4.91%
26- 59 years	137	84.05
60+ years	18	11.04%
Prefer not to answer		
Unknown		
Unduplicated Total	163	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	2	1.23%
Asian	32	19.63%

Black or African American	9	5.52%
Native Hawaiian or Other Pacific Islander	1	0.61%
White/ Caucasian	50	30.67%
Other	49	30.08%
More than one race	0	0%
Prefer not to answer	20	12.27%
Unknown		
Unduplicated Total	163	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	49	30.06%
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	49	30.06%
Non-Hispanic or Non-Latino as follows:		

African		
Asian Indian/ South Asian	0	0%
Cambodian	1	.61%
Chinese	4	2.45%
Eastern European	0	0%
European	0	0%
Filipino	0	0%
Japanese	0	0%
Korean	1	0.61%
Middle Eastern	1	0.61%
Vietnamese	8	4.91%
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity	1	
Prefer not to answer		
Unknown	98	60.12%
Unduplicated Total	163	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	63	38.65%
Female	100	61.35%

Prefer not to answer		
Unknown		
Unduplicated Total	163	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	N/A	
Female	N/A	
Transgender (Male to Female)	N/A	
Transgender (Female to Male)	N/A	
Transgender (Undefined)	N/A	
Genderqueer	N/A	
Questioning or Unsure	N/A	
Another gender identity	N/A	
Prefer not to answer	N/A	
Unknown	N/A	
Unduplicated Total	N/A	

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	N/A	
Heterosexual/ Straight	N/A	
Bisexual	N/A	
Questioning/ Unsure	N/A	
Queer	N/A	
Another sexual orientation	N/A	
Prefer not to answer	N/A	
Unknown	N/A	
Unduplicated Total	N/A	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	27	16.56%
Spanish	12	7.36%
Vietnamese	8	4.91%
Chinese	4	2.45%
Tagalog	0	0%
Farsi	3	1.84%
Other		
Prefer not to answer		
Unknown	113	69.32%
Unduplicated Total	163	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military	42	25.77%
Prefer not to answer		
Unknown	121	74.23%
Unduplicated Total	163	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	0	0%
Difficulty hearing or speaking	4	2.45%
Other communication disability	0	0%
Cognitive	51	31.29%
Physical/ Mobility	0	0%
Chronic Health Condition	0	0%
Other non-communication disability	0	0%

No Disability	105	64.42%
Prefer not to answer		
Unknown		
Unduplicated Total	163	100%

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
	N/A	
	N/A	
Unduplicated Total	N/A	

	FY 2023	
Educational Status	**# Served**	**% of Served**
	N/A	
Unduplicated Total	N/A	

	FY 2023	
Employment Status	**# Served**	**% of Served**
Competitive Employment	115	70.55%
Unemployed	48	29.44%
Unduplicated Total	163	100%

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Not Tracked		
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Not Tracked		
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Not Tracked		
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
Clients already receiving MH services are referred into IPS, not out to MH	Existing MH clients are referred into IPS	N/A	Unknown; not tracked	None; referrals flow into IPS, not from IPS

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	**Attendance**	**Average Attendance per Group**
None; support is individualized to the client	N/A	N/A

9. Detailed Outcomes

The total number of clients served was 163; 82 new clients received services in FY23. The active caseload was 115 per Employment Specialist (ES), and the total number of new jobs started by clients was 83, and the number of clients closed due to successful transition to employment was 32. Further, 11 clients enrolled in formal education programs targeted to their preferred employment. 49 clients were closed out without obtaining IPS supported employment; it is unknown how many obtained employment independently vs. not continuing to pursue employment. Additionally, 12 clients were also enrolled in the State Department of Rehabilitation Services for additional supports. There were a total of 4.5 ESs with IPS caseload.

10. Evaluation Summary

In order to receive a “5” for the category “Number of IPS Clients on Supervisor’s Caseload”, the Supervisor should be fully committed to supporting the ESs at no more than 10:1 per full-time supervisor. One supervisor carried a total of 35 cases, due to staffing shortages and the time needed to be trained for this specific position.

❖ Success Stories

A refugee father of a family from Syria arrived to the US, and experienced depression and anxiety over not being able to provide sufficiently for his family. The ESs worked with him intensively, getting him connected with ESL classes, driver training and helping him obtain his barber license and other related services, using translation apps and with potential employers to return him to his dream job of being a barber, which was his established career back in Syria. He says: “I love it here in America. Now I’m good and I want to help others.” He is also now volunteering at his mosque.

A client who was in an FSP Adult program was referred to IPS, and the ES supported the client with building a resume, practicing interviews, and discussing employer expectations and possible job accommodations. The client’s first week on the job was stressful, and they were experiencing personal life stressors (a breakup, moving to a new location). The whole service team worked with the client and the employer to temporarily reduce hours until the client/employee felt more comfortable with the job. IPS closed the client after a successful transition to employment; the client said: “Work was the only time I felt myself, it gave me something to focus on other than my stressors or mental health.”

A client came to the program with Engineer experience, diagnosis with ADHD and anxiety and had difficulty leaving their house so they wanted a remote position. They hadn’t worked in the field for a couple years, struggled to find a job due to lack of current skills. We found a internship opportunity with a company, about a month-long paid program through the company to learn the skills needed to do the job. After becoming a permanent employee, the client after discussing their accommodation needs with staff had disclosed their disability to their manager who was supportive of the accommodations needed for the job. The client also became the leader of a small support group at the company, where they now encourage fellow coworkers to get together through work events.

COUNTY CLINICS

DOWNTOWN BEHAVIORAL HEALTH CENTER (DTBH), CENTRAL WELLNESS AND BENEFITS CENTER (CWBC), AND VIETNAMESE AMERICAN SERVICES CENTER – BEHAVIORAL HEALTH (VASCBH)

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Downtown Mental Health Center Service Teams (DTMH): The goal of DTMH is to assist individuals within the context of a mutual partnership effort to achieve higher levels of functioning, develop community/family support systems wherever possible, promote self-reliance and self-sufficiency, and encourage individuals to work or to return to work whenever possible. Service teams work with clients suffering from serious mental illness who exhibit severe problems in normal daily functioning, offering a full array of mental health services including case management services, crisis intervention and medication support services. DTMH has two fulltime service teams operating Monday through Friday and serves more than 700 clients. All teams are comprised of case managers and a psychiatrist. While both clinics are standard outpatient clinics that serve homeless consumers, the Valley Homeless Healthcare Program locates some of its health care services for homeless residents at DTMH to facilitate convenient access to care.

Central Wellness Benefits Center (CWBC): The goal of the CWBC is to assist clients in accessing health benefits while managing their medication needs. If qualified for coverage, CWBC links clients to more extensive behavioral health outpatient services within County of Santa Clara. Clients are referred to CWBC for basic behavioral health and crisis intervention services. CWBC also provides ongoing medication services and assists clients with benefits enrollment services as needed. CWBC is co-located at Valley Medical Center with Barbara Arons Pavilion (BAP), Emergency Psychiatric Services (EPS), and Mental Health Urgent Care (MHUC). Services are available in English, Spanish, Russian, Portuguese, Farsi, Tamil, Telugu, and Vietnamese.

The Vietnamese American Service Center – Behavioral Health (VASCBH) is designated as a culturally proficient outpatient behavioral health site to provide behavioral health services primarily to children, youth, adult and older adult Vietnamese and Latino populations of Santa Clara County who have severe mental illness. The focus of the program is to provide the services within the cultural community of the consumers, utilizing appropriate intervention methods. The staff, which includes clerical, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Psychiatrists, Rehabilitation Counselors, Licensed Psychiatric Technicians and Mental Health Peer Support Workers, is bilingual and/or bicultural in Spanish and Vietnamese. The staff work as a treatment team for the consumers/clients with a multi-disciplinary perspective in developing the course of treatment.

The VASC-BH is housed in a brand-new County-owned building, located in a high need, southeast areas of Santa Clara County, together with other service programs from the Ambulatory Care and Social Services Agency, creating a multi-dynamic treatment and service facility, and one-stop shop for the community. Per the Office of the County Executive report, the work of the VASC was informed by findings from the County Public Health Department health assessments – "Status of Vietnamese Health: Santa Clara County, 2011" and "Status of Latino/Hispanic Health, Santa Clara County, 2012" – which identified significant health disparities in the Vietnamese American community and local communities surrounding the VASC. Thus, behavioral health services were identified among other integrated services to be provided at the VASC: primary ambulatory care; dental; pharmacy; laboratory services; health and benefits application assistance services; and senior nutrition program. The VASC had a grand opening in February 2022.

2. Program Goals, Objectives & Outcomes

❖ Goals

i. Reduce subjective suffering from mental illness
ii. Increase meaningful use of time and capabilities in school, work, and activity
iii. Reduce homelessness and increase safe and permanent housing
iv. Increase access to substance use treatment
v. Increase natural networks of supportive relationships
vi. Increase self-help and client/family involvement
vii. Reduce disparities in access to mental health services
viii. Reduce disparities in service access
ix. Reduce psycho-social impact of trauma

❖ Objectives

i. Engage underserved clients who have not benefitted from traditional outpatient mental health services due to complex risk factors including substance use, community violence, interpersonal family violence, general neglect and exposure to trauma, social and emotional isolation, and physical decline and losses by providing culturally and linguistically proficient services
ii. The program shall address and participate in therapeutic activities, assessments, and/or linkage to services that

a. Facilitate the reduction of client's psychiatric hospital admissions, including Emergency Psychiatric Services (EPS) episodes.
b. Assist in the prevention/reduction in the rate of incarcerations for the specified target population.
c. Increase client's access to substance use treatment.
d. Increase and strengthen the natural support systems through family engagement in the experience of care, self-help, and other types of support systems.
e. Identify issues including, but not limited to, dual diagnosis, physical disabilities, medications, and connect the client with a Primary Care Physician (PCP) to facilitate treatment of concurrent primary health care and ongoing behavioral health needs.
f. Address and participate in therapeutic activities, assessments and/or linkage services that shall identify physical and psychological conditions specific to target population.
g. The contractor shall initiate coordination and linkage with other providers and institutions including community-based resources that serve adults and/or older adults in Santa Clara County, recognizing that older adults may be less experienced in seeking these resources.
h. The contractor shall encourage clients to actively participate in their recovery and self-monitor milestones and goals towards self-determination, family and vocational education, and recreational services.
i. The contractor shall provide time-limited services for each client through age-appropriate care coordination as the single point of responsibility for services.
j. The contractor shall actively work with the client in their recovery process and assist the client to move towards a lower level of care within the criteria set for the program.
k. The contractor shall utilize Evidence Based Practices (EBPs), Promising Practices (PPs), and/or Community Informed Practices whenever clinically indicated and based on client's diagnoses. The contractor shall report and track both the fidelity and outcomes of any and all practices utilized.

❖ Outcome

i. Clients are able to access medication and behavioral health support, including therapy and case management, needed to manage their symptoms and maintain wellness, as well as avoid the need for more intensive interventions such as hospitalization or full-service partnership (FSP).

ii. Clients stabilized or experience improved integration in social settings, for the greatest possible opportunities to remain in the community.
iii. Reduce costs to other agencies, including health care (e.g., emergency room visits, inpatient hospital services).

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =4879		
Number Served	**Program Expenditure**	**Cost per Person**
2277	$ 8,939,460	$ 3,925.98

4. Evaluation Activities

Focus Areas including:
i. Access and Linkage- Developed and implemented Same Day Access for beneficiaries to access behavioral health services on the same day of request.
ii. Improving the county mental health service delivery system for all clients and their families through therapy, rehabilitative services, collateral, psychiatry, case management and the expansion of peer support services.
iii. Providing mental health treatment using evidence-based practices which may include Motivational Interviewing (MI), Stages of Change, Cognitive Behavioral Therapy (CBT), Trauma-Focused CBT (TF-CBT), Solution-Focused Brief Therapy (SFBT), trauma-informed approaches, and integrated co-occurring disorder practices such as Integrated Dual Disorder Treatment (IDDT), and peer supports such as Wellness Recovery Action Planning. As well, culture and language needs were supported for the six threshold languages for the County, in addition to a myriad of other languages.

The method of measuring client outcomes was determined by a Milestones of Recovery Scale (MORS) score as evaluated by direct service providers on a monthly basis. The score help determine the client's appropriate level of care (higher – FSP, IFSP, ACT, lower – graduation, PCP-if requiring ongoing medication).

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	0	0%
16 -25 years	137	6%
26- 59 years	1697	75%
60+ years	443	19%
Prefer not to answer		

Unknown		
Unduplicated Total	2277	

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	19	1%
Asian	344	15%
Black or African American	83	4%
Native Hawaiian or Other Pacific Islander	8	0%
White/ Caucasian	524	23%
Other	790	35%
More than one race	0	0%
Declined to Answer	25	1%
Unknown	484	21%
Unduplicated Total	2277	

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:	747	33%
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		

Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino		
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal	958	42%
More than one ethnicity		
Prefer not to answer		
Unknown	572	25%
Unduplicated Total	2277	

	FY 2023

Gender (Assigned at Birth)	# Served	% of Served
Male	N/A	N/A
Female	N/A	N/A
Prefer not to answer		
Unknown		
Unduplicated Total	N/A	

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	**1053**	46%
Female	**1224**	54%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	2277	

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		

Prefer not to answer		
Unknown		
Unduplicated Total	N/A	N/A

	FY 2023	
Primary Language	**# Served**	**% of Served**
American Sign Language	0	0%
Arabic	3	0%
Armenian	1	0%
Cambodian	2	0%
Cantonese	4	0%
Chinese	2	0%
English	1331	58%
Farsi	9	0%
Hindi	3	0%
Japanese	0	0%
Korean	5	0%
Laotian	0	0%
Mandarin	22	1%
Other Non-English	28	1%
Portuguese	5	0%
Russian	7	0%
Spanish	449	20%
Tagalog	7	0%

Thai	0	0%
Unknown	256	11%
Vietnamese	138	6%
Unduplicated Total	2277	

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran	1	0%
Served in Military		
Family of Military		
No Military	65	3%
Prefer not to answer		
Unknown	2211	97%
Unduplicated Total	2277	

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	0	0%
Difficulty hearing or speaking	1	0%
Other communication disability		0%
Cognitive	500	29%
Physical/ Mobility	8	0%
Chronic Health Condition		0%
Other non-communication disability	109	2%
No Disability		0%
Prefer not to answer		0%
Unknown	1763	69%

Unduplicated Total	2277	

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total	N/A	

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total	N/A	

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total	N/A	

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total	N/A	

	FY 2023	
Health Status	**# Served**	**% of Served**
Unduplicated Total	N/A	

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total	N/A	

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**

Unduplicated Total	N/A	

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total	N/A	

7. Referrals

FY 2023				
Unduplicated N =1344				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
1344	Outpatient	917	Unknown	Unknown

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
Unknown	Unknown	Unknown

9. Detailed Outcomes

The three County Clinics programs received a total of 1472 referrals from the Behavioral Health Call Center during FY23. There were 1,1,31 admissions. There were also 1,042 discharges, about 72%* of which were considered successful discharges, which resulted from receiving favorable outcome during treatment.
*Percent of successful discharges is shared by County Contracted Providers that provide services for the same program type.

10. Evaluation Summary

❖ Success Story

52-year-old Hispanic, Spanish/English speaking, heterosexual female who immigrated from Mexico in her 20s. She sought therapy after suicide attempt. She was going through a lot of transitions: moving away from her home, empty nesting, and ending an unhealthy relationship on top of health issues. She wasn't raised to talk about how she is feeling let alone giving herself time to feel. Individual was looking to learn about the anxiety she had lived with for so long and how to manage panic attacks. She has learned to normalize how she is feeling, healthy coping skills, and new perspectives on how to overcome challenges that can impact her mental health. Individual has been able to manage her anxiety that has helped her find stable employment and live independently.

❖ Achieved Outcomes

i. Downtown and CWBC has seen an increased number of successful discharges.
ii. Clients obtained employment through CWBC's IPS program.
iii. Same Day Access has been formally rolled out at Downtown, which results in a higher referral to admission conversion rate.

❖ Challenges

i. High rate of no show/cancellations for both in person and telephone/telehealth sessions.
ii. Serving uninsured clients were restricted only to one clinic in San Jose. Uninsured clients in South County or far North County must travel far to obtain services.
iii. Clinic is seeing a reduce number of referrals.
iv. High client to staff ratio reduces services for beneficiaries.

CRIMINAL JUSTICE RESIDENTIAL AND OUTPATIENT

EVAN'S LANE OUTPATIENT AND RESIDENTIAL

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

As is the case across the country, in County of Santa Clara there are a large number of individuals with serious mental illness who cycle in and out of the justice system. In order to help ensure that the County has the appropriate supports and services in place for these individuals, the County funds residential treatment services and outpatient services for justice-involved individuals, as well as treatment and support for cooccurring disorders.

The Criminal Justice Services (CJS) Evan's Lane Outpatient and Residential program provides comprehensive behavioral health services for clients that combine components of recovery-oriented, evidence-based practices, promising practice, and trauma-informed practices. The program promotes recovery and shall increase client quality of life, community connections, self-reliance, and shall decrease negative outcomes, such as hospitalizations, isolation, abuse, incarceration, and homelessness. The program works collaboratively with community navigators, community providers, other mental health agencies, substance use treatment services providers, physical health providers, educational systems, other groups that provide supportive services, and justice partners, such as, but not limited to, probation, the courts, the district attorneys, and public defenders.

In the FY24 and FY25 annual plan update, a Division name change will be reflected. The Criminal Justice Services (CJS) Division changed its name to the Forensic, Diversion and Reintegration (FDR) Division. This change was officially announced in the FY23 SLC meetings.

2. Program Goals, Objectives & Outcomes

Outpatient and residential services provided at a wellness and recovery centers for individuals who are involved in the criminal justice system to meet the needs of re-entering the community.

❖ **Outcomes**

i. Promote recovery and increase quality of life
ii. Decrease negative outcomes such as hospitalization, incarceration, and homelessness
iii. Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
142 94 (residential) 48 (outpatient)	$ 11,274,130	$ 79,395.28

4. Evaluation Activities

The following outcomes and measures are established by Santa Clara County expected of CJS IOP program:

i. Timeliness and Access

The CJS Evan's Lane Outpatient and Residential program shall monitor its compliance with the timeliness and access requirements as set forth in Code of Federal Regulations (CFR) 42, Section 438. The IOP program must adhere to these requirements for all geographic areas within Santa Clara County and adhere to the State standards for time and distance requirements. Based on population density, the IOP program must provide behavioral health services within ten (10) working days. Services must be accessible within fifteen (15) miles or thirty (30) minutes from a beneficiary's residence.

ii. Engagement in Services (Timeliness/Access)

   a. Performance Objective: Decrease the number of business days from the date of request to an appointment being offered for mental health services to ten (10) days.

iii. Successful Discharges (Quality)

   a. Performance Objective: Increase the percent of successful discharges to 60%.

The following evidence-based practice standard and promising practice standard are established by Santa Clara County expected of CJS Evan's Lane Outpatient and Residential program. The CJS Evan's Lane Outpatient and Residential program shall document that all staff have been trained in accordance with licensing requirements. In addition to licensing requirements, the FSP program staff shall have the following additional experience, training and skills:

i. Staffing shall at least meat the licensing requirements as set forth in CCR Regulations Title 9, Title 19, Title 22 and Medi-Cal Regulations;
ii. The team shall have specific expertise in working with their target population;
iii. Knowledge and skills in the principles of psychosocial rehabilitation and recovery process;
iv. Understanding of psychopathology and physical health problems within the context of client's age and culture;
v. Effectively address client's culture and language needs;
vi. Awareness of language and cultural influences on the individual;
vii. Knowledge and training of Trauma Informed Care, Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, Motivational Interviewing, Criminal Thinking, and experience working with adult victims of abuse and trauma, personality disorders, and co-occurring disorders;
viii. Use of peer support and/or family/caregiver partners;
ix. Confidentiality;
x. Crisis Assessment and Intervention;
xi. Understanding of Wellness and Recovery Principles;
xii. Knowledge of local community resources available to the client population, including self-help centers and ethnic community resources;
xiii. Understanding of the BHSD System of Care; and
xiv. Understanding of the justice system and its impact on clients.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years	15	9%

26- 59 years	137	85%
60+ years	10	6%
Prefer not to answer		
Unknown		
Unduplicated Total	162	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	2	1.2%
Asian	8	4.9%
Black or African American	10	6.2%
Native Hawaiian or Other Pacific Islander		
White/ Caucasian	38	23.5%
Other	63	38.9%
More than one race		
Prefer not to answer	3	1.9%
Unknown	38	23.5%
Unduplicated Total	162	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American	1	0.6%
Mexican/ Mexican-American/ Chicano		
Puerto Rican	31	19.1%

South American	3	1.9%
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino	35	21.6%
Hispanic or Latino Subtotal	70	
Non-Hispanic or Non-Latino as follows:		
African	3	1.9%
Asian Indian/ South Asian		
Cambodian		
Chinese	1	0.6%
Eastern European		
European		
Filipino	3	1.9%
Japanese		
Korean	1	0.6%
Middle Eastern	1	0.6%
Vietnamese	2	1.2%
Non-Hispanic/ Non-Latino (undefined)	4	2.5%
Other Non-Hispanic/ Non-Latino	43	26.5%
Non-Hispanic or Non-Latino Subtotal	58	
More than one ethnicity		
Prefer not to answer	1	0.6%
Unknown	33	20.4%
Unduplicated Total	162	100.0%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	112	69.1%
Female	50	30.9%

Prefer not to answer		
Unknown		
Unduplicated Total	162	100.0%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	112	69.1%
Female	50	30.9%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	162	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown		
Unduplicated Total	Not Available-Not a required field	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	117	72.2%
Spanish	5	3.1%
Vietnamese	1	0.6%
Chinese		
Tagalog		
Farsi		
Other		
Prefer not to answer		
Unknown	39	24.1%
Unduplicated Total	162	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military	20	12.3%
Prefer not to answer		
Unknown	142	87.7%
Unduplicated Total	162	100.0%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability	1	0.6%

No Disability		
Prefer not to answer		
Unknown	161	99.4%
Unduplicated Total	162	100%

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Imminent risk of homelessness	1	0.6%
Jail Transitioning Program	3	1.9%
Literally Homeless	1	0.6%
Not Homeless	33	20.4%
Other	48	29.6%
Unknown	76	46.9%
Unduplicated Total	162	100%

	FY 2023	
Educational Status	**# Served**	**% of Served**
Associate degree	6	3.7%
Bachelors Degree	7	4.3%
Elementary School	1	0.6%
GED	8	4.9%
High School	36	22.2%
Middle School	4	2.5%
None		
Other	6	3.7%
Unknown	94	58.0%
Unduplicated Total	162	100.0%

	FY 2023	
Employment Status	**# Served**	**% of Served**
Disabled	1	0.6%
Employed Student/Part Time		
Full Time	6	3.7%
Other	1	0.6%
Part Time	9	5.6%
Unemployed Looking For Work	8	4.9%
Unemployed/Not Seeking Employment	47	29.0%
Unknown	90	55.6%
Unduplicated Total	162	44.4%

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Not Available-System does not collect this data		
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Not Available-System does not collect this data		
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Not Available-System does not collect this data		
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Not Available-System does not collect this data		
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Not Available-System does not collect this data		
Unduplicated Total		

7. Referrals

The following processes are established by the County of Santa Clara expectations of the Forensic, Diversion, and Reintegration Evan's Lane Outpatient and Residential program:
The Evan's Lane Outpatient and Residential program shall accept referrals that are generated through the BHSD Collaborative Court Staff, BHSD Re-Entry Resource Center staff, and other CJS providers. These may include referrals that are a result of:

i. Individuals needing to step down from a higher level of care or individuals from a lower level of care
ii. Referrals from other Counties for clients that have benefits associated with Santa Clara County; and
iii. Referrals from Adult Custody Heath, the Probation Department, the Parole Department, the Pretrial Department, Faith Based Resource Centers, and other justice partners as determined appropriate by the BHSD CJS Division and which would be processed by the BHSD Collaborative Court staff or BHSD Re-Entry Resource Center staff.

The Evan's Lane Outpatient and Residential program shall accept referrals five (5) days per week, during regular scheduled business hours. Individuals referred to this level of care must meet Medi-Cal medical necessity criteria in order to be enrolled into the program. Individuals who do not meet the criteria for behavioral health services or that need a different level of care must be directed and linked by the program to appropriate alternative resources or another provider.

The Evan's Lane Outpatient and Residential program shall comply with a Feedback Loop Process to ensure that referral sources are notified of the status of the referral, provided the appropriate sections of the assessment, and informed of outcomes and/or next steps.

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
147	ADULT OP	66	103	40

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
4	16	4

9. Detailed Outcomes

Per FY23 internal division data, the Evan's Lane Outpatient and Residential outcomes and performance area are as followed:
Unduplicated beneficiaries served in the Outpatient Program was 94. The successful discharge rate was 51%.

10. Evaluation Summary

The Evan's Lane Outpatient and Residential program has had several milestone successes for FY2023. The program filled several clinical positions with staff who were dedicated to improving the lives with justice-involved individuals. The program managers also reported that the new staff members contributed to a positive work environment due to their desire to improve their clinical skills and achieve their professional growth within the clinic. Additionally, the clinic set its goal of becoming a co-occurring program in FY23. Therefore, the program underwent an arduous journey to become certified to provide Substance

Use Treatment Services. At the time of this reporting, the program has submitted all of its documentation and is awaiting final approval from the State.

Although some COVID-19 restrictions have eased this past year, the program reported that group treatment continues to be a challenge due to ongoing fluctuations of COVID-19 transmissions from large gathering. The program attempted virtual groups but faced some resistance from individuals who feared their personal information would be shared in group setting. Finally, the program reported that department hiring freeze has impacted its ability to hire and on-board vacant clinical positions.

Criminal Justice Outpatient Services Program

Criminal Justice Outpatient Services in Santa Clara County covers 2 different programs.

1. CJS Aftercare
2. CJS Intensive Outpatient

The total cost per person, across all programs in this category can be found below. The following pages are detailed reports for each individual program in this category.

FY 2023		
Number Served	Program Expenditure	Cost per Person
243	$ 1,682,999	$ 6,925.92

CRIMINAL JUSTICE SERVICES (CJS) AFTERCARE

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

As is the case across the country, in County of Santa Clara there are a large number of individuals with serious mental illness who cycle in and out of the justice system. In order to help ensure that the County has the appropriate supports and services in place for these individuals, the county funds treatment services for justice-involved individuals who need aftercare support, as well as treatment and support for cooccurring disorders.
The County's outpatient treatment programs for justice-involved individuals provide culturally and linguistically appropriate services including individual, group, and family counseling and education on wellness, recovery, and resiliency. These programs offer comprehensive, coordinated services that vary in level of intensity. Outpatient programs may address a variety of needs, including situational stressors, family relations, interpersonal relationships, mental health issues, life span issues, psychiatric illnesses, and substance use disorders and other addictive behaviors.
In the FY24 and FY25 annual plan update, a Division name change will be reflected. The Criminal Justice Services (CJS) Division changed its name to the Forensic, Diversion and Reintegration (FDR) Division. This change was officially announced in the FY23 SLC meetings.

2. Program Goals, Objectives & Outcomes

❖ **Outcomes**

i. Increase stability and quality of life
ii. Decrease signs and symptoms of mental illness

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
25	See cover page	See cover page

** Program expenditures includes all funds (ex MediCal leverage), not only MHSA funds.

4. Evaluation Activities

The following outcomes and measures are established by the County of Santa Clara expectations of the Forensic, Diversion, and Reintegration Aftercare program at Community Solutions:

i. Timeliness and Access

The Aftercare program shall monitor its compliance with the timeliness and access requirements as set forth in Code of Federal Regulations (CFR) 42, Section 438. The Aftercare program must adhere to these requirements for all geographic areas within Santa Clara County and adhere to the State standards for time and distance requirements. Based on population density, the Aftercare program must provide behavioral health services within

ten (10) working days. Services must be accessible within fifteen (15) miles or thirty (30) minutes from a beneficiary's residence.

ii. Engagement in Services (Timeliness/Access)

a. Performance Objective: Decrease the number of business days from the date of request to an appointment being offered for mental health services to ten (10) days.
b. Performance Objective: Decrease the percent of open client no shows to 25%.

iii. Successful Discharges (Quality)

Performance Objective: Increase the percent of successful discharges to 60%.

iv. Acute Care Readmissions (Quality)

a. Targeted System Performance: No more than 5% of clients receiving inpatient hospital services are readmitted within thirty (30) days.
b. Metric: Number and percentage of clients discharging from acute care services who are readmitted within thirty (30) days for any reason.
c. Improvement Objective: Reduce the percentage of clients receiving inpatient hospital services who are readmitted within thirty (30) days to no more than 7%.

v. Successful Discharges (Quality)

a. Targeted System Performance: At least 60% of discharges are successful, as measured by Milestones of Recovery Scales (MORS).
b. Metric: Number and percentage of clients who discharged successfully from a program (as indicated by change in MORS scores).
c. Improvement Objective: Increase the number of clients who successfully discharge to at least 35%, as indicated by improvement in MORS score at discharge.

The following evidence-based practice standard and promising practice standard are established by the County of Santa Clara expectations of the Forensic, Diversion, and Reintegration Aftercare program at Community Solutions. The Aftercare program shall document that all staff have been trained in accordance with licensing requirements. In addition to licensing requirements, the FSP program staff shall have the following additional experience, training and skills:

i. Staffing shall at least meat the licensing requirements as set forth in CCR Regulations Title 9, Title 19, Title 22 and Medi-Cal Regulations.
ii. The Aftercare team shall have specific expertise in working with their target population.
iii. Knowledge and skills in the principles of psychosocial rehabilitation and recovery process.
iv. Understanding of psychopathology and physical health problems within the context of client's age and culture.
v. Effectively address client's culture and language needs.
vi. Awareness of language and cultural influences on the individual.
vii. Knowledge and training of Trauma Informed Care, Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, Motivational Interviewing, Criminal Thinking, and experience working with adult victims of abuse and trauma, personality disorders, and co-occurring disorders.
viii. Use of peer support and/or family/caregiver partners.
ix. Confidentiality
x. Crisis Assessment and Intervention
xi. Understanding of Wellness and Recovery Principles
xii. Knowledge of local community resources available to the client population, including self-help centers and ethnic community resources
xiii. Understanding of the BHSD System of Care; and
xiv. Understanding of the justice system and its impact on clients.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years	3	11%
26- 59 years	21	78%
60+ years	3	11%
Prefer not to answer		
Unknown		
Unduplicated Total	27	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native		
Asian	3	11.1%
Black or African American	4	14.8%
Native Hawaiian or Other Pacific Islander		
White/ Caucasian	8	29.6%
Other	11	40.7%
More than one race		
Prefer not to answer		
Unknown	1	3.7%
Unduplicated Total	27	100%

	FY 2023

Ethnicity	# Served	% of Served
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano	4	14.8%
Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino	9	33.3%
Hispanic or Latino Subtotal	13	
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese	2	7.4%
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		

Non-Hispanic or Non-Latino Subtotal	2	
More than one ethnicity		
Prefer not to answer	11	40.7%
Unknown	1	3.7%
Unduplicated Total	27	100.0%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	20	74.1%
Female	7	25.9%
Prefer not to answer		
Unknown		
Unduplicated Total	27	100.0%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	20	74.1%
Female	7	25.9%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	27	100%

	FY 2023

Sexual Orientation	# Served	% of Served
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown		
Unduplicated Total	Not Available-Not a required field	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	27	100.0%
Spanish		
Vietnamese		
Chinese		
Tagalog		
Farsi		
Other		
Prefer not to answer		
Unknown		
Unduplicated Total	27	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		

Family of Military		
No Military	1	3.7%
Prefer not to answer		
Unknown	26	96.3%
Unduplicated Total	27	100.0%

	FY 2023	
Disability*	**# Served**	**% of Served**
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability	2	7.4%
No Disability		
Prefer not to answer		
Unknown	25	92.6%

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unknown	27	100.0%
Unduplicated Total	27	100%

	FY 2023	
Educational Status	**# Served**	**% of Served**
Associate degree	5	18.5%
Bachelors Degree	1	3.7%

Elementary School	3	11.1%
High School	12	44.4%
Middle School	1	3.7%
None	1	3.7%
Other	3	11.1%
Unknown	1	3.7%
Unduplicated Total	27	100.0%

	FY 2023	
Employment Status	**# Served**	**% of Served**
Disabled	2	7.4%
Employed Student/Part Time	1	3.7%
Full Time	3	11.1%
Other	1	3.7%
Part Time	4	14.8%
Unemployed Looking For Work	8	29.6%
Unemployed/Not Seeking Employment	8	29.6%
Unknown	3	11.1%
Unduplicated Total	27	100.0%

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
“Not Available – System does not collect this data”		
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
"Not Available – System does not collect this data"		
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
"Not Available – System does not collect this data"		
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
"Not Available – System does not collect this data"		
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
"Not Available – System does not collect this data"		
Unduplicated Total		

7. Referrals

The following processes are established by the County of Santa Clara expectations of the Forensic, Diversion, and Reintegration Aftercare program at Community Solutions:

The Aftercare program shall accept referrals that are generated through the BHSD Collaborative Court Staff, BHSD Re-Entry Resource Center staff, and other CJS providers. These may include referrals that are a result of:

i. Individuals needing to step down from a higher level of care or individuals from a lower level of care
ii. Referrals from other Counties for clients that have benefits associated with Santa Clara County; and

iii. Referrals from Adult Custody Heath, the Probation Department, the Parole Department, the Pretrial Department, Faith Based Resource Centers, and other justice partners as determined appropriate by the BHSD CJS Division and which would be processed by the BHSD Collaborative Court staff or BHSD Re-Entry Resource Center staff.

The Aftercare program shall accept referrals five (5) days per week, during regular scheduled business hours. Individuals referred to this level of care must meet Medi-Cal medical necessity criteria in order to be enrolled into the program. Individuals who do not meet the criteria for behavioral health services or that need a different level of care must be directed and linked by the program to appropriate alternative resources or another provider.
The Aftercare program shall comply with a Feedback Loop Process to ensure that referral sources are notified of the status of the referral, provided the appropriate sections of the assessment, and informed of outcomes and/or next steps.

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
0	AFTERCARE	0	0	0

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
8	86	8

9. Detailed Outcomes

Per FY23 financial data and internal division data, the Aftercare outcomes and performance area as followed:
Unduplicated beneficiaries served was 25. The successful discharge rate was 100% for this program.
Annual budget for direct service was $185,817 but program expended $112,884, which was underutilized.
Annual budget for outreach, client flex funds, and housing budget total $57,538 but the program expended $44,786, which was underutilized.

10. Evaluation Summary

Due to increase utilization of the Aftercare program, the contracted caseload was increased from 10 to 20 for FY23. Over this past year, the Aftercare program did a great job in implementing programmatic changes to smoothy transferring individuals throughout the different levels of care within their agency. The program reported that they were able to accept individuals from higher levels of care, such as the Forensic Assertive Community Treatment and Full-Service Partnership teams and serve them successfully in the Aftercare program. Once individuals complete the Aftercare program, they also successfully transitioned to traditional, non-justice programs. The program manager also stated that they were able to utilize housing flex funds to provide temporary housing to individuals facing homelessness.

Even with the increase in contracted capacity for FY23, the program felt that the increase in referrals and demand for services have grown. With the implementation of CaAIM for FY24 where programs no longer have contracted capacity, the County hopes to expand this program. The program manager at Aftercare also reported that lack of long -term housing is a challenge for justice-involved individuals.

CJS INTENSIVE OUTPATIENT

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The Criminal Justice Services (CJS) Intensive Outpatient Treatment Program works with justice-involved in developing skills to manage stress and better cope with emotional and behavioral issues.
The program provides the following services:

i. Group, individual, case management, outreach and family therapy
ii. Frequent visits at home or in the community (usually 3-5 days per week), and an average of 3-4 hours of treatment per day for a set period of time (often 4-6 weeks, depending on the program)

The program provides comprehensive behavioral health services for clients that combine components of recovery-oriented, evidence-based practices, promising practice, and trauma-informed practices. The program promotes recovery and shall increase client quality of life, community connections, self-reliance, and shall decrease negative outcomes, such as hospitalizations, isolation, abuse, incarceration, and homelessness. The program works collaboratively with community navigators, community providers, other mental health agencies, substance use treatment services providers, physical health providers, educational systems, other groups that provide supportive services, and justice partners, such as, but not limited to, probation, the courts, the district attorneys, and public defenders.
In the FY24 and FY25 annual plan update, a Division name change will be reflected. The Criminal Justice Services (CJS) Division changed its name to the Forensic, Diversion and Reintegration (FDR) Division. This change was officially announced in the FY23 SLC meetings.

2. Program Goals, Objectives & Outcomes

❖ **Outcomes**

i. Promote recovery and increase quality of life
ii. Decrease negative outcomes such as hospitalization, incarceration, and homelessness
iii. Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 311		
Number Served	Program Expenditure	Cost per Person
218	See cover page	See cover page

Evaluation Activities

The following outcomes and measures are established by Santa Clara County expected of CJS IOP program:

i. Timeliness and Access

The IOP program shall monitor its compliance with the timeliness and access requirements as set forth in Code of Federal Regulations (CFR) 42, Section 438. The IOP program must adhere to these requirements for all geographic areas within Santa Clara County and adhere to the State standards for time and distance requirements. Based on population density, the IOP program must provide behavioral health services within ten (10) working days. Services must be accessible within fifteen (15) miles or thirty (30) minutes from a beneficiary's residence.

ii. Engagement in Services (Timeliness/Access)

   a. Performance Objective: Decrease the number of business days from the date of request to an appointment being offered for mental health services to ten (10) days.
   b. Performance Objective: Decrease the percent of open client no shows to 25%.

iii. Successful Discharges (Quality)

   a. Performance Objective: Increase the percent of successful discharges to 60%.

iv. Acute Care Readmissions (Quality)

   a. Targeted System Performance: No more than 5% of clients receiving inpatient hospital services are readmitted within thirty (30) days.
   b. Metric: Number and percentage of clients discharging from acute care services who are readmitted within thirty (30) days for any reason.
   c. Improvement Objective: Reduce the percentage of clients receiving inpatient hospital services who are readmitted within thirty (30) days to no more than 7%.

v. Successful Discharges (Quality)

   a. Targeted System Performance: At least 60% of discharges are successful, as measured by Milestones of Recovery Scales (MORS).
   b. Metric: Number and percentage of clients who discharged successfully from a program (as indicated by change in MORS scores).
   c. Improvement Objective: Increase the number of clients who successfully discharge to at least 35%, as indicated by improvement in MORS score at discharge.

The following evidence-based practice standard and promising practice standard are established by Santa Clara County expected of CJS IOP program. The CJS IOP program shall document that all staff have been trained in accordance with

licensing requirements. In addition to licensing requirements, the FSP program staff shall have the following additional experience, training and skills:

i. Staffing shall at least meat the licensing requirements as set forth in CCR Regulations Title 9, Title 19, Title 22 and Medi-Cal Regulations;
ii. The IOP team shall have specific expertise in working with their target population;
iii. Knowledge and skills in he principles of psychosocial rehabilitation and recovery process;
iv. Understanding of psychopathology and physical health problems within the context of client's age and culture;
v. Effectively address client's culture and language needs;
vi. Awareness of language and cultural influences on the individual;
vii. Knowledge and training of Trauma Informed Care, Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, Motivational Interviewing, Criminal Thinking, and experience working with adult victims of abuse and trauma, personality disorders, and co-occurring disorders;
viii. Use of peer support and/or family/caregiver partners;
ix. Confidentiality;
x. Crisis Assessment and Intervention;
xi. Understanding of Wellness and Recovery Principles;

xii. Knowledge of local community resources available to the client population, including self-help centers and ethnic community resources;
xiii. Understanding of the BHSD System of Care; and
xiv. Understanding of the justice system and its impact on clients.

4. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	Not Applicable	Not Applicable
16 -25 years	24	8%
26- 59 years	266	86%
60+ years	21	7%
Prefer not to answer	Not Available	Not Available
Unknown	Not Available	Not Available
Unduplicated Total	311	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	4	1.3%
Asian	32	10.3%
Black or African American	40	12.9%
Native Hawaiian or Other Pacific Islander	4	1.3%
White/ Caucasian	96	30.9%
Other	95	30.5%
More than one race	Not Available	Not Available
Prefer not to answer	10	3.2%

Unknown	30	9.6%
Unduplicated Total	311	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	Not Available	Not Available
Central American	Not Available	Not Available
Mexican/ Mexican-American/ Chicano	44	14.1%
Puerto Rican	1	0.3%
South American	4	1.3%
Hispanic/ Latino (undefined)	51	16.4%
Other Hispanic/ Latino	Not Available	Not Available
Hispanic or Latino Subtotal	100	
Non-Hispanic or Non-Latino as follows:		
African	3	1.0%
Asian Indian/ South Asian	4	1.3%
Cambodian	1	0.3%
Chinese	3	1.0%
Eastern European	Not Available	Not Available
European	2	0.6%
Filipino	4	1.3%
Japanese		
Korean	2	0.6%

Middle Eastern	2	0.6%
Vietnamese	9	2.9%
Non-Hispanic/ Non-Latino (undefined)	5	1.6%
Other Non-Hispanic/ Non-Latino	144	46.3%
Non-Hispanic or Non-Latino Subtotal	179	
More than one ethnicity	Not Available	Not Available
Prefer not to answer	6	1.9%
Unknown	26	8.4%
Unduplicated Total	311	100.0%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	210	67.5%
Female	101	32.5%
Prefer not to answer	Not Available	Not Available
Unknown	Not Available	Not Available
Unduplicated Total	311	100.0%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	210	67.5%
Female	101	32.5%
Transgender (Male to Female)	Not Available	Not Available
Transgender (Female to Male)	Not Available	Not Available
Transgender (Undefined)	Not Available	Not Available
Genderqueer	Not Available	Not Available
Questioning or Unsure	Not Available	Not Available
Another gender identity	Not Available	Not Available

Prefer not to answer	Not Available	Not Available
Unknown	Not Available	Not Available
Unduplicated Total	311	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	Not Available	Not Available
Heterosexual/ Straight	Not Available	Not Available
Bisexual	Not Available	Not Available
Questioning/ Unsure	Not Available	Not Available
Queer	Not Available	Not Available
Another sexual orientation	Not Available	Not Available
Prefer not to answer	Not Available	Not Available
Unknown	Not Available	Not Available
Unduplicated Total	Not Available-Not a required field	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	295	94.9%
Spanish	10	3.2%
Vietnamese	2	0.6%
Chinese	1	0.3%
Tagalog	Not Available	Not Available
Farsi	Not Available	Not Available
Other	1	0.3%
Prefer not to answer	Not Available	Not Available

Unknown	2	0.6%
Unduplicated Total	311	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	Not Available	Not Available
Veteran	1	0.3%
Served in Military	Not Available	Not Available
Family of Military	Not Available	Not Available
No Military	67	21.5%
Prefer not to answer	Not Available	Not Available
Unknown	243	78.1%
Unduplicated Total	311	100.0%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	Not Available	Not Available
Difficulty hearing or speaking	Not Available	Not Available
Other communication disability	Not Available	Not Available
Cognitive	Not Available	Not Available
Physical/ Mobility	Not Available	Not Available
Chronic Health Condition	Not Available	Not Available
Other non-communication disability	8	2.6%
No Disability	Not Available	Not Available
Prefer not to answer	Not Available	Not Available
Unknown	303	97.4%
Unduplicated Total	311	100%

*Participants may choose more than one option for Disability.

5. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**

Imminent risk of homelessness	Not Available	Not Available
Jail Transitioning Program	Not Available	Not Available
Literally Homeless	Not Available	Not Available
Not Homeless	Not Available	Not Available
Other	Not Available	Not Available
Unknown	311	100.0%
Unduplicated Total	311	100%

	FY 2023	
Educational Status	**# Served**	**% of Served**
Associate degree	16	5.1%
Bachelors Degree	9	2.9%
Doctorate Degree	1	0.3%
Elementary School	3	1.0%
GED	15	4.8%
High School	173	55.6%
Masters Degree	2	0.6%
Middle School	8	2.6%
None		
Other	7	2.3%
Unknown	77	24.8%
Unduplicated Total	311	100.0%

	FY 2023	
Employment Status	**# Served**	**% of Served**
Disabled	8	2.5%

FT homemaker	1	
Employed Student/Part Time	Not Available	Not Available
Full Time	4	1.3%
Other	1	0.3%
Part Time	13	4.1%
School, Full Time	1	0.3%
School, Part Time	1	0.3%
Unemployed Looking For Work	18	5.6%
Unemployed/Not Seeking Employment	217	67.8%
Unknown	56	17.5%
Unduplicated Total	320	82.2%

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Not Available-System does not collect this data		
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Not Available-System does not collect this data		
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Not Available-System does not collect this data		
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Not Available-System does not collect this data		
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Not Available-System does not collect this data		
Unduplicated Total		

6. Referrals

The following processes are established by the County of Santa Clara expectations of the Forensic, Diversion, and Reintegration IOP program:

The IOP program shall accept referrals that are generated through the BHSD Collaborative Court Staff, BHSD Re-Entry Resource Center staff, and other FDR providers. These may include referrals that are a result of:

i. Individuals needing to step down from a higher level of care or individuals from a lower level of care;
ii. Referrals from other Counties for clients that have benefits associated with Santa Clara County; and
iii. Referrals from Adult Custody Heath, the Probation Department, the Parole Department, the Pretrial Department, Faith Based Resource Centers, and other justice partners as determined appropriate by the BHSD FDR Division and which would be processed by the BHSD Collaborative Court staff or BHSD Re-Entry Resource Center staff.

The IOP program shall accept referrals five (5) days per week, during regular scheduled business hours. Individuals referred to this level of care must meet Medi-Cal medical necessity criteria in order to be enrolled into the program. Individuals who do not meet the criteria for behavioral health services or that need a different level of care must be directed and linked by the program to appropriate alternative resources or another provider.
The IOP program shall comply with a Feedback Loop Process to ensure that referral sources are notified of the status of the referral, provided the appropriate sections of the assessment, and informed of outcomes and/or next steps.

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
375	IOP	225	68	14

7. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
0	0	0

8. Detailed Outcomes

The IOP program outcomes and performance area as followed:

i. Unduplicated beneficiaries served was 218. The successful discharge rate was 34% for this program.
ii. Annual budget for direct service was $1,804,283 but program is projected to expend $886,908, which was underutilized.
iii. Annual budget for outreach, client flex funds, and housing budget total $520,199 but the program expended $384,618, which was underutilized.

9. Evaluation Summary

Despite having staffing challenges, the IOP program continues to have a solid core of case managers who have been with the program since inception. The IOP program continues to provide individual rehabilitation, individual therapy, medication support, and intensive case management services. For individuals needing

support with substance use services, the program assists the individuals to AA/NA groups. The IOP program also works hard in connecting individuals with stable housing. The IOP program reports that placement continues to be the biggest barrier for justice-involved individuals as housing can either be extremely expensive or low quality with poor supervision.

Nevertheless, the IOP program also piloted CalAIM changes with the County. The program remains flexible with referrals and continues to serve as a transitional team to stabilize justice-involved individuals and graduating them to lower levels of care.

BEHAVIORAL HEALTH URGENT CARE (MENTAL HEALTH URGENT CARE)

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Behavioral Health Urgent Care (BHUC) is an outpatient clinic for County of Santa Clara residents who are experiencing behavioral health crises. BHUC is co-located near Emergency Psychiatric Services (EPS), Barbara Arons Pavilion, and Valley Medical Center to facilitate ease of access for consumers. Behavioral Health Urgent Care was formerly known as Mental Health Urgent Care.

BHUC's goal is to provide crisis intervention, psychosocial assessment, and brief treatment to meet the immediate needs of people experiencing a crisis and refer them to the appropriate follow-up treatment. The program is designed to help consumers avoid involuntary hospitalization and incarceration, as well as to be an alternative to EPS. Consumers may either refer themselves as a "walk-in" or be referred by a provider, police officer, or family member.

BHUC operates a walk-in crisis clinic that is open from 8 am to 7 pm, seven days a week throughout the year, including holidays, for those seeking voluntary services, including: * Assessment for 5150 involuntary hold * Crisis intervention for people who do not require a 5150 hold * Brief treatment to stabilize the individual and conduct a psychosocial assessment to determine needs for follow-up * Linkage to ongoing services as appropriate, in addition to continuing temporary treatment for up to 60 days, while consumers wait to be connected to ongoing services * Urgent bridge psychiatric medications services to support BH service teams * Same day access for new clients to BH system discharged from EPS and other psychiatric hospitals.

BHUC staff can provide services is several languages spoken by the communities served, including English, Farsi, Korean, Spanish, and Vietnamese.

2. Program Goals, Objectives & Outcomes

i. Outcome 1: Consumers are connected to urgent mental health care services and experience fewer visits to EPS and episodes of hospitalization.
ii. Outcome 2: Decrease homelessness.
iii. Outcome 3: Reduce costs to various public service agencies, including health care (e.g., emergency room visits, inpatient hospital services)

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 2640		
Number Served	Program Expenditure	Cost per Person
2640	$4,914,704	$ 1,861.63

4. Evaluation Activities

i. Access and Linkage- Developed and implemented Same Day Access for new clients discharged from EPS, BAP and psychiatric in-patient hospitals and referrals via BH Call Center for follow up on-going treatment.
ii. Improving the county mental health service delivery system for all clients and their families by help clients avoid involuntary hospitalization and incarceration, as well as to be an alternative to EPS.
iii. Developing and implementing strategies for reducing ethnic/racial disparities by reducing barriers through walk in access without appointments and open every day throughout the year.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	12	1%
16 -25 years	516	20%
26- 59 years	1871	70%
60+ years	241	9%
Prefer not to answer		
Unknown		
Unduplicated Total	2640	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	31	1%
Asian	480	18%
Black or African American	213	8%
Native Hawaiian or Other Pacific Islander	10	1%
White/ Caucasian	740	28%
Other	1061	40%
More than one race		
Prefer not to answer	28	1%
Unknown	77	3%

Unduplicated Total	2640	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino	1085	41%
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	1085	41%
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		

Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal	1414	54%
More than one ethnicity		
Prefer not to answer		
Unknown	141	5%
Unduplicated Total	2640	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	1485	56%
Female	1149	43%
Prefer not to answer		
Unknown	6	1%
Unduplicated Total	2640	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	1485	56%
Female	1149	43%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		

Unknown	6	1%
Unduplicated Total	2640	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown / not available	2640	100%
Unduplicated Total	2640	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	2108	80%
Spanish	314	12%
Vietnamese	42	2%
Chinese / Cantonese / Mandarin	36	1%
Tagalog	6	1%
Farsi	19	1%
Other	95	3%
Prefer not to answer		
Unknown	20	1%
Unduplicated Total	2640	100%

	FY 2023	
Military Status	**# Served**	**% of Served**

Active Military		
Veteran	1	0%
Served in Military		
Family of Military		
No Military	323	12%
Prefer not to answer		
Unknown	2316	88%
Unduplicated Total	2640	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive / Mental domain		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability		
No Disability		
Prefer not to answer		
Unknown		
Unduplicated Total	Not available	

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Educational Status	**# Served**	**% of Served**

Unduplicated Total	Not available	

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Health Status	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total	Not available	

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Mental health urgent care	2640	100%

Unduplicated Total	2640	100%

7. Referrals

FY 2022				
Unduplicated N = 2640				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
	Outpatient BH service team via BH Call Center; EPS and psychiatric hospitals follow-up; walk-in urgent care and linkages services			

8. Group Services Delivered

FY 2023		
Unduplicated N = 0		
Number of Groups	Attendance	Average Attendance per Group
None		

9. Detailed Outcomes

i. The BHUC maintained its service operation everyday throughout the year, including weekends and legal holidays, even during the Covid 19 pandemic shelter in place environment. The program staff were working on-site and provided the services for any clients / community members walked in and requested services.

ii. Over two thousand client episodes were open for services in FY 23

iii. BHUC expanded the same day access for new clients who were discharged from EPS, BAP and contracted psychiatric hospitals in July 2022, to improve timely access and follow up treatment after EPS / hospital discharges.

iv. BHUC's daily service operation, with some evening hours, weekend and holidays, and walk-in access allow for reliable and easy access for the whole community residents and reduce barriers to BH services.

10. Evaluation Summary

The BHUC was quite unique with its service operation everyday throughout the year, including weekends and legal holidays, even during the Covid 19 pandemic shelter in place environment. Every day, the program staff worked on-site and provided the services for any clients / community members walked in and requested services. As such, BHUC is a reliable and accessible resource for BH services for the community, especially in urgent and crisis situations. Everyone can walk in, welcome and served in person.

In the FY 23, the program expanded the same day access for new clients who were discharged from contracted acute psychiatric hospitals (in addition to EPS/BAP), to help reduce no-show rate of scheduled intake appointments, as well as providing timely follow up treatment after hospital discharge. Obviously, this same day access initiative showed great collaboration and efforts from various partners, including EPS, BAP, BH Call Center, other contracted acute psychiatric hospitals and BHSD 24-hour care unit.

Also, in the FY23, the BHUC served as a site for the new Peer Navigator program, where anyone could come in and talk with our MH peer mentor to get assistance with service referral and linkage, as well as other community resources.

COMMUNITY PLACEMENT TEAM AND INSTITUTION OF MENTAL DISEASE (IMD) ALTERNATIVE

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2022 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The Community Placement Team (CPT) coordinates placement at MHSA-funded residential and temporary housing programs for consumers being discharged from Emergency Psychiatric Services (EPS) and/or the Barbara Arons Pavilion (BAP) who are also high utilizers of mental health services. The CPT reviews and approves referrals for BHSD's adult and older adult population ages 18 and over who are residents of Santa Clara County and are requiring supplemental services. All referrals must meet the following criteria: 1) must have a primary diagnosis of Serious Mental Illness and 2) have severe functional impairments that prevent them from functioning independently in the community. The goal of the CPT is to provide a smooth transition for consumers after they experience a crisis by identifying and facilitating a supportive "landing pad" as they return to the community, preventing future crisis, and increasing participation in services. CPTs may refer consumers to services that support breaking the cycle of hospitalization, institutionalization, and homelessness. Such services include FSPs, clinic appointments, or supportive housing.

The Institution of Mental Disease (IMD) Alternative Program utilizes MHSA funds to provide intensive day treatment services for consumers transitioning from IMDs back to the community. These residential services assist the county in efficiently and effectively managing limited resources by providing an alternative to utilization of inpatient psychiatric and medical services while supporting the placements in least restrictive setting in the community. Thus, to prevent or decrease the rate of decompensation and reduce placements at higher levels of care. Services are provided at the following sites: Momentum's Adult Residential Treatment (ART), Community's La Casa Transitioning Housing Unit, Drake House RCFE (located in Monterey County). These programs provide onsite case management services, crisis interventions, medication assistance, psychiatry support, ADL assistance, residential services, 24 hour nursing support, and other clinical support. Services in these locations are provided for adults diagnosed with Severe Mental Illness or Co-occurring disorders.

2. Program Goals, Objectives & Outcomes

i. Outcomes 1: Increased connection to care to reduce the number of consumers cycling between institutional settings and homelessness.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Number Served	Program Expenditure	Cost per Person
298	$ 5,994,661**	$20,116.31

** Program expenditure includes all funds, not only MHSA funds.

4. Evaluation Activities

This information is currently unavailable but will be gathered for future reporting.

5. Demographic Data

This information is currently unavailable but will be gathered for future reporting.

6. Additional Data Collection Requirements

This information is currently unavailable but will be gathered for future reporting.

7. Referrals

This information is currently unavailable but will be gathered for future reporting.

8. Group Services Delivered

This information is currently unavailable but will be gathered for future reporting.

9. Detailed Outcomes

This information is currently unavailable but will be gathered for future reporting.

10. Evaluation Summary

This information is currently unavailable but will be gathered for future reporting.

ADULT RESIDENTIAL TREATMENT (ART)

CSS Outreach and Engagement (O&E) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The program is designed to provide housing, medication, mental health treatment, and social support for the Severely Mentally Ill (SMI) clients ages 18 years and older who are ready to transition from a locked setting into a lower level of care. Upon discharge from a locked setting, this step-down placement supports each client's further stabilization in the community and facilitate the transition to outpatient community services for ongoing maintenance. The program shall serve as a step-down from Institutions for Mental Diseases (IMD), Mental Health Rehabilitation Centers (MHRC), and acute inpatient psychiatric hospitals. The program provides rehabilitative services in a non-institutional, therapeutic community setting and offer a wide range of activities and services for clients who are at risk of hospitalization or another institutional placement. The length of stay for this program is a minimum of 12 months to a maximum of 24 months.

2. Program Goals, Objectives & Outcomes

The program is designed to achieve the following goals:

i. Reduce subjective suffering from mental illness
ii. Assist clients in progressing from intensive psychiatric behavior interventions to functioning independently in the least restrictive setting
iii. Provide an alternative to utilization of state hospital days and acute hospital administrative days, effectively managing limited County resources
iv. Prevent or decrease the rate of decompensation, thus reducing placements at higher, more costly levels of care
v. Prevent client re-hospitalizations into acute psychiatric or medical facilities, as well as criminal incarceration
vi. Improve access to medical and dental healthcare, and successfully link clients to outpatient services before discharge
vii. Prevent and/or reduce the homelessness rate of clients suffering from mental health and substance use challenges

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 88		
Number Served	Program Expenditure	Cost per Person
164	$ 4,266,309	$26,014.08

4. Evaluation Activities

The program engages in the following areas for evaluation activities:

i. Access and Linkages by engaging with clients in the community and acute care settings.
ii. Reduction of ethnic/racial disparities by hosting educational events to the community
iii. Having peer support and family education support services
iv. Provide food, clothing, and shelter to engage unserved individuals, and when appropriate their families
v. Outreach to individuals such as community leaders, those who are homeless, those who are incarcerated in county facilities

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years	11	12%
26- 59 years	66	75%
60+ years	11	12%
Prefer not to answer		
Unknown		
Unduplicated Total	88	

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native		
Asian	6	6%
Black or African American	5	5%
Native Hawaiian or Other Pacific Islander	1	1%
White/ Caucasian	36	36%
Other	29	29%
More than one race	2	2%

Prefer not to answer	2	2%
Unknown	9	9%
Unduplicated Total	90	

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	25	28%
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	25	28%
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		

Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal	55	62%
More than one ethnicity		
Prefer not to answer		
Unknown	8	9%
Unduplicated Total	88	

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	50	
Female	38	
Prefer not to answer		
Unknown		
Unduplicated Total		

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	50	57%
Female	38	43%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	88	100

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown		
Unduplicated Total		

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	87	99%
Spanish		

Vietnamese		
Chinese		
Tagalog	1	1%
Farsi		
Other		
Prefer not to answer		
Unknown		
Unduplicated Total	88	100

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military	13	15%
Prefer not to answer		
Unknown	75	85%
Unduplicated Total	88	

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability		
No Disability		
Prefer not to answer		
Unknown		
Unduplicated Total		

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

	FY 2023	
Educational Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Employment Status	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**

Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total		

7. Referrals

Referrals may come from the community, inpatient settings, and custody health.

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or

mental health versus treatment that is not)				overseen by county mental health)
284	Adult residential treatment	Not tracked	Not available	Not available

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
This is not currently available and will be tracked for future reporting	Not available	Not available

9. Detailed Outcomes

For FY23 there is an increase in utilization compared to FY22. Please see data above.

10. Evaluation Summary

The program continues to provide services to the community, and we continue to require this level of care to help divert clients to the community from inpatient settings.

ASSISTED OUTPATIENT TREATMENT

CSS General System Development (GSD) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

In May 2021, the Board of Supervisors voted to adopt and implement Assisted Outpatient Treatment (AOT) in Santa Clara County. The AOT program launched on February 16, 2022. This report applies to the first full year of program implementation.

AOT implementation is guided by AB 1421, also known as “Laura’s Law”, which refers to a legal process by which a judge may compel an individual to comply with a treatment plan on an outpatient basis. AOT is a less restrictive form of civil commitment for individuals with severe mental illness who are unable or unwilling to receive or adhere to community mental health services voluntarily. Under AOT, patients may be ordered to receive treatment only if, after a civil- not criminal- hearing, a court finds that the client meets strict criteria. In Santa Clara County, individuals may be enrolled in AOT services voluntarily and with a court order. Clients are offered multiple opportunities to engage voluntarily every step of the way from the receipt of the AOT referral to the petition filing and court hearing.

AOT Triage team is a county operated team that screens all referrals to determine AOT eligibility, the team begins assertive outreach, provides linkage with appropriate behavioral health resources, and, when criteria are met, conducts warm handoff and joint outreach with AOT services provider. When AOT petition and court hearing are requested, AOT triage team works with the court team and AOT services provider on filing and serving the petition and providing the evaluation by the AOT psychologist.

AOT services are implemented within Adult Assertive Community Treatment program. Assertive Community Treatment (ACT) is an evidence-based behavioral health program for people with serious mental illness who are at risk of or would otherwise be served in institutional settings (e.g. hospitals, jails/prisons) or experience homelessness. ACT is a comprehensive community-based model of treatment, support, and rehabilitation for individuals with serious mental illness who are unwilling or unable to engage in mental health services and who are experiencing frequent and repetitive hospitalizations and/or incarcerations, likely to be homeless, and may suffer from a co-occurring disorder. Often referred to as a “hospital without walls”, ACT teams provide intensive community support. AOT teams provide services based on intensified ACT model, with even lower staff to client ratio.

During this initial year of implementation, the program continued focusing on community outreach to increase awareness of the program and referral process, triaging referrals, and ramping up and expanding the services. Court Collaborative comprised of BHSD leadership, Superior court judge, and offices of county counsel and public defender met monthly to discuss and coordinate AOT petition and court hearing processes. AOT Advisory Committee transitioned from monthly to bi-monthly meetings and continued providing input on the program implementation and evaluation.

2. Program Goals, Objectives & Outcomes

Assisted Outpatient Treatment (AOT) strives to interrupt the cycle of repetitive psychiatric crises and resulting hospitalizations, incarcerations, and homelessness for people with the most serious mental health problems who struggle to engage in services.

❖ Goals and Objectives

i. Promote and incorporate recovery principles in service delivery.

ii. Decrease or prevent the debilitating symptoms of mental illness and co-occurring substance use that the individual may experience.
iii. Meet basic needs and enhance the quality of life in daily living activities.
iv. Improve socialization and development of natural supports.
v. Improve support with finding and keeping competitive employment.
vi. Reduce hospitalization, homelessness, and institutionalized care.
vii. Decrease the role of families and significant others in providing care while increasing days in the community through housing stability.
viii. Reduce experiences of crisis as well as substance use, violence, and victimization.
ix. Strengthen recovery, self-sufficiency, and other psychosocial outcomes, including housing, education, employment/income, and access to entitlement benefits.
x. Increase reintegration into community life with a focus on stability, particularly in the area of symptom management and reduction of harmful behaviors and suicide

❖ **Expected Program Outcomes**

i. Increase self-help activities and promote health with wellbeing for clients within a safe environment by providing outreach and engagement activities.
ii. Assist the highest risk client with behavioral health needs to remain within the community, attend school/work, prevent hospitalization and involvement in the justice systems.
iii. Improve access to and engagement with services of underserved Adult and Older Adult clients to assist in managing their behavioral health needs.
iv. Decrease hospital and other institutional utilization by engaging clients in services that are relevant and include evidence-based models/promising practices in the provision of individual, group and family treatment modalities.
v. Increase awareness and education regarding needs of the target population by integrating partnerships with adult and older adult service systems, housing and other community resources.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 81		
Number Served	**Program Expenditure**	**Cost per Person**
81	$3,397,762	$41,947.67

Cost-based expenses, such as housing and flex fund to support AOT clients' needs, are included in ACT and Master Lease expenses due to AOT services being contracted out as part of ACT program, and separate Master Lease Housing program created to support AOT clients' needs. In addition, BHSD is working on addressing issues with service data submission by providers into the county system, which may have also affected the cost calculations.

4. Evaluation Activities

The Access and Linkage: Access to the AOT level of care is by referral directly to the AOT program. Family members, behavioral health providers, law enforcement officers, and superior court judge can request AOT petition and make a referral. AOT eligibility criteria are defined by the legislature. BHSD conducted a series of sessions to educate community members about AOT program, AOT criteria and how to make a referral. BHSD AOT program has a county-based triage team that processes all referrals, investigates AOT criteria, and works on linking the referred individuals with the appropriate level of care. If AOT criteria are met, the individual is assigned to the AOT team. BHSD Triage team and provider AOT team start collaborating immediately on joint

outreach and warm handoff. BHSD monitors timely access by holding bi-weekly meetings with each AOT team and reviewing progress on recent referrals. BHSD referral tracking tool collects referral data including timelines and disposition.

Mental health services and supports: BHSD established contractual obligations for AOT providers to maintain high intensity of mental health services. BHSD monitors service provision and utilization using data in electronic health records, and bi-weekly meetings with providers reviewing progress in engaging the clients. If the individual fails to engage in services despite multiple opportunities and attempts, AOT providers and BHSD AOT psychologist initiate AOT petition for civil commitment to outpatient treatment. BHSD has a petition tracking tool to assure that all required timelines are met.

Improving the county mental health service delivery system for all clients and their families: BHSD Triage Team serves as an additional access point for community members to learn about behavioral health services and get their loved ones connected with the services they need. When the Triage Team receives AOT referral and AOT criteria are not met, the team works with the referring party and the referred individual on assessing the needs and assisting with access to the appropriate level of care. BHSD referral tracking tool collects data on referral sources and referral dispositions, which helps to identify training needs in the community and the service delivery system.

Developing and implementing strategies for reducing ethnic/racial disparities: BHSD collects demographic data and compares ethnic and racial background of individuals in AOT program with those in other BHSD programs, to identify potential disparities. As the implementation of AOT program continues into the second year, BHSD will develop strategies to reduce any identified disparities.

Peer support and family education services: Peer Support Specialists (PSS) are an integral part of AOT team and provide Wellness and Recovery Plan (WRAP) services to individuals and families. Each AOT team is expected to have a PSS. BHSD monitors providers to assure adequate staffing and requests staffing reports as needed.

Food, clothing, and shelter to engage unserved individuals, and when appropriate their families: AOT offers housing, flex funds, and other services to support client's stabilization in the community. The program applies housing first model and offers housing and other basic resources to individuals at the time of referral to AOT provider prior to enrollment, if needed. BSHD monitors provision of these services via monthly reports on clients' housing arrangements, rents, and other expenditures to support clients' needs.

In addition, the DHCS requires AOT-specific evaluation report annually. The program designed an evaluation plan to meet DHCS and other reporting requirements. This includes two outcomes measurement surveys: 1 – AOT New Admission Survey to be submitted by provider within 30 days of receiving referral, and 2 – AOT Treatment and Discharge Survey, to be submitted every 6 months after receiving a referral and enrolling the client.

5. Demographic Data

The demographics in section 5 were reported by BHSD Analytics and Reporting Unit. The data came from two electronic records systems Unicare and myAvatar, as contract providers were still being onboarded into myAvatar throughout FY23. Care was taken to remove any duplicates, however, some inconsistencies between county level data and provider-reported data remained. This should be resolved in the next FY when all programs' data will be sourced from myAvatar.

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		

16 -25 years	8	9%
26- 59 years	70	81%
60+ years	6	7%
Prefer not to answer		
Unknown		
Unduplicated Total	86	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	1	1%
Asian	15	17%
Black or African American	11	12%
Native Hawaiian or Other Pacific Islander		
White/ Caucasian	30	35%
Other	23	28%
More than one race		
Prefer not to answer	1	1%
Unknown	5	6%
Unduplicated Total	86	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		

Caribbean	6	7%
Central American	6	7%
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino	16	18%
Hispanic or Latino Subtotal	**28**	**32%**
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		

Non-Hispanic or Non-Latino Subtotal	**53**	**62%**
More than one ethnicity		
Prefer not to answer		
Unknown	5	6%
Unduplicated Total	86	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	50	58%
Female	36	42%
Prefer not to answer		
Unknown		
Unduplicated Total	86	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	50	58%
Female	36	42%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	86	100%

	FY 2023

Sexual Orientation	# Served	% of Served
Gay or Lesbian	1	1%
Heterosexual/ Straight	10	12%
Bisexual	1	1%
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer	30	35%
Unknown	44	51%
Unduplicated Total	86	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	74	86%
Spanish	3	4%
Vietnamese		
Chinese	1	1%
Tagalog		
Farsi		
Other	1	1%
Prefer not to answer		
Unknown	7	8%
Unduplicated Total	86	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran	4	5%
Served in Military		
Family of Military		

No Military	14	16%
Prefer not to answer		
Unknown	68	79%
Unduplicated Total	86	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability	61	71%
No Disability	1	1%
Prefer not to answer		
Unknown	24	28%
Unduplicated Total	86	100%

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

The data in the additional requirements section was not available in the county records system, and only one provider was able to report some of it. The numbers below are based on that provider's report and represent about half of the individuals in AOT services during the reporting period.

	FY 2023	
Residential Status	**# Served**	**% of Served**
Housed while receiving services	36	88%
Unhoused/AWOL	5	12%
Unduplicated Total	41	

	FY 2023	
Educational Status*	**# Served**	**% of Served**

Enrolled in school setting during the reporting period	1	2%
Not enrolled in school setting	40	98%
Unduplicated Total	41	

*Education status categories were not defined. In the future we will work on defining standard categories to report on and for providers to include in their data collection.

	FY 2023	
Employment Status*	**# Served**	**% of Served**
Obtained job placement/employed-actively working	1	2%
Not currently employed	40	98%
Unduplicated Total	41	

* Employment status categories were not defined. In the future we will work on defining standard categories to report on and for providers to include in their data collection.

	FY 2023	
Sources of Financial Support*	**# Served**	**% of Served**
SSI/SSDI/GA/family	7	17%
No financial support	34	83%
Unduplicated Total	41	

* Financial support categories were not defined. In the future we will work on defining standard categories to report on and for providers to include in their data collection.

	FY 2023	
Health Status	**# Served**	**% of Served**
Linked to PCP	6	85%
Declined PCP services	35	14%
Unduplicated Total	41	

*Health Status measure was not defined and was reported by one provider agency as shown in the table above. Linkage with Primary Care Physician is aligned with behavioral health assessment and care planning requirements. The other AOT provider has the health status and linkage with PCP information in the client's clinical record and is working on modifying their Electronic Health Record system to collect this data in a format amenable for quantitative reports.

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Co-occurring disorders	34	85%
Unknown	7	14%
Unduplicated Total	41	

	FY 2023	
Assessment of Daily Living Functions, when appropriate*	**# Served**	**% of Served**
Unduplicated Total		

*Service providers assess and record all pertinent information in client's health record, however daily living functions assessment is not available as quantitative data report. We are currently not mandating a standardized measure on ADL functions.

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Unduplicated Total		

*Service providers maintain record of emergency and crisis interventions in client's health record, as well as incident reports. This data was not available as an aggregate quantitative report. Some preliminary data on county hospital emergency services use by AOT clients was reported in the AOT annual report to the County Board of Supervisors.

7. Referrals

The BHSD triage team received 182 referrals in FY23. Of those, 71 were deemed to meet AOT criteria and were referred to AOT services provider. The remaining 111 were offered other services, as appropriate. Due to the characteristics of the population served by AOT program, such as history of failure to engage with treatment despite being offered multiple opportunities, the engagement in treatment may be inconsistent throughout the course of treatment. AOT services providers initiate outreach upon the receipt of the referral and offer services immediately. In cases of persistent lack of engagement and follow though, combined with a risk of severe

deterioration, a petition is filed with the court for civil commitment to outpatient treatment. In FY23, there were 6 AOT petitions filed.

FY 2023				
Unduplicated N =71				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
71	AOT	57 individuals consented to treatment	Unknown	Warm handoff between triage team and provider begins immediately upon referral.

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	**Attendance**	**Average Attendance per Group**
n/a	n/a	n/a

9. Detailed Outcomes

Consenting to treatment was used as an indicator for successful engagement into treatment. Based on provider reports, in FY 23, AOT providers received 71 referrals. By the end of June 2023, 57 (80%) of the referred individuals consented to treatment. The interval between referral and consent to treatment varies widely in AOT, due to some individuals requiring extended outreach period, which is unlimited per BHSD policy for AOT. Service provision, such as case management, often starts while still in outreach.

Due to ongoing transition into myAvatar during FY 23, there are some discrepancies between county records and provider-reports on charges for services, admissions, discharges, and timeliness. The outcomes indicators data are affected by these discrepancies, and we are working on resolving the issues for the future reports. The following is based on the data available in county records and monitored by the BHSD Quality Management for timeliness indicators and internal AOT program tracking for discharge related indicators.

i. % with assessment appointment within 10 business days: 0%. This indicator does not reflect AOT services accurately. Some of the factors affecting this data include: 1) Individuals referred by court while still in custody take on average over two weeks to be released and receive services; 2) Many individuals who meet AOT criteria are challenging to locate after the referral and/or initial contact; and 3) Some continue refusing services despite multiple attempts.

ii. Average days to first offered assessment appointment: 17 days as reported by one provider and 9 days for the second provider.
iii. No show rates: One provider reported 15% and the second provider reported 18% no show rates. AOT services are provided in the community and are usually not clinic-based and often not appointment-based. Thus, no show rates are not very accurate indicator of client engagement.
iv. Total discharges: 21

a. Successful (10):
- Moved and linked with out of county services – 5
- Re-direct/transfer to other intensive BH outpatient services – 3
- Linked to services via private plan - 2

b. Other discharge outcomes (11):
- Unable to locate – 1
- Moved out of the country – 1
- Incarcerated – 5
- Re-connected to VA without follow through – 1
- Conserved/admitted to state hospital – 2
- Deceased – 1

v. % successful discharges: 48%.

Housing placement is an important outcome in AOT program due to many referred individuals with extensive history being unsheltered and struggling with obtaining and/or maintaining housing. Housing-related outcomes were assessed at the time of 1 year since program launch (for the period of February 2022 – March 2023) and a little after the end of FY23, at the beginning of September 2023.
AOT housing/shelter status distribution during the initial year of AOT implementation (individuals with multiple types of placements maybe duplicated):

i. Master Lease – 14%
ii. B&C – 21%
iii. Scattered site (with family or independent living) – 20%
iv. Shelter – 28%
v. Provided with tent – 3%
vi. Other (unsheltered, incarcerated, hospitalized, in crisis residential or substance use treatment residential) – 34%

AOT housing/shelter status distribution at the beginning of September 2023 (unduplicated), categories revised to more accurately reflect the program:

i. Master Lease – 9%
ii. B&C – 16%
iii. Living with family – 17%
iv. Independent living – 5%
v. In other residential/treatment settings – 15%
vi. Incarcerated – 12%
vii. Unsheltered – 3%
viii. Unable to locate 23%

10. Evaluation Summary

The AOT program was launched in our county in February 2022. After a full year in operation a program evaluation report was provided to the County Board of Supervisors. The initial implementation year, it's

outcomes, challenges and successes are described in detail in the report. The initial outcomes indicate that assertive engagement strategies and unlimited outreach period yield high rates of voluntary enrollment in services. The preliminary pre- and post-enrollment data show trends of reduction in emergency psychiatric services utilization and in incarcerations. Two success stories highlight the value of extensive outreach and strengthening client's natural supports:

1 - After receiving a referral from local law enforcement, the AOT Triage Team, in collaboration with AOT CCP, began to engage an individual that was extremely resistant to treatment and required long period of outreach. When the individual was arrested, the AOT provider coordinated the release and arranged housing to avoid gaps in service delivery. The client accepted the release arrangements stating that they remember and appreciate the outreach efforts. Since the release, this individual has remained sober, adhered to medication orders, attended all psychiatric appointments, and has maintained their housing. The client has also started attending and speaking at AA meetings and is currently in search of employment.

2 - An AOT participant was living with a family member, and both became at risk of losing housing due to eviction. The AOT program provided a temporary motel placement for both the client and the family member, and once it was established that the family member was a positive support to the individual, AOT was able to find a housing placement where both could continue living together. With the support of the family member and AOT, the individual is taking their medication, engaging in treatment, and has been stable in the current setting for the last four months.

Master Lease (ML) Housing program has been expanded to support the needs of individuals enrolled in AOT services. ML program onboarded 3 new properties bringing 20 additional beds and increasing to the overall 5 homes with total 40 beds. ML program continues providing a low barrier access to shared independent living for individuals enrolled in BHSD's intensive outpatient services. Housing individuals referred to AOT presents multiple challenges due to severity of needs including behavioral issues, and BHSD continues collaborating with providers on finding solutions, including licensed B&C placements and providing support to family members living with and housing AOT clients.

Crisis Stabilization Unit and Crisis Residential

Crisis Stabilization Unit and Crisis Residential Treatment in Santa Clara County covers 2 different programs.

1. Crisis Stabilization Unit
2. Crisis Residential Treatment

The total cost per person, across all programs in this category can be found below. The following pages are detailed reports for each individual program in this category.

FY 2023		
Number Served	Program Expenditure	Cost per Person
1,628	$9,513,957	$5,843.95

CRISIS STABILIZATION UNIT

CSS Outreach and Engagement (O&E) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The program is designed to provide services to adult (ages 18-59) and older adult (ages 60 and older) clients who are in voluntary psychiatric crisis whose needs can be accommodated safely in a less restrictive setting. This program offers an array of services including screening, assessment, and peer support services in order to stabilize a crisis and divert the client from a higher level of care to be integrated back into the community or other appropriate treatment setting in a timely manner. This process is critical to the successful long-term outcomes for the clients, some of whom are stabilized within a few hours, but still need to learn successful coping mechanisms to avoid regression upon discharge. The program encourages use of treatment in the least restrictive setting that is clinically appropriate to meet the client's needs.

Furthermore, the program engages 1) underserved adult and older adult clients who have not benefitted from traditional outpatient mental health services due to complex risk factors including substance use, community violence, interpersonal family violence, general neglect and exposure to trauma, social and emotional isolation, and physical decline and losses by providing culturally and linguistically proficient services. 2) Conducts comprehensive assessment with emphasis on crisis intervention services necessary to stabilize and restore the client to a level of functioning that requires a less restrictive level of care. 3) Provides continuous 24-hour observation and supervision for clients who do not require intensive clinical treatment in an inpatient setting and would benefit from a short-term structured stabilization setting. 4)Initiates coordination and linkage with other providers and institutions including naturally occurring resources that serve adults and older adults in Santa Clara County, recognizing that older adults may be less experienced in seeking these resources

2. Program Goals, Objectives & Outcomes

❖ Goals

The program shall align the program to achieve the following goals:

i. Reduce subjective suffering from mental illness
ii. Increase meaningful use of time and capabilities in school, work, and activity
iii. Reduce homelessness and increase safe and permanent housing
iv. Increase access to substance use treatment
v. Increase natural networks of supportive relationships
vi. Increase self-help and consumer/family involvement

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 361		
Number Served	Program Expenditure	Cost per Person

910	See cover page	See cover page

4. Evaluation Activities

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years	42	13%
26- 59 years	267	80%
60+ years	23	7%
Prefer not to answer		
Unknown		
Unduplicated Total	332	

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	4	1.2%
Asian	36	11%
Black or African American	40	12%
Native Hawaiian or Other Pacific Islander	3	0.9%
White/ Caucasian	100	30%
Other	104	31%
More than one race		
Prefer not to answer	5	1.5%

Unknown	40	12%
Unduplicated Total	332	

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	112	34%
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		

Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	178	54%
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer		
Unknown	41	12%
Unduplicated Total	332	

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	224	67%
Female	107	32%
Prefer not to answer		
Unknown	1	2%
Unduplicated Total	332	

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	224	67%

Female	107	32%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	1	2%
Unduplicated Total		

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown		
Unduplicated Total	*Not available*	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	309	93%
Spanish	13	3.9%
Vietnamese	2	0.6%
Chinese	3	0.9%
Tagalog		
Farsi		

Other	1	0.3%
Prefer not to answer		
Unknown	4	1.2%
Unduplicated Total	332	

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military	62	19%
Prefer not to answer		
Unknown	270	81%
Unduplicated Total	332	

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking	1	0.3%
Other communication disability		
Cognitive	174	52%
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability	1	0.3%
No Disability		
Prefer not to answer		
Unknown	156	47%
Unduplicated Total	332	

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023

Residential Status	# Served	% of Served
Not tracked; clients are in this program for a brief duration (approx. 24 hours)		
Unduplicated Total		

	FY 2023	
Educational Status	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

	FY 2023	
Employment Status	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Not tracked		

Unduplicated Total		

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment	**Kind of treatment to which the individual was referred** **Short-term 24 hours length of stay**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** N/A	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation N/A**
This is not currently available and will be tracked for future reporting	Not available	Not available	Not available	Not available

8. Group Services Delivered

FY 2023

Unduplicated N =		
Number of Groups	**Attendance**	**Average Attendance per Group**
Not applicable	N/A	N/A

9. Detailed Outcomes

This program continues to be needed due to the importance of needing to divert client from custody health and emergency psychiatric settings. Their utilization has decreased slightly compared to FY22 due to recruitment retention.

10. Evaluation Summary

This program continues to be needed due to the importance of needing to divert client from custody health and emergency psychiatric settings.

CRISIS RESIDENTIAL

CSS Outreach and Engagement (O&E) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The program is designed to provide a 24-hour, short-term, less restrictive, structured, and voluntary therapeutic residential services for clients experiencing mental health crisis. These clients often require support beyond the resources available in the community. The licensed residential program shall serve adults (ages 18-59), and older adults (ages 60 years and older) throughout Santa Clara County as an alternative to hospitalization for clients with sub-acute psychiatric symptoms and possible co-occurring disorders (substance use) in the least restrictive environment possible, leading to a reduction in involuntary hospitalizations, incarcerations, and homelessness. The program engages underserved adults and older adults who have not benefitted from traditional outpatient mental health services due to complex risk factors including substance use, community violence, interpersonal family violence, general neglect and exposure to trauma, social and emotional isolation, and physical decline and losses by providing culturally and linguistically proficient services. The program provides and facilitates psycho-educational individual client and group sessions that are specific to increasing client's understanding of the importance of medication compliance and its effectiveness. Program also encourages clients to actively participate in their recovery and self-monitor their milestones and goals towards self-determination, family and vocational education, and recreation services.

2. Program Goals, Objectives & Outcomes

❖ Goals

The program shall align the program to achieve the following goals:

i. Reduce subjective suffering from mental illness
ii. Increase meaningful use of time and capabilities in school, work, and activity
iii. Reduce homelessness and increase safe and permanent housing
iv. Increase access to substance use treatment
v. Increase natural networks of supportive relationships
vi. Increase self-help and consumer/family involvement
vii. Increase access to services by facilitating transitions to less intensive level of care and assist clients to return to the community

3. Clients Served & Annual Cost per Client Data

A total of 946 clients were served from the two crisis residential programs.

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
718	See cover page	See cover page

4. Evaluation Activities

The program engages in the following areas for evaluation activities:

i. Access and Linkages by engaging with clients in the community and acute care settings.
ii. Reduction of ethnic/racial disparities by hosting educational events to the community
iii. Having peer support and family education support services
iv. Provide food, clothing, and shelter to engage unserved individuals, and when appropriate their families
v. Outreach to individuals such as community leaders, those who are homeless, those who are incarcerated in county facilities

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	0	
16 -25 years	43	
26- 59 years	335	
60+ years	42	
Prefer not to answer		
Unknown		
Unduplicated Total	420	

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	6	1.4%
Asian	52	12%
Black or African American	34	8%
Native Hawaiian or Other Pacific Islander	1	0.2%
White/ Caucasian	143	34%
Other	138	33%

More than one race		
Prefer not to answer	4	0.9%
Unknown	42	10%
Unduplicated Total	420	

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	141	34%
Other Hispanic/ Latino		
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		

Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	229	55%
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer		
Unknown	50	12%
Unduplicated Total	420	

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	256	61%
Female	164	39%
Prefer not to answer		
Unknown		
Unduplicated Total	420	

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	256	61%
Female	164	39%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	420	

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	420	100%
Unduplicated Total		

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	385	92%
Spanish	19	5%
Vietnamese	10	2%
Chinese	1	0.2%
Tagalog		
Farsi	2	0.4%
Other		
Prefer not to answer		
Unknown		
Unduplicated Total	417	

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran	2	0.4%

Served in Military		
Family of Military		
No Military	73	17%
Prefer not to answer		
Unknown	345	82%
Unduplicated Total	420	

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	1	0.2%
Difficulty hearing or speaking	1	0.2%
Other communication disability		
Cognitive		
Physical/ Mobility	1	0.2%
Chronic Health Condition		
Other non-communication disability	214	51%
No Disability		
Prefer not to answer		
Unknown	201	48%
Unduplicated Total	418	

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

	FY 2023	
Educational Status	**# Served**	**% of Served**
Not tracked		

Unduplicated Total		

	FY 2023	
Employment Status	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

	FY 2023	
Health Status	**# Served**	**% of Served**
Not tracked		
Unduplicated Total		

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Not tracked		
Unduplicated Total	Not tracked	

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Not tracked		

Unduplicated Total	Not tracked	

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
Not tracked		
Unduplicated Total	Not tracked	

7. Referrals

Referrals may come from the community, inpatient settings, and custody health.

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment**	**Average duration of untreated mental illness** N/A	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation**
1024	Short-termed crisis residential treatment	946	N/A	21-30 days

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
Four groups/day are offered which totals approx. 4,000 groups/year	Attendance is not available	Not available

9. Detailed Outcomes

The total admissions have increased from 664 in FY22 to 946 from FY23.

10. Evaluation Summary

This program continues to increase in service utilization compared to FY22. We continue to have a shortage of crisis residential beds to divert clients from acute care settings.

CONNECTIONS PROGRAM

CSS Outreach and Engagement (O&E) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The Connections Program is a collaboration with Adult Protective Services (APS) to provide short-term counseling and linkage services to older adults ages 60 and older who are at risk of abuse or neglect and have come to the attention of APS. Under the Social Services Agency (SSA), APS responds to calls regarding potential elder and dependent adult abuse and neglect.

Connections Program primarily serves older adults with mental illness who are isolated, homebound, and not currently connected to mental health services. In addition to mental health needs, older adults who come through APS referrals are often at risk for physical and financial abuse and neglect. Many of the older adults who receive services through Connections have a serious mental illness— including schizophrenia, anxiety, and bipolar disorder— and are experiencing untreated symptoms. Additionally, serious financial abuse, the risk of losing one's home, and lack of a support system are among the risk factors commonly faced by consumers of this program.

When APS receives a case that is an appropriate referral to the Connections Program, the unit supervisor at APS alerts the Connections Program clinician. The Connections program clinician, along with APS staff and the Public Health Nurses, provide coordinated consultation and assessment to the referred consumers. The Connections team provides phone and in-home services, short-term counseling, and linkages to County mental health services. The Connections program clinician specifically assesses for unmet behavioral health needs and possible connections to existing County services, while the APS staff focus on investigating safety and risk of the consumer.

2. Program Goals, Objectives & Outcomes

❖ **Outcome**

i. Improve functioning and quality of life for older adults at risk of abuse and neglect
ii. Reduce symptoms and impacts of mental illness for older adults
iii. Reduce risk of abuse and neglect

3. Clients Served & Annual Cost per Client Data

In FY2023 a total of 98 clients were served.
In addition, there were a total of 180 client inquiries/consultations from APS to the Connections Program, which allowed APS to determine whether a case needed to be open for further investigation.

FY 2023		
Unduplicated N = 98		
Number Served	Program Expenditure	Cost per Person

98	$262,997	$2,683.64

4. Evaluation Activities

Focus Areas including:

i. Identifying unserved individuals and when appropriate their families
ii. Access and Linkage
iii. Family education support services
iv. Outreach to entities (OAs)

Evidence-based practice standards and promising practice standards were used in The Connections Program. These include Motivational Interviewing, Solution-Focused Brief Therapy, Trauma Informed Systems, Seeking Safety, and Critical Incident Stress Management. The County of Santa Clara Behavioral Health Services Department offers regular training and refresher courses on these standards.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years	5	5%
26- 59 years	9	9%
60+ years	84	86%
Prefer not to answer		
Unknown		
Unduplicated Total	98	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native		
Asian	20	20%
Black or African American	8	8%
Native Hawaiian or Other Pacific Islander		

White/ Caucasian	48	49%
Other	21	21%
More than one race	1	1%
Prefer not to answer		
Unknown		
Unduplicated Total	98	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano	15	79%
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	4	21%
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	19	100%
Non-Hispanic or Non-Latino as follows:		
African	1	4%
Asian Indian/ South Asian	4	17%
Cambodian		
Chinese	9	38%
Eastern European	1	4%
European	1	4%
Filipino	1	4%

Japanese	1	4%
Korean	2	8%
Middle Eastern		
Vietnamese	3	13%
Non-Hispanic/ Non-Latino (undefined)	1	4%
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal	24	100%
More than one ethnicity	1	1%
Prefer not to answer		
<1 ethnicity	97	99%
Unduplicated Total	98	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	25	26%
Female	73	74%
Prefer not to answer		
Unknown		
Unduplicated Total	98	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	25	26%
Female	73	74%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		

Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	98	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight	47	48%
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	51	52%
Unduplicated Total	98	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	92	94%
Spanish	1	1%
Vietnamese	2	2%
Chinese	3	3%
Tagalog		
Farsi		
Other		
Prefer not to answer		
Unknown		
Unduplicated Total	98	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military	1	1%
Family of Military	1	1%
No Military	96	98%
Prefer not to answer		
Unknown		
Unduplicated Total	98	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking	2	2%
Other communication disability	3	3%
Cognitive	8	8%
Physical/ Mobility	17	17%
Chronic Health Condition	12	12%
Other non-communication disability	3	3%
No Disability	28	29%
Prefer not to answer		
Unknown	25	25%
Unduplicated Total	98	100%

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Unknown	98	100%
Unduplicated Total	98	100%

	FY 2023	
Educational Status	**# Served**	**% of Served**
In School	3	3%
Not in School	95	97%
Unduplicated Total	98	100%

	FY 2023	
Employment Status	**# Served**	**% of Served**
Looking for employment	3	3%
Not working	36	37%
On medical leave		
Retired	39	40%
Unknown	10	10%
Works full-time	6	6%
Works part-time	4	4%
Unduplicated Total	98	100%

	FY 2023	
Sources of Financial Support	**# Served**	**% of Served**
Employment	11	11%
Family	9	9%
Inheritance		
Rental property	3	3%
Savings account	19	19%
SSI	23	23%
SSDI	3	3%
Unknown	30	31%

Unduplicated Total	98	100%

	FY 2023	
Health Status	**# Served**	**% of Served**
Unknown	98	100%
Unduplicated Total	98	100%

	FY 2023	
Substance Abuse Issues	**# Served**	**% of Served**
Alcohol	6	10%
Cannabis		
Methamphetamine	2	3%
Various substances	3	5%
Unknown	48	81%
Unduplicated Total	98	100%

	FY 2023	
Assessment of Daily Living Functions, when appropriate	**# Served**	**% of Served**
Unknown	98	100%
Unduplicated Total	98	100%

	FY 2023	
Emergency Interventions	**# Served**	**% of Served**
5150 assessment	2	2%
911 welfare check	2	2%

Hospital ED	6	6%
MCRT	4	4%
No emergency	84	86%
Unduplicated Total	98	100%

7. Referrals

The primary role of The Connections Program is centered on its namesake of connecting APS clients to on-going behavioral health services. Connections include making referrals to the County Behavioral Health Call Center when appropriate, offering care coordination efforts with the client's health insurance or a private provider, and working with cross-system partnerships like APS and DAAS to determine curated services for the client. Ultimately, the client has the choice of whether or not to pursue recommendations and suggestions offered to them by The Connections Program. Sometimes clients are not ready to engage in treatment services and will deny that they need help. Other times, they prefer to have case management or medication management only without the talk therapy piece. There are clients that want to focus on improving their physical health and mobility issues before starting behavioral health services. And others may prefer more spiritual avenues and turn to places of worship to alleviate their emotional stress. There are also times when clients relay that The Connections Program met their immediate mental health needs, and they felt no further l need to initiate services in an ongoing setting.

FY 2023				
Unduplicated N = 98				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
51	Referred to County Behavioral Health Call Center, PCP, non-profit agencies, etc. to connect to mental health services. Refer for long-term mental health services. Case Management, Linkage/resources Older adult phone support line	Unknown	Unknown	3.5 business days

	Support groups for specialized needs.			

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
N/A	N/A	N/A

9. Detailed Outcomes

*D*ata collection and measure outcomes tools included the Connections Program Excel Data Points, Power BI dashboard, and the MHSA PEI quarterly and annual reports.
Clients are successfully discharged from the Connections Program when their baseline mental health is determined, needs are identified, and coping skills are defined.
Additionally, clients are assessed to determine their readiness for discharge. Clients are ready when their symptoms have decreased, they are applying their learned coping skills, are able to utilize safety plan that identifies tools they can access and phone numbers they can use. Then they agree to initiate ongoing mental health services referral/s by connecting them to County of Santa Clara Behavioral Health Call Center or community resources that extend beyond the Connections Program. As well as their awareness of how to access mental health services in the future with the ability to reference a specific program or entry point to establish care.

10. Evaluation Summary

Program Growth: The Connections Program was granted an additional position to hire a clinician (MFT or PSW) to support the APS program expansion, for which the Program Manager is actively recruiting candidates. Currently, the Program Manager is actively recruiting for this position. The Connections Program and APS continue to collaborate successfully by conducting semi-annual meetings and frequent check-ins to ensure continuity of care across systems.
Challenges: This year, The Connections Program encountered an increase in non-English speaking clients. To mitigate this, the program utilized the County of Santa Clara translation services including Transperfect Connect and Morningside Telephonic Interpreting to communicate effectively with clients.
Measurement: Data collection and measure outcomes tools included The Connections Program Excel Data Points, Power BI dashboard, and the CSS Report. Clients are successfully discharged from The Connections Program when their baseline mental health is determined, needs are identified, and coping skills are defined. Additionally, clients are discharged when they agree to initiate on-going mental health services beyond The Connections Program, and/or acknowledge awareness of how to access mental health services in the future with the ability to reference a specific program or entry point to establish care.
Outcomes:
Improved functioning and quality of life for older adults at risk of abuse and neglect. Reduced symptoms and impacts of mental illness for older adults. Reduced risk of abuse and neglect

Success Story: while providing outreach services to a client's spouse, the spouse stated the Connections Program has been the most helpful of all the programs he has encountered at the County. The spouse was grateful for guidance on how to fill out the AB1424 form (which allows family members to communicate about

their relative's mental health history to psychiatric and court authorities, who must read the information and keep a copy in the client's health chart or court record.) The spouse was also appreciative of receiving for family members to communicate about their relative's mental health history to psychiatric and court authorities, who must read the information and keep a copy in the client's health chart or court record.) The spouse was also appreciative of receiving psychoeducation regarding 5150 criteria (involuntary hospitalization due to mental health symptoms), the process that occurs after a 5150 hold is initiated, and when to access the new 988 mental health crisis line. There was a slightly more emotional support service than child welfare has to offer. The Connections Program helped a client navigate the complexities of what private insurance versus Medi-Cal would offer her adult son with schizoaffective disorder. Exploring with the client what each insurance potentially offered and lacked allowed the client to make an informed decision regarding her son's d client to make an informed decision regarding her son's care to make an informed decision.

Due to The Connections Program having a strong partnership with The Mobile Crisis Response Team (MCRT), Connections was able to warn APS about a shared client that was highly dangerous and had a warrant out for his arrest. Furthermore, Connections was able to assist an MCRT client receive priority services at APS. Connections also helped educate APS supervisors and social workers about the new BHSD program TRUST, which offers urgent mental health services for individuals and/or families needing immediate support. This is an example of cross systems working together to provide a "whatever it takes" model for the client to stabilize and to then be referred for mental health services. Also, Connections was able to link a Cantonese speaking client to a Cantonese speaking clinician with a community service agency to bridge services, as client was on a 10-month long waitlist for counseling services through her insurance provider.

OUTREACH AND ENGAGEMENT PROGRAMS

IN-HOME OUTREACH TEAMS (IHOT)

CSS Outreach and Engagement (O&E) Program

COMMUNITY SERVICES AND SUPPORT (CSS) 1-YEAR PROGRAM REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The County will implement two models of In-Home Outreach Teams (IHOT) based on models demonstrated to be effective through their use in Alameda, San Diego, and Ventura Counties.

County-Run IHOT: County of Santa Clara's IHOT team is modeled after the RISE team in Ventura County. The Ventura model is a "Rapid Integrated Support Team," a mobile team of clinicians and peer specialists who receive referrals from the community and follow-up with people post-crisis for 30 to 60 days to assess needs and facilitate connection to mental health services. This team serves as the main entry point into the mental health system and plays "air traffic control" for referrals to mental health services in the County. The County team is staffed with clinicians and peers. When the County team receives a call from someone seeking mental health services or someone who wishes to refer someone to mental health services, the team will make a determination of whether to refer the call to the appropriate service or conduct initial outreach and engagement with the individual referred to determine the appropriate level of care. Once needs are assessed, the IHOT team will facilitate a warm hand-off to the appropriate services, which may include the community based IHOT described below. Throughout this process, the County IHOT will conduct outreach and engagement as necessary to engage.

Community-Based IHOT: The community-based IHOT team is modeled after the Alameda and San Diego County IHOTs and is comprised of non-clinical staff such as peers, family members, and case managers. This type of IHOT team receives referrals from the community and works with referred consumers for up to four months to facilitate their connection to mental health services. The only source of referrals for the community based IHOT is the County run IHOT team. When a consumer is referred to the community based IHOT, staff work with the consumer to facilitate their referral to needed services and their movement through different levels of care.

2. Program Goals, Objectives & Outcomes

❖ Goals

Reduce the amount of repeat EPS, Emergency Dept, Jail, Mobile Crisis Team and Law Enforcement visits for individuals that are not connected to behavioral health and substance treatment services. Outreach to and engage with individuals that have been resistant to care in the past and successfully link them to ongoing behavioral health services.

❖ Objectives

The IHOT program is designed to provide intensive outreach and engagement, mental health screening, in-home intervention, family education, and support and linkage to treatment for individuals who are not voluntarily engaging in services that connect them with ongoing mental health treatment.

❖ Outcomes

i. Outcome 1: Targeted outreach and engagement would meet people "where they're at" and facilitate connection to the appropriate level of services per consumer.

ii. Outcome 2: Utilization of higher cost services will decrease as utilization of more cost effective and levels of care that appropriately meet consumers' needs will increase.

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 373		
Number Served	Program Expenditure	Cost per Person
373	$ 1,572,927	$4,216.96

4. Evaluation Activities

Focus Areas that IHOT addresses:

i. Identifying unserved individuals, and when appropriate their families: IHOT program receives referrals for individuals who are not connected to or engaging in behavioral health or substance treatment services and has had 3 or more visits with mental health system (i.e., EPS, Emergency Dept, Emergency Medical Services, Jail, Mobile Crisis Teams, Law Enforcement) within the past year. IHOT staff will then work with these individuals to get them connected to appropriate services to reduce their contact with EPS, Emergency Dept, Emergency Medical Services, Jail, Mobile Crisis Teams and Law Enforcement. IHOT staff will connect with individual's family members and support systems as needed for continuity of care, education regarding resources/support needed by individual and assistance in connecting individual with services.

ii. Access and Linkage: IHOT program helps support referred individuals by getting them connected to behavioral health or substance treatment services by contacting county behavioral health call center for referrals to these services or contacting individual's previous provider of these services to get individual reconnected with their service team. IHOT staff will assist individuals with scheduling transportation to scheduled appointments as needed. IHOT staff will attempt to address barriers and limitations that individual has had in the past with accessing behavioral health services and support individuals in overcoming these barriers.

iii. Peer support and family education support services: IHOT teams employ peer mentors and peer support workers that have lived experience as part of their teams in order to provide individuals with support regarding navigation of behavioral health services and guidance regarding the challenges faced by individuals that are experiencing untreated mental health issues, substance use disorders, homelessness, involvement with the criminal justice system and other challenges.

iv. Food, clothing, and shelter to engage unserved individuals, and when appropriate their families: IHOT does not directly provide food, clothing and shelter to individuals but connects these individuals to resources that can assist with these needs. IHOT staff can support individuals with getting connected to shelter placements by contacting shelter hotline, Crisis Stabilization Unit or Mission Street Recovery Station and connecting individuals to community agencies that provide food, clothing and other basic needs.

v. Outreach to individuals such as those who are homeless, those who are incarcerated in county facilities or those currently hospitalized: IHOT staff will outreach and engage with individuals who are homeless/unhoused, currently incarcerated or currently hospitalized. IHOT staff will meet with these individuals wherever is convenient for the individuals (i.e., county jail, court, homeless encampment, in the community) in order to engage with individuals and provide them with services.

vi. Outreach to entities: IHOT program collaborates with community entities including MCRT, TRUST, Police Departments, Law Enforcement Liaisons, Justice System, community agencies that provide resources to homeless individuals and other community resources in order to provide support and resources to individuals receiving support from IHOT program.

Community and or practice-based evidence standard:

i. IHOT program asked individuals that were participating in IHOT services to voluntarily provide feedback regarding the IHOT program and services provided to individuals. IHOT staff connected with individuals receiving services in order to ensure that these individuals were being linked to resources and support needed by each individual. Individuals participating in IHOT services were able to report back to IHOT providers what was working and not working when receiving services from IHOT teams. Based on this feedback, the IHOT service providers were able to modify their approach when working with individuals, tailor any trainings that were being provided to new and current staff and ensure that individuals were being connected to the appropriate resources and services. IHOT teams were also able to provide culturally relevant services to individuals through accessing language translation services, connecting individuals to culturally appropriate resources and employing staff that aligned with individual's races and ethnicities. Through the IHOT teams' intensive engagement and outreach methods, IHOT staff were able to connect with individuals in the community, jails, hospitals or other locations in order to meet the individual "where they're at" and provide appropriate resources and services.

5. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	0	0 %
16 -25 years	35	9.4 %
26- 59 years	305	81.8 %
60+ years	33	8.8 %
Prefer not to answer	0	0 %
Unknown	0	0 %
Unduplicated Total	373	=100 %

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	3	0.8 %
Asian	23	6.2 %

Black or African American	39	10.5 %
Native Hawaiian or Other Pacific Islander	6	1.6 %
White/ Caucasian	87	23.3 %
Other	118	31.6 %
More than one race	0	0 %
Prefer not to answer	0	0 %
Unknown	97	26.0 %
Unduplicated Total	373	=100 %

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	0	0 %
Central American	0	0 %
Mexican/ Mexican-American/ Chicano	61	16.3 %
Puerto Rican	0	0 %
South American	1	0.3 %
Hispanic/ Latino (undefined)	54	14.5 %
Other Hispanic/ Latino	1	0.3 %
Hispanic or Latino Subtotal	117	31.4 %
Non-Hispanic or Non-Latino as follows:		

African	39	10.4 %
Asian Indian/ South Asian	12	3.2 %
Cambodian	0	0 %
Chinese	3	0.8 %
Eastern European	67	18.0 %
European	0	0 %
Filipino	3	0.8 %
Japanese	1	0.3 %
Korean	0	0 %
Middle Eastern	1	0.3 %
Vietnamese	9	2.4 %
Non-Hispanic/ Non-Latino (undefined)	2	0.5 %
Other Non-Hispanic/ Non-Latino	21	5.6 %
Non-Hispanic or Non-Latino Subtotal	156	41.8 %
More than one ethnicity	0	0 %
Prefer not to answer	0	0 %
Unknown	100	26.8 %
Unduplicated Total	373	=100 %

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**

Male	236	63.3 %
Female	137	36.7 %
Prefer not to answer	0	0 %
Unknown	0	0 %
Unduplicated Total	373	=100 %

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	234	62.8 %
Female	135	36.2 %
Transgender (Male to Female)	2	0.5 %
Transgender (Female to Male)	2	0.5 %
Transgender (Undefined)	0	0 %
Genderqueer	0	0 %
Questioning or Unsure	0	0 %
Another gender identity	0	0 %
Prefer not to answer	0	0 %
Unknown	0	0 %
Unduplicated Total	373	=100 %

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	1	0.3 %
Heterosexual/ Straight	49	13.1 %
Bisexual	0	0 %
Questioning/ Unsure	0	0 %
Queer	0	0 %
Another sexual orientation	1	0.3 %
Prefer not to answer	7	1.9 %

Unknown	315	84.4 %
Unduplicated Total	373	=100 %

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	281	75.3 %
Spanish	9	2.4 %
Vietnamese	2	0.5 %
Chinese	1	0.3 %
Tagalog	0	0 %
Farsi	0	0 %
Other	1	0.3 %
Prefer not to answer	0	0 %
Unknown	79	21.2 %
Unduplicated Total	373	=100 %

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	0	0 %
Veteran	3	0.8 %
Served in Military	0	0 %
Family of Military	0	0 %
No Military	255	68.4 %
Prefer not to answer	2	0.5 %
Unknown	113	30.3 %
Unduplicated Total	373	=100 %

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	2	0.5 %
Difficulty hearing or speaking	0	0 %
Other communication disability	0	0 %

Cognitive	4	1.1 %
Physical/ Mobility	6	1.6 %
Chronic Health Condition	20	5.4 %
Other non-communication disability	2	0.5 %
No Disability	66	17.7 %
Prefer not to answer	0	0 %
Unknown	273	73.2 %
Unduplicated Total	373	=100 %

*Participants may choose more than one option for Disability.

6. Additional Data Collection Requirements

	FY 2023	
Residential Status	**# Served**	**% of Served**
Transient/Homeless	170	45.6 %
Housed	169	45.3 %
Unknown	34	9.1 %
Unduplicated Total	373	=100 %

	FY 2023	
Educational Status	**# Served**	**% of Served**
Less than High School	10	2.7 %
High School Graduate or GED	37	9.9 %
Some college or College graduate	15	4.0 %
Prefer not to answer	12	3.2 %
Not Collected	299	80.2 %
Unduplicated Total	373	=100 %

Additional data points were not required to be collected for the IHOT program.

7. Referrals

FY 2023				
Unduplicated N = 373				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
County referrals = 29 Community Based Organizations = 71 Unable to connect with individual, individual moved, individual incarcerated, individual in SNF/Locked Facility or individual declined services = 273	Outpatient mental health/SUTS services (community clinics) i.e. Momentum for Mental Health, Telecare, Community Solutions, Gardner, Salvation Army, City Team Ministries, Kaiser, MHS/Turn, VA, AACI and County BHSD service providers	Individuals connected to county providers = 29 Individuals connected to Community Based Organizations = 71	3 years	2 weeks

8. Group Services Delivered

This program does not offer group services.

9. Detailed Outcomes

❖ Outcome 1:

Targeted outreach and engagement would meet people “where they’re at” and facilitate connection to the appropriate level of services per consumer.
IHOT program increased their ability to connect with individuals in the community, in custody, at court dates or at the hospital by improving tracking of individuals in hospital or custody settings, outreaching to known locations/support systems and relying on support from community agencies i.e. MCRT, TRUST and Law Enforcement. IHOT staff increased ability to appropriately screen individuals for services needed and connect individuals to appropriate resources and behavioral health services.

Data collected:

i. Increased presentations to community based organizations, County programs and non-profit organizations regarding services provided by IHOT program.
ii. Increased engagement and outreach efforts by County and CCP teams (homeless encampments, hospital/ED/EPS, Jail/Court, known address, co-response with MCRT, TRUST and police, community visits)
iii. Increased number of referrals to services (FY 2021-2022 referrals=55, FY 2022-2023 referrals=100)

❖ **Outcome 2**

Utilization of higher cost services will decrease as utilization of more cost effective and levels of care that appropriately meet consumers' needs will increase.
IHOT teams were able to connect 100 of 373 referred individuals to either community based or County behavioral health services which decreased these individuals visits to higher cost services i.e. EPS, ED, County Jail.

10. Evaluation Summary

Program Success: During fiscal year 2022-2023, the IHOT program was able to increase the number of individuals connected with ongoing behavioral health services from 55 in FY2021-2022 to 100 in FY2022-2023. The use of the centralized IHOT email address has also improved the referral process and assignment of eligible IHOT referrals to one of the three IHOT providers. IHOT was also able to collaborate with the new TRUST program in obtaining referrals and coordinating joint visits with the TRUST team to individuals that are IHOT eligible.
Success story: The Bill Wilson Center IHOT team was able to outreach to and engage with one of their older adult clients that was homeless in San Jose. Several of these engagement efforts were joint visits with MCRT and Law Enforcement. Bill Wilson Center, with assistance from Law Enforcement and the County IHOT team, were able to contact this individual's family that lived in Sacramento and reconnect individual with her extended family. The client's family was able to provide some emotional support and financial support to client and temporarily housed this individual. The Bill Wilson Center IHOT team was able to connect this individual to behavioral health services in Santa Clara County.
Barriers and Challenges: The biggest barrier and challenge that has been faced by the IHOT programs are locating and connecting with referred individuals. Oftentimes, due to the individual's housing status, it has been challenging for the IHOT staff to contact referred individuals due to their phone numbers, addresses or locations changing since referral was made. IHOT teams make every effort to outreach to referred individuals by attempting to locate individual at address provided, contacting phone number(s) provided and attempting to locate individual at hospital, jail, court date or homeless encampments. Multiple attempts are made to locate and connect with referred individuals before referrals are closed out.
During the 2022-2023 fiscal year, the County IHOT team implemented, along with the two CCP IHOT teams, a pilot project with EPS and BHUC in order to obtain more referrals and hopefully connect with referred individuals the day of the initial referral. This pilot project garnered an increase in referrals from BHUC and the covering IHOT teams were able to successfully connect with individuals at the time of referral. The IHOT teams were also able to connect with referred clients from EPS at the time of clients discharge from EPS. The pilot program will be continued into the 2023-2024 fiscal year.

MENTAL HEALTH SERVICES ACT

PREVENTION & EARLY INTERVENTION

ANNUAL PROGRAM UPDATES

FY2025

SANTA CLARA COUNTY BEHAVIORAL HEALTH SERVICES DEPARTMENT

connect empower transform

SANTA CLARA COUNTY MENTAL HEALTH SERVICES ACT

Table of Contents

INTRODUCTION

The MHSA PEI programs are intended to implement strategies that prevent mental illness from becoming severe and disabling. Prior to the new PEI definitions and revised PEI regulations of October 15, 2015, Santa Clara County had developed and adopted PEI programs that emphasized reaching and serving individuals and families who are subject to cumulative risk factors (prevention, early intervention) as well as reducing disparities in access to services (access and linkage to treatment). The PEI program priorities, based on those definitions, emphasize a lifespan approach, founded on strong system partnerships, rooted in cultural competency throughout, and focused on connectedness.

In 2018, Santa Clara County released its FY 2018 – 2020 three-year plan along with the Santa Clara County MHSA Needs Assessment Report conducted by Resource Development Associates (RDA). At this time, the new PEI regulations, including program categories and program strategies, were incorporated, aligned and measured. This served as the foundation for the categorization of PEI programs in the three-year plan and helped to initiate efforts to collect data for the programs in each of the strategies.

The FY2021 – 2023 MHSA Three-Year Plan continued in a similar direction, with Prevention & Early Intervention being one of the key focus areas for Santa Clara County Community Program Planning Process. With the FY2019-2021 Three-Year Prevention & Early Intervention Evaluation Report and the FY2022 Prevention & Early Intervention Annual Update, Santa Clara County has been working towards strengthening data collection and outcome measurement across all Prevention & Early Intervention Programs. These data and outcomes continue to be shared with the MHSA Stakeholder Leadership Committee (SLC) and members of the public, and the findings and recommendations from the FY2022 Prevention & Early Intervention programs served as a foundation for the planning process and were used to inform programming for the County's community program planning process for the FY2024-2026 MHSA Three-Year Plan.

For the purposes of this report, the state-defined categories are being aligned with Santa Clara County's existing PEI program structure. Additionally, the state-defined PEI strategies are being aligned based on program goals and objectives in all existing PEI programs. As required, Santa Clara County MHSA PEI programs all are stand-alone programs.

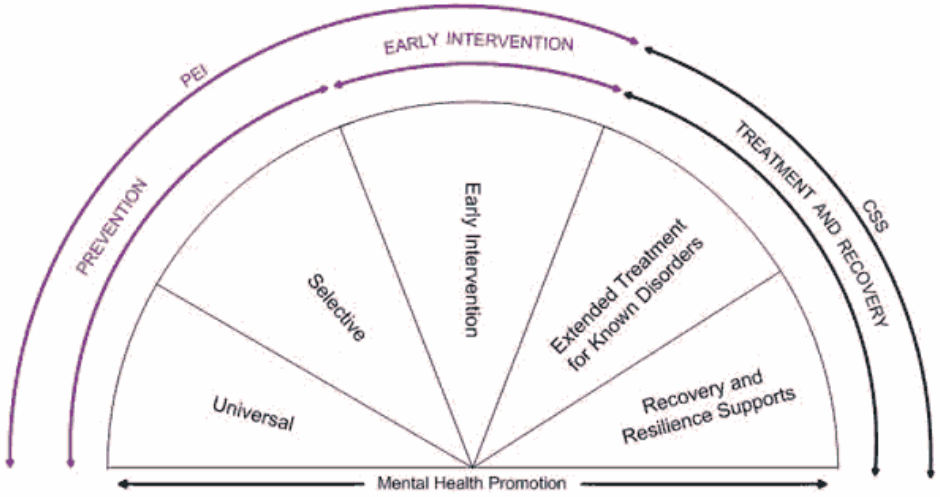
KEY STATE DEFINED PEI PROGRAMS

1. Prevention Program
2. Early Intervention Program
3. Outreach for Increasing Recognition of Early Signs of Mental Illness Program
4. Access and Linkage to Treatment Program
5. Stigma and Discrimination Reduction Program
6. Timely Access to Services for Underserved Population Program
7. Suicide Prevention Program

KEY STATE DEFINED PEI STRATEGIES

1. Access and Linkage to Treatment
2. Improving Timely Access to Services for Underserved Populations
3. Strategies that are Non-Stigmatizing and Non-Discriminatory
4. Outreach for Increasing Recognition of Early Signs of Mental Illness

This diagram shows the spectrum of MHSA services from prevention through treatment and recovery. For purposes of this report, Prevention and Early Intervention programs will be addressed, focusing on evaluation data and outcomes from FY2022 as part of the FY2022 annual Prevention & Early Intervention Program Update.



LOCAL PEI PROGRAM ALIGNMENT WITH STATE REQUIREMENTS

State Defined PEI Program	PEI Program Name
1. Prevention Program	Violence Prevention Program and Intimate Partner Violence Prevention Program (implementation planned for FY23)
	Support for Parents
	Promotores
	Older Adult Prevention and Early Intervention
2. Early Intervention Program	Raising Early Awareness Creating Hope (REACH)
	Integrated Prevention Services for Cultural Communities (IPSCC)
	Elder Story Telling
	School Linked Services (SLS) Initiative
3. Outreach for Increasing Recognition of Early Signs of Mental Illness	Older Adult In-Home Peer Respite Program
	Law Enforcement Training
4. Stigma and Discrimination Reduction	New Refugees Program
	Cultural Communities Wellness Program
5. Access and Linkage to Treatment	Services for Children 0-5
	Office of Consumer Affairs
	Office of Family Affairs
	Re-entry Resource Centers
	LGBTQ+ Access and Linkage
6. Suicide Prevention	Suicide Prevention Strategic Plan
7. Improve Timely Access to Services for Underserved Populations	Culture-Specific Wellness Centers

PREVENTION PROGRAMS

Intimate Partner Violence Prevention Program

Also known as H.E.A.R.T. (Healthy, Equitable, & Respectful Together)
PEI Prevention Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

❖ Program Description/Status

To reduce stigma and promote participation, the Intimate Partner Violence program is marketed to the public and clients as the HEART (Healthy, Equitable, & Respectful Together) program. As an Intimate Partner Violence Prevention program, HEART has two main objectives: promoting healthy relationships through education and outreach, and providing resource referrals (such as housing, food services, etc.) to ensure that the community has what they need to stay safe. HEART's programming is available to individuals of all ages, backgrounds, and identities. Through our programming, we also aim to emphasize that IPV is inclusive of interpersonal relationships beyond those of a romantic nature, including but not limited to roommates, friends, chosen family, family of origin, etc. Through our programming and workshops, HEART empowers our participants to build and/or sustain their healthy relationships, while also being able to identify signs of abuse.
This program will serve 16 years old and above under and unserved individuals in the county. This program will provide education and outreach to the community. The program is designed to reduce disparities by utilizing a non-clinical networking model among service providers to exchange information about activities and resources that promote economic stability, educational success, access to healthcare, housing, and legal services for families. The program will focus on preventing dating violence, domestic abuse (DA), and IPV through trainings, presentations, education, outreach, and mental health education, in various community locations such as housing shelters, community centers, religious organizations, colleges, food banks, and resource centers. Presenting in the community will allow the information to be more widely disseminated to at-risk and vulnerable populations. The program will bring awareness of dating violence by teaching clients about healthy relationships and safe boundaries to prevent DA and IPV to clients 16 years of age and older who are unserved and underserved.
HEART'S program is designed to redirect attention to a growing community need regarding intimate partner violence. This program provides education and outreach to the community. HEART is designed to reduce disparities by utilizing a non-clinical networking model among service providers to exchange information about activities and resources to promote economic stability, educational success, access to healthcare, housing, and legal service for families.

❖ Services

HEART focuses on preventing dating violence, domestic abuse, and IPV through resource referrals, trainings, presentations, education, outreach, and mental health education in various community locations such as community centers, colleges, and resource centers. By presenting our workshops in the community, HEART can allow for the information to be more widely disseminated to at-risk and vulnerable populations. This program brings awareness of dating violence by teaching clients about healthy relationships and safe boundaries to prevent IPV to clients primarily over the age of 16 who are underserved or potentially unserved.

i. In partnership with community partners and County of Santa Clara departments, HEART redirected attention to a growing community needs regarding intimate partner violence.
ii. HEART offered culturally and linguistically targeted outreach within communities and neighborhoods to create enhanced linkages/referrals from and to nearby community services.
iii. HEART provided an array of outreach, engagement, and prevention activities and education for new participants.
iv. HEART provided peer support, outreach, engagement and educational services to underserved and unserved communities to reduce stigma and discrimination and increase access to Intimate Partner Violence prevention services.

❖ Target Population

HEART serves clients who reside in Santa Clara County who are potentially at-risk for DA and IVP within the following populations: TAY ages 16-25, Adults ages 26-59, Older Adults ages 60 and older.
This program also serves additional vulnerable and at-risk communities which include, but are not limited to, the following: Ethnic and cultural groups with language barriers who are unserved, underserved, and underrepresented; Communities that may or may not have an underlying behavioral health (BH) and/or cooccurring addiction diagnosis; Communities that are multi-racial, multi-cultural, and/or multi-generational; and Santa Clara County residents of all sexual orientations, gender identities, and gender expressions, including clients who have been marginalized due to their Sexual Orientation and Gender Identity and Expression (SOGIE), and those who identify as part of LGBTQ community.

HEART provides prevention services and resource referrals to address and reduce intimate partner violence. Survivors of IPV are often more susceptible to facing a degree of health issues including suicide, school failure, incarcerations, unemployment, suffering, homelessness, and separation of home life – and therefore, program participants are taught the importance of healthy relationships, while promoting self-care and safety against abuse. While we teach and advocate for the safety of our workshop participants within their various interpersonal relationships, we also provide resource referrals for a plethora of services one may experience in an unsafe or unhealthy situation. This includes, but is not limited to: counseling services, clothing, housing resources, food, substance use treatment, suicide prevention services, and trauma support.

2. Program Goals, Objectives & Outcomes

❖ Program Goals

HEART is designed to reduce disparities by utilizing a non-clinical networking model among service providers to exchange information about activities and resources that promote economic stability, educational success, access to healthcare, housing, and legal services for families. Goals include, but are not limited to:
i. Increase knowledge about safe and healthy relationship skills.
ii. Disrupt the developmental pathways toward IPV.
iii. Support participants to increase safety and lessen harm.
iv. Increase access to ethnic and culturally reflective, strengths-based behavioral health (BH) outreach, education, preventive counseling, and trainings that are culturally and linguistically appropriate.
v. Ensure early access for BH at nearby clinics, to lower BH illness and suicide rates, enhance wellness and resilience, and reduce barriers to health education/services.
vi. Reduce disparities in timely access to related information, services, and supports for the target population.
vii. Increase the target population's knowledge and skills that contribute to increasing prevention of IPV.

viii. Increase collaboration with other community organizations providing support and services to at risk clients of IPV
ix. Increase collaboration with community stakeholders and organizations to serve ethnic and culture-specific underserved, underrepresented, unserved and/or multicultural populations, including the Lesbian, Gay, Bisexual, Transgender, Queer, Questioning + (LGBTQ+) communities
x. Increase suicide prevention awareness among members of all targeted age groups by helping to inform the participants of the factors and symptoms of mental health issues
xi. Increase protective factors that may lead to improved mental, emotional, and relational functioning.

❖ Program Objectives

i. Inform and educate participants about warning signs of IPV and DA
ii. Increase participants' ability to identify potential stressors and signs of unhealthy relationships
iii. Enable participants to foster healthy relationships in TAY, adults, and older adults through education and outreach
iv. Increase participant awareness of behavioral health stressors and protective factors which effect program participants
v. Enable participants to identify red flags in IPV relationships and refer clients to appropriate services and resources
vi. Increase and strengthen the natural support systems, self-help, and other types of support systems

❖ Program Outcomes

i. Improved mental functioning
ii. Improved emotional functioning
iii. Improved relational functioning
iv. Increased knowledge of mental health resources within Santa Clara County, including those specifically centering different ethnic and cultural groups
v. Increased knowledge and ability of mental health service providers to engage and serve the identified target population
vi. Increased capacity of service providers to provide support to the target population
vii. Increased health, mental health, and well-being of families and children
viii. Increased community awareness of behavioral health issues and resources

3. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 131		
Number Served	Program Expenditure	Cost per Person
Total= 3691	**$128,596.68**	**$34.84**
131 (Workshops Feb - June)		

540 (Outreach Events starting April 26)		
3,018 (Social Media Accounts Engaged/Post) **138** (Social Media Followers		
2 (1:1 Services)		

4. Evaluation Activities

During HEART's first fiscal year, we prioritized our efforts to make our program content as accessible as possible for all. Throughout our workshop programming and education, we highlight and include the importance of recognizing healthy and unsafe signs of all interpersonal relationships – and not just those of romantic nature. HEART recognizes that romantic relationships may not be applicable for every individual or all communities, and formats our workshops with inclusive language, scenarios, and activities which cross over all the relationship types that exist, such as between friends, family, partners, and co-habitants.

Although HEART's programming is targeted to all underserved and marginalized groups, we are directly intentional about centering LGBTQ+ communities in our work, as LGBTQ+ folk, trans people and non-binary people are equally as likely, if not more so, than their cisgender and heterosexual peers to experience IPV at some point in their lifetimes. Research shows that LGBT people face a multitude of barriers to seeking help that are unique to their sexual orientation and gender identity. These include Legal definitions of domestic violence that exclude same-sex couples; Dangers of "outing" oneself when seeking help and the risk of rejection and isolation from peers; The lack of, or survivors not knowing about, LGBT-specific or LGBT-friendly assistance resources; and potential homophobia from staff of service providers or from non-LGBT survivors of IPV with whom they may interact (UCLA, 2015). Other structural factors like age, poverty, and other forms of stigma, can further intersect with LGBTQ+ identities to place some groups at higher risk than others, and this often contributes to the heightened barriers associated with accessing or seeking preventative services (Human Rights Campaign, 2022).

HEART recognizes this severe need and impact, and therefore aims to also make our work as multigenerational as possible. By involving and targeting young people, we can teach participants about unsafe relationship signs, while providing them with the power to uplift the safe connections that they deserve as they grow older. In addition, we work with older adults and elders to challenge the beliefs and stigma they might hold surrounding relationship expectations and encourage them to practice and apply behaviors such as healthy conflict resolution and explore their love languages. HEART also recognizes the significance and impact of intersectionality, and specifically breaks down the different ways in which communities are impacted by IPV. In doing so, HEART uses inclusive content and language within our education as an intentional effort to make our services as accessible as possible. Our program strategies are non-stigmatizing, and instead focuses on strategies such as discussing healthy conflict resolution, uplifting positive relationships, and acknowledging that individuals may come from traumatic experiences. This allows us to incorporate harm reduction in a way that acknowledges the different experiences participants hold with their relationships. HEART prioritizes the use of language which is "people centered" and not lecture based, which opens the space for relatability, collaboration, and connection. We are intentional with the methods we use in presenting our content, and it is designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory.

In addition to workshops and educational content, we provide 1:1 peer support and resource referrals for those who may prefer/need a more personal and intentional approach. This also allows us to work closely

with participants who may have barriers to accessing technology and strengthens our relationships within the community.

The community we serve directly informs our work. At the end of each session, folks are encouraged to provide us with feedback during a post-survey, and we take their suggestions and interests into consideration as a means of being community centered. We utilize participant feedback as an area of opportunity, and directly inform our presentations based on the needs and asks of the community. For example, patrons of the DeFrank Center were interested in learning more about sexual violence prevention and consent, and we crafted a series of 2 additional workshops to breakdown each topic thoroughly. We encourage and allow for the community to guide our content based on their needs and interests regarding IPV.

5. Demographic Data

Between 2/6/23 – 6/15/23, HEART served a total **of 131 people. Please note that most of the Demographic data listed pertains to workshops which took place after April 20, 2023, as post-workshop surveys were not yet implemented prior to this date. In addition, although encouraged, participants are not required to complete the survey if they do not wish to.*

Prior to the implementation of our online demographic survey, we were using physical sign-in sheets which asked participants only for their age, gender identity, and residential zip code (to capture HEART's reach throughout the county). We have since incorporated a more detailed post-survey which participants are given the link and QR code to following each workshop. This survey allows us to capture all the necessary demographic details of each participant, while also allowing clients the ability to provide us with written feedback, praise, or recommendations for future workshops.

Moving forward, we will implement the use of both physical sign-in sheets, as well as the online demographic survey, at every event to ensure that we have as many bases covered as possible. This will allow us to hold more accurate data. For those participants who may be unable to complete the demographic survey online, we will have physical sign-in sheets available that cover participant age, gender identity, race, ethnicity, and residential zip code.

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	1	0.7%
16 -25 years	45	34%
26- 59 years	10	7.6%
60+ years	8	6.1%
Prefer not to answer	n/a	n/a
Unknown	67	51%
Unduplicated Total	131	

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	1	0.7%
Asian	4	3%
Black or African American	4	3%
Native Hawaiian or Other Pacific Islander	3	2%
White/ Caucasian	11	8.3%
Other	2	1.5%
More than one race	6	4.5%
Prefer not to answer	1	0.7%
Unknown	99	75.6%
Unduplicated Total	131	

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	1	0.7
Central American	1	0.7
Mexican/ Mexican-American/ Chicano	6	4.5
Puerto Rican	n/a	n/a
South American	n/a	n/a
Hispanic/ Latino (undefined)	8	6.1
Other Hispanic/ Latino	n/a	n/a

Hispanic or Latino Subtotal	15	11
Non-Hispanic or Non-Latino as follows:		
African	3	2.2
Asian Indian/ South Asian	n/a	n/a
Cambodian	n/a	n/a
Chinese	3	2.2
Eastern European	n/a	n/a
European	5	3.8
Filipino	4	3
Japanese	n/a	n/a
Korean	1	0.7
Middle Eastern	1	0.7
Vietnamese	n/a	n/a
Non-Hispanic/ Non-Latino (undefined)	n/a	n/a
Other Non-Hispanic/ Non-Latino	n/a	n/a
Non-Hispanic or Non-Latino Subtotal	17	12.9
More than one ethnicity	1	0.7
Prefer not to answer	1	0.7
Unknown	96	73
Unduplicated Total	131	

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**

Male	Not available	Not available
Female	Not available	Not available
Prefer not to answer	Not available	Not available
Unknown	Not available	Not available
Unduplicated Total	Not available	Not available

*For the sake of inclusivity, safety, and respect of our program participants, their gender assigned at birth is not asked of them. Data is collected through current gender identity instead. Please see below.

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	7	5.3
Female	7	5.3
Transgender (Male to Female)	2	1.5
Transgender (Female to Male)	3	2.2
Transgender (Undefined)	n/a	n/a
Genderqueer	10	7.6
Questioning or Unsure	1	0.76
Another gender identity	1	0.7
Prefer not to answer	1	0.7
Unknown	99	75.5
Unduplicated Total	131	

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	7	5.3
Heterosexual/ Straight	3	2.2
Bisexual	7	5.3
Questioning/ Unsure	2	2.2
Queer	5	3.8

Another sexual orientation	7	5.3
Prefer not to answer	2	2.2
Unknown	98	75
Unduplicated Total	131	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	30	22.9
Spanish	1	0.7
Vietnamese	0	0
Chinese	1	0.7
Tagalog	0	0
Farsi	0	0
Other	0	0
Prefer not to answer	0	0
Unknown	99	75.5
Unduplicated Total	131	

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	0	0
Veteran	2	2
Served in Military	1	1
Family of Military	9	7
No Military	18	13
Prefer not to answer	0	0
Unknown	101	77
Unduplicated Total	131	

	FY 2023

Disability*	# Served	% of Served
Difficulty seeing	2	21
Difficulty hearing or speaking	0	0
Other communication disability	4	3
Cognitive	7	5
Physical/ Mobility	1	1
Chronic Health Condition	4	3
Other non-communication disability	0	0
No Disability	11	8
Prefer not to answer	2	2
Unknown	100	76
Unduplicated Total	131	

*Participants may choose more than one option for Disability.

6. Referrals

FY 2023				
Unduplicated N = 131				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
0 (1 program participant was referred to housing services, but it was not disclosed if they hold "serious mental illness")	Housing services	1	n/a	n/a

7. Group Services Delivered

HEART provides a variation of Healthy Relationships and Intimate Partner Violence Prevention workshops throughout Santa Clara County. Considering that HEART's programming and services are open to all, our target

populations are expansive. Per our contract expectations, HEART has primarily targeted and served LGBTQ+ populations and ethnic groups, as the need for IPV services for folk in this demographic is often overlooked. In addition, HEART has led group workshops for youth, young adults, adults, and elders of all identities and backgrounds.

We have led workshops for folk in online youth groups and conferences (LGBTQ Youth Space and Next Door Solutions), community groups (such as The Young Women's Freedom Center and the Billy DeFrank Center), college classes and clubs (West Valley College and DeAnza College), senior groups (POZitive Living and Avenidas Rainbow Collective), and many more.

Each workshop is crafted as an interactive group experience, in which participants are provided with prevention education against abuse, are encouraged to connect with their peers through storytelling and support, are provided with community resources, and are encouraged to participate in group discussions and activities. Workshop topics have included: Relationship Representation in Media and How this Effects Young People, Healthy Communication and Conflict Resolution, Consent, Sexual Violence Awareness, Identifying the Cycle and Signs of Abuse, Understanding Love Languages, How Good Relationships Benefit Our Health, Peer Support, Self-Care, Safety Plans and Support Systems, and much more.

FY 2023		
Unduplicated N = 131		
Number of Groups	Attendance	Average Attendance per Group
16	131	8

8. Detailed Outcomes

Following each educational workshop, participants are invited and encouraged to participate in a post-survey which incorporates demographic data collection and open-ended feedback questions. In return, this feedback is utilized to inform our work. Our current survey was largely adapted from pre-existing PEI surveys used from LGBTQ+ Wellness, and it allows us to analyze the themes/trends in feedback by using open ended questions. [Please find Heart's post-workshop demographic survey here: https://forms.gle/ZjVEcGM5nyuT6ict5]

Success stories and positive feedback trends show that the majority of participants enjoyed the facilitation style and facilitators, the program format, openness, and ability to practice community building. Nearly all participants reported that they left the workshop having learned that they deserve healthy and safe relationships in all aspects of their lives. Response trends also show that participants valued learning about addressing conflict in a healthy way and identifying signs of abuse and enjoyed creating their own "Healthy Relationship Checklists". Participants also mention successfully learning about the behaviors they should seek out/practice to have healthy relationships of their own. (For more direct quotes, see #9. Evaluation Summary).

When asked for suggestions on how HEART can improve and what to include in the future, trends show that participants had little to no feedback, other than making opportunities for more activities. Moving forward, we aim to incorporate this suggestion, as we aim to structure our education in both a meaningful and approachable way for participants of all varying identities and backgrounds.

Moving forward, our goal is to improve our survey collection by adding more quantifiable and statistic related questions which will allow for us to better measure participant takeaways. For example, we aim to incorporate questions which allow participants to rate their learnings on a scale (e.g., "On a scale from 1 to 5, I feel more knowledgeable about how to approach conflict in my relationship"), and this will allow us to measure pre/post understandings of IPV.

9. Evaluation Summary

Between HEART's program launch in January of 2023 and the end of FY23 in June, we have achieved tremendous growth and exciting success. During the first 6 months of our programming, we facilitated 16 workshops, attended numerous outreach events and trainings, canvassed throughout the county, provided 1:1 resource referrals, began to build a social media presence, and connected with many organizations within the community to introduce our services to potential partners and collaborators to make the effort to grow our program even further.

For example, after only 3 months as a public program, HEART was invited to facilitate monthly Healthy Relationships workshops for the patrons of the Billy DeFrank Center for the foreseeable future. In addition, HEART participated in 2 Prevention conferences as a guest facilitator and has since been accepted to facilitate a workshop in Santa Clara County's Domestic Violence Conference come October. We are constantly strengthening our relationships with many community partners and have been invited back to lead recurring workshops with many of our past collaborators.

Our efforts to make this work as meaningful as possible has been achieved. Following each workshop, clients left us with rave reviews and sincere tokens of gratitude. Participants stated that we "created a very comfortable space to share", that it was "therapy listening in", and that "it was very encouraging and fun at the same time". In addition, some of the key takeaways highlighted by workshop participants included:

i. "I didn't really understand what makes a healthy and unhealthy relationship before this and it has helped me open my eyes to what behaviors I should seek out/do to have healthy relationships."
ii. "This helped build my confidence and competence with interpersonal relationships."
iii. "I feel uplifted from focusing on positive relationships. I'm leaving with insights on how to show up better for my loved ones."
iv. "I learned that consent is not just "yes" and "no", but it involves interactions with the individual such as being enthusiastic."
v. "I learned more signs to recognize when abuse could be present in a relationship."
vi. "I learned that we all deserve healthy and safe relationships in all aspects of our life."
vii. "I learned how to handle conflict in my relationship."

❖ Challenges

i. Due to hiring challenges, HEART launched in late January, which shortened our ability to reach as many clients and participants as expected in the fiscal year. However, we reached a total of 131 workshop participants between February and June, which is an impressive accomplishment in comparison to the goal of 300 for FSY23 between July and June.
ii. Justin launched and operated the entirety of the HEART program solo until late May. Although great work was achieved in this short time span, it was challenging to coordinate educational content creation, social media, outreach events, potential collaborator meetings, and workshops. This may have limited our ability to participate in multiple events which occurred around the same dates. However, Isabella, HEART's Community Partner, began working with the program in May, which increased our community engagement and ability to make contact, connect with, and canvas throughout the community.

HEART's first 6 months as an Intimate Partner Violence prevention program is a testament to an exciting future. Having served 131 workshop participants in 4 months and countless individuals at various resource fairs, our program is headed towards great success. We are very excited for HEART's continued growth, and we will continue to nurture the safety and interpersonal wellness of our community.

Support For Parents Program

The Support for Parents program in Santa Clara County covers 4 different programs.

1. Mentor Parent Program
2. Nurse Family Partnership
3. Reach Out and Read
4. Triple P

The total cost per person, across all programs in this category can be found below. The following pages are detailed reports for each individual program in this category.

FY 2023		
Number Served	Program Expenditure	Cost per Person
13,618	**$741,210.77**	**$54.43**

Support For Parents Mentor Parents Program

PEI Prevention Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The Mentor Parents Program provides early intervention supports to a selective population of substance dependent parents whose children have been or currently are at risk of being removed from their care. Mentor parents work in conjunction with Dependency Advocacy Center (DAC) attorneys to encourage early engagement in recovery-oriented services and provide guidance to parents in addressing barriers impacting recovery and reunification. Mentor parents, because of their own previous involvement with the child welfare system, can share lived experiences with parents currently at risk of or engaged in the dependency system.

2. Program Indicators

The Mentor Parent works closely with the client, the client's attorney, and various service providers to provide the best advocacy and support possible. The Mentor Parent's training coupled with his or her real-life experience as a former parent involved in the child welfare system allow for non-threatening, supportive, and strength-based interactions between client and mentor; thereby increasing the likelihood that the parent will provide information necessary to support the early identification of mental health disorders. Mentor Parents are instrumental in helping clients access community-based resources that are outside the court mandated case plan critical to family success with reunification, such as housing, employment, transportation, childcare, parenting, domestic violence, educational, and vocational opportunities. Through the support of the mentor parents, parents currently navigating the dependency and child welfare systems are supported to engage with their case plan and learn from the mentor parents to promote reduction of prolonged suffering and involvement with child welfare.

3. Program Goals, Objectives & Outcomes

i. Engage and encourage parent/guardian involvement in their child's academic success and school.
ii. Strengthen parent/guardian and child's relationship and support a healthy relationship.
iii. Support maintaining a child at home with parent/ guardian.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 118		
Number Served	Program Expenditure	Cost per Person
118	**Refer to cover page**	**Refer to cover page**

5. Evaluation Activities

Mentor Parent Program engages in a comprehensive evaluation process and a thorough review of every parent and legal guardian entering the Court's Juvenile Dependency system at every detention and initial hearing. The evaluation consists of reading the Department of Family and Children's Services court report with particular attention to the legal petition, social worker's narrative, and recommended service referrals. Additionally, the process includes interfacing with the assigned attorney to discuss the potential for a Dependency Wellness Court (DWC) application, as well as a cross-reference check for a client's previous history with the court system and the Mentor Parent program. As a significate partner to DWC, the Mentor Parents incorporate information gathered from the multi-disciplinary team members to support the client in their recovery and help to resolve any of the barriers to reunification and/or recovery identified by the team.

Evaluation and review of every parent has allowed targeted outreach efforts to fathers in the Dependency System and parents in custody. As a result, DAC and the Mentor Parent Program has maintained two mentor father positions to connect with in-custody parents at the courthouse.

DAC utilize a client satisfaction Survey and an evaluation tool developed by San Jose State University's School of Social Work. This tool, the Self-Sufficiency Matrix, focuses on examining the Mentor Parent Program's impact on increased client self-sufficiency. It examines areas of housing, employment, transportation, life skills, family/social relations, community involvement, parenting skills, legal, and substance abuse.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years	5	4
26- 59 years	68	58
60+ years	11	9
Prefer not to answer		
Unknown	34	29
Unduplicated Total	118	100

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native		
Asian	21	18

Black or African American	19	16
Native Hawaiian or Other Pacific Islander		
White/ Caucasian	41	35
Other		
More than one race		
Prefer not to answer	3	2
Unknown	34	29
Unduplicated Total	118	100

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
330Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano	10	8
Puerto Rican	2	2
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino	18	15
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African	11	9
Asian Indian/ South Asian	1	1

Cambodian		
Chinese		
Eastern European		
European	1	1
Filipino	6	
Japanese		5
Korean		
Middle Eastern	2	2
Vietnamese	4	3
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	11	9
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity	9	8
Prefer not to answer	9	8
Unknown	34	29
Unduplicated Total	118	100

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	34	29
Female	50	42
Prefer not to answer		
Unknown	34	29
Unduplicated Total	118	100

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	34	29
Female	50	42
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	34	29
Unduplicated Total	118	100

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	1	1
Heterosexual/ Straight	74	62
Bisexual	2	2
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer	7	6
Unknown	34	29
Unduplicated Total	118	100

	FY 2023	
Primary Language	**# Served**	**% of Served**

English	74	63
Spanish	10	8
Vietnamese		
Chinese		
Tagalog		
Farsi		
Other		
Prefer not to answer		
Unknown	34	29
Unduplicated Total	118	100

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military	84	71
Prefer not to answer		
Unknown	34	29
Unduplicated Total	118	100

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	5	4
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility	2	2
Chronic Health Condition	10	8
Other non-communication disability		
No Disability	58	50

Prefer not to answer	9	7
Unknown	34	29
Unduplicated Total	118	100

*Participants may choose more than one option for Disability.

7. Referrals

Through fostering a supportive and collaboration relationship Mentor Parents gather information necessary to support the early identification of mental health disorders and they are instrumental in helping clients bridge engagement with the DWC mental health liaison and access community-based resources that are outside the court mandated case plan and critical to family success with reunification. Although no referrals were made for higher level of care, continued coordination with DWC mental health liaison and community resources were provided, such as housing, employment, transportation, childcare, parenting, domestic violence, educational, and vocational opportunities.

FY23: During this period the following community resources and referrals were supported:

Community Resource	Number of Referrals	Percentage of Total Referrals
Substance Abuse	130	19%
Mental Health	73	10%
Domestic Violence	21	3%
Medical	22	3%
Housing	190	27%
Food	37	5%
Education	16	2%
Employment	8	1%
Child Care	20	2%
Clothing	10	1%
Financial/Credit Education	8	1%
Other	146	21%
TOTAL	681	100%

FY 2023
Unduplicated N = 73

Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
73	Outpatient services	Unk	Unk	unk

8. Group Services Delivered

Mentor Parent Program does not provide group services. All services provided on one-on-one and individualized for the family.

FY 2023		
Unduplicated N = n/a		
Number of Groups	Attendance	Average Attendance per Group
n/a		

9. Detailed Outcomes

Mentor Parents provide varying degrees of service that largely depends on how much the parent wishes to engage with the Mentor and whether the parent chooses to participate in DWC. Services provided by the Mentor Parents can include, but are not limited to the following: helping the client navigate the court system, providing support, sharing their experiences as a parent in the system, accessing services, identifying community resources, attending DFCS Child Family Team meetings, attending all court hearings, visiting clients in the field (i.e. at residential treatment facilities, at 12-step meetings, etc.), guiding the client through DWC phase work, coaching a client on how to interface with service providers, working with the attorney to advocate for the client. It is difficult to narrow in on a specific data set due to the nature of Juvenile Dependency cases. Cases last for varying lengths of time – a case can close in a few months or last several years
FY23: 84 parents participated in DWC out of the total 118 DWC participants, 23 parents completed or otherwise exited the program with 21 of those cases resulted in the child remaining with the parent or reunification with the parent and subsequent dismissal of their legal case.

❖ Success Story

I first met Dolores R. when she was about halfway through her dependency case. She is the mother of three children, although only her youngest child (age 1) was under the court's jurisdiction. She and her husband

lived together and were both in reunification. When I started working with Dolores, she was already having step down visitation but her and her family were homeless and looking for a place to live. She had not yet utilized the full array of services available to her from DWC. I connected her with FIRST 5 services and their housing navigator. The housing navigator helped Dolores locate and apply for housing and she and her family were able to move into a beautiful Victorian house. They rent the home and still live there today. Further, Dolores and her husband took advantage of the therapy offered and

found it to be extremely helpful. Dolores and I talked about how therapy had helped me when I was in the program. After several sessions, Dolores called me and told me how much she enjoyed being able to talk with someone about her problems. Furthermore, Dolores and her husband attended online meetings in the beginning of their case since they first entered the system in the middle of COVID-19. I was able to provide her a list of different meetings that I thought would be a good fit for her. She was also able to find a sponsor, which was even a bigger hurdle to overcome because of COVID. I was able to supply her recovery books for her journey as well.

I was able to visit her in person to offer my support; this was helpful for her to feel supported and motivated. Further, she always made her DWC hearings online and was very engaged with the DWC team. It was a joyous day when her youngest son was returned to her and her husband. I went to visit her and saw her son running all through their home. He was eager to show me his room that he shared with his older brother. Near the end of her legal case, Dolores was a changed woman and mother. She was testing clean for her entire case and never missed a drug testing call. She willingly and happily engaged in all of her services, and she really embraced her sobriety. It was a pleasure to be in the courtroom when the judge dismissed her legal case. In September of this year, Dolores and her husband were honored and received the 11th Annual Santa Clara County Reunification Day award.

10. Evaluation Summary

The Mentor Program has seen a decrease in referrals due to changes at the Department of Family and Children Services (DFCS) deferral to prevention services, resulting in both fewer removals of children from their parents and a decrease in the number of dependency cases coming before the court. The decrease in dependency filings also diminished the number of DWC participants. Families that do come before the court, demonstrate higher level of need as they face compounding stressors/removals for substance use disorder, mental health, and domestic violence/physical child abuse. The Mentor Program adjusted to meet current level of need by providing a wider array of services and increasing the frequency of contact with parents/caregivers and created a recruitment to phase providing a light touch in effort to continue to encourage utilization of the program. The adjustments to services have created a continuum of care from light touch to more intensive support for caregivers accepting DWC enrollment.

San Jose State Student Research findings by Stephanie Hamilton and Julie Walker:

The overall results of the satisfaction survey confirm that the program's participants are satisfied with all aspects of the program, including their individual mentors (scoring an average of 4.46 out of 5), DWC support (average score of 4.44), and recovery support (average score of 4.35). rated their overall satisfaction as 4.69, thereby revealing a high level of satisfaction with both their mentors and the program. The satisfaction survey highlighted the mentors' exceptional engagement skills, which was a common theme in the focus group and narrative feedback. The parents also conveyed a great deal of contentment with the aid they received during their process of recovery. findings highlight the overall positive effect of the program on the participants' self-sufficiency across nine domains as well as a high level of client satisfaction with the program, across all categories of mentor parents, the DWC, and recovery support.

Support For Parents Nurse Family Partnership

PEI Prevention Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

NFP is a countywide, community-based program providing first time mothers who reside in the County's high-risk communities with prenatal and postpartum support. NFP targets low-income mothers who are pregnant with their first child before the 28th week of pregnancy. Priority is given to expectant mothers involved with the mental health system, foster care system, juvenile/criminal justice systems, and schools in identified investment communities. NFP is comprised of a team of eight public health nurse home visitors. Each public health nurse can carry a caseload of 25 first-time mothers to deliver home visits from pregnancy until the child's second birthday.

2. Program Indicators

NFP nurse explores six important key domains in the program:

i. Personal health
ii. Environment health
iii. Life course development
iv. Maternal Role
v. Family and friends
vi. Health and Human services.

The time spent in each domain may vary depending on the mother's situation and needs throughout the stages of the program (Pregnancy, Infancy and Toddlerhood). The ability to assess client's status also allows for a more rapid identification and intervention for clients experiencing the onset of psychiatric illness. One of the NFP program's missions is to promote health equity and eliminate disparities to improve the outcomes of the mothers and children who are served. With the NFP Program being a long-term home visitation program, it enables nurse home visitors the ability to screen clients for prenatal, and postnatal depression and possible suicide risk at multiple intervals throughout the two-and-a-half-year period supporting the mitigation of involvement with child welfare, prolonged suffering from behavioral health concerns and increasing parent-child relationship and school readiness.

3. Program Goals, Objectives & Outcomes

Outcome 1: Engage and encourage parent/guardian involvement in their child's academic success and school
Outcome 2: Strengthen parent/guardian and child's relationship and support a healthy relationship
Outcome 3: Support maintaining a child at home with parent/ guardian

4. Clients Served & Annual Cost per Client Data

FY 2023

Unduplicated N = 248		
Number Served	Program Expenditure	Cost per Person
248	**Refer to Cover Page**	**Refer to Cover Page**

*Number served is inclusive of 154 mothers and 94 children (248)

5. Evaluation Activities

The Nurse-Family Partnership (NFP) Program is a client-centered, evidenced-based community health program in which the nurse provides individualized parent coaching to ensure that the visits and materials are relevant to the mother. The PHN can also help identify the risk factors that can lead to maternal and child mortality. The three main goals of the NFP Program include: 1) Improving pregnancy outcomes, 2) Improving child health and development, and 3) Improving the economic self-sufficiency of the family, aligning with the County's MHSA goals of 1) Reducing stigma and discrimination, 2) Reducing disparities in access to mental health services, 3) Reducing Psycho-Social impact of trauma, 4) Intervention of at risk children, youth, and young adults experiencing onset psychiatric illness, and 5) Reducing and preventing of suicide risk. There is alignment of the NFP Program goals, as priority of referrals are given to mothers who are high risk including teen mothers, history of foster care, and families who receives traditional outpatient mental health services due to complex risk factors including substance abuse, community violence, interpersonal family violence, general neglect, and exposure to trauma.

The strength based therapeutic relationship between the nurse home visitor and the new/ expecting mother allows the opportunity for a nurse home visitor to conduct comprehensive nursing assessment and identify social determinants of health and provide early intervention for critical behavioral changes needed throughout the first two-years of the child's life. The ability to assess client's status also allows for a more rapid identification and intervention. Since the NFP Program is a long-term home visitation program, it also provides nurse home visitors the ability to screen the mothers for prenatal, and postnatal depression and possible suicide risk, at five different time intervals, over the two-and-a-half-year period. The utilization of standardized evidenced based screening/assessment tools, such as the Ages and Stages Questionnaire- 3rd edition (ASQ-3), Ages and Stages Questionnaire: Social Emotional 2nd edition (ASQ:SE- 2), Edinburgh Postnatal Depression Scale, Generalized Anxiety Disorder Assessment (GAD-7), Intimate Partner Violence (IPV) Screening, and life course goals related to subsequent pregnancies, school enrollment and workforce participation. In addition, the Public Health Department distributes Customer Satisfaction Survey twice in the year.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	94	37.9
16 -25 years	93	37.5
26- 59 years	61	24.6
60+ years		

Prefer not to answer		
Unknown		
Unduplicated Total	248	100

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native		
Asian	8	3.23
Black or African American		
Native Hawaiian or Other Pacific Islander		
White/ Caucasian	157	63.31
Other		
More than one race		
Prefer not to answer	2	.80
Unknown	81	32.66
Unduplicated Total	248	100

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	2	.81
Central American		
Mexican/ Mexican-American/ Chicano	87	35.25
Puerto Rican		

South American	2	.81
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino	62	25
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian	6	2.42
Cambodian		
Chinese		
Eastern European		
European	4	1.61
Filipino	2	.81
Japanese		
Korean		
Middle Eastern		
Vietnamese	6	2.24
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer	2	.81
Unknown	75	30.24
Unduplicated Total	248	100

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	47	18.95
Female	201	81.05
Prefer not to answer		
Unknown		
Unduplicated Total	248	100

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	47	18.95
Female	201	81.05
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	248	100

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		

Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	248	100
Unduplicated Total	248	100

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	150	60.48
Spanish	88	35.48
Vietnamese	6	2.42
Chinese		
Tagalog		
Farsi		
Other	3	1.22
Prefer not to answer	1	.4
Unknown		
Unduplicated Total	248	100

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military		
Prefer not to answer		
Unknown	248	100
Unduplicated Total	248	100

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability		
No Disability		
Prefer not to answer		
Unknown	248	100
Unduplicated Total	248	100

*Participants may choose more than one option for Disability.

7. Referrals

For many of the mothers enrolled in the program, the transition to motherhood can be challenging as some have experienced isolation, abuse, relationship problems with father of baby, lack of family/friend support and many other adversities. This is the critical time that a nurse home visitor can be extremely helpful in providing community resources and linkage to an array of supportive services for mothers and their children. Although higher level of referrals was not identified, the following referrals were supported:
There were 483 referrals made by the nurse home visitors. Below are the highest referrals that were made for the clients:

Referral	Number/Percentage
Charitable Services (ALLGS, diaper resources, formula)	48
WIC Program	22
Injury Prevention	30
Mental Health Treatment or Therapy/Crisis/Support group	32
Housing	19
Dental Services-Client	36
Lactation Consultation	28
Primary Care- Well Child	18

And additional 32 referrals made to mental health services.

FY 2023

Unduplicated N = 32				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
32	Outpatient services	unk	unk	unk

8. Group Services Delivered

FY 2023		
Unduplicated N = n/a		
Number of Groups	Attendance	Average Attendance per Group
n/a		

9. Detailed Outcomes

During this period, a total of 125 mothers were supported and of those, 102 were newly enrolled clients. Of the 23 continuing clients, 5 participants graduated from the program. Six infants of 50 born were delivered premature and 18 (36%) of the mothers initiated breastfeeding.

10. Evaluation Summary

The Program continued to experience similar challenges presented in the previous year relating to the pandemic and staffing shortages at the beginning of the fiscal year. Participants also expressed challenges in returning to in-person services and NFP program adjusted by providing a hybrid telehealth and in-person approach. There was a significant increase in enrollment the mid-year as NFP program filled vacant positions.
The NFP program is actively transitioning to a new electronic health recorded system to enhance capturing data and reporting that aligns with the program.

Support For Parents Reach Out and Reach

PEI Prevention Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

An early literacy and education program in partnership with pediatric clinics to make early literacy promotion an essential part of pediatric health care. At every well-child check-up, from six (6) months through five (5) years, pediatric providers give each child a new and developmentally appropriate book to take home and read with parents. Physician screening for developmental delays is part of the program, and children with identified developmental delays are referred to specialists for further services to ensure that problems are addressed quickly before adverse effects are fully realized in a school setting.

2. Program Indicators

The ROR network of pediatric care physicians provide families, at routine check-ups, with the knowledge and tools they need to make reading a part of their daily routine. By integrating reading aloud into pediatric care, giving each child a new, developmentally appropriate book to take home and promote the benefits of reading with their child helps to create strong parent-child bonds, promotes healthy brain development, and supports ensure that their children are prepared to learn when they enter school. In addition, Physician screen for developmental delays, and refer children with identified developmental delays to specialists for further services, ensuring that problems are addressed quickly before adverse effects are fully realized.

3. Program Goals, Objectives & Outcomes

Outcome 1: Engage and encourage parent/guardian involvement in their child's academic success and school
Outcome 2: Strengthen parent/guardian and child's relationship and support a healthy relationship
Outcome 3: Support maintaining a child at home with parent/ guardian

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
12,940	**Refer to Cover Page**	**Refer to Cover Page**

5. Evaluation Activities

Reach Out and Read's effectiveness is consistently supported by independent, peer-reviewed research. Studies show that the model has a significant effect on parental behavior and attitudes toward reading aloud and that children who participate in the program demonstrate higher language scores. Our impact has been documented in ethnically and economically diverse families throughout the nation. Evaluation activities include the collection on the information on Health Center well-child visits, parent and physician annual surveys, number of books distributed and the present of children receiving books when applicable.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	12,940	100
16 -25 years		
26- 59 years		
60+ years		
Prefer not to answer		
Unknown		
Unduplicated Total	12,940	100

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	73	.50
Asian	1731	13.37
Black or African American	732	5.60
Native Hawaiian or Other Pacific Islander	79	.60
White/ Caucasian	9549	74
Other	134	1.03
More than one race		
Prefer not to answer	642	4.90

Unknown		
Unduplicated Total	12,940	100

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American	690	5.35
Mexican/ Mexican-American/ Chicano	6493	50.20
Puerto Rican	29	.22
South American	240	1.85
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino	1955	15.22
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African	215	1.66
Asian Indian/ South Asian	351	2.71
Cambodian	30	.23
Chinese	242	1.87
Eastern European		
European	140	1.08
Filipino	373	2.88
Japanese		

Korean	40	.31
Middle Eastern	192	1.48
Vietnamese	466	3.6
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	134	1.04
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity	708	5.4
Prefer not to answer	642	4.9
Unknown		
Unduplicated Total	12940	100

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	6635	51.28
Female	6305	48.72
Prefer not to answer		
Unknown		
Unduplicated Total	12940	100

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	6635	51.28
Female	6305	48.72
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		

Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	12940	100

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	12940	100
Unduplicated Total	12,940	100

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	7612	58.83
Spanish	4638	35.84
Vietnamese	212	1.64
Chinese		
Tagalog		
Farsi	31	.24
Other	447	3.45
Prefer not to answer		

Unknown		
Unduplicated Total	12,940	100

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military		
Prefer not to answer		
Unknown	12,940	100
Unduplicated Total	12,940	100

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	391	3.02
Difficulty hearing or speaking	227	2.14
Other communication disability	1352	10.45
Cognitive		
Physical/ Mobility	449	3.25
Chronic Health Condition	5304	41
Other non-communication disability	626	4.84
No Disability	4591	35.3
Prefer not to answer		
Unknown		
Unduplicated Total	12,940	100

*Participants may choose more than one option for Disability.

7. Referrals

ROR does not provide screening or referrals to other services or supports. The program supports distribution and promotion of skills to support parent/caregiver-child engagement.

FY 2023

Unduplicated N = n/a				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
n/a				

8. Group Services Delivered

ROR does not provide screening or referrals to other services or supports. The program supports distribution and promotion of skills to support parent/caregiver-child engagement.

FY 2023		
Unduplicated N = n/a		
Number of Groups	Attendance	Average Attendance per Group
n/a		

9. Detailed Outcomes

Physicians and Parents reported limited time to engage in surveys as time in clinic continues to be limited due to pandemic safety measures. Of the surveys collected parents reported the following:

i. 60% of parents began reading to their children beginning 12 months or younger
ii. 75% of parents read at least 4 days or more
iii. 70% of parents acknowledge that reading to their child has greatly improved or somewhat improved with their child.

Physicians reported the Reach Out and Read Program has supported aid them with continue surveillance, led to making a referral.

ROR book disbursement 19, 337 bilingual English/ Spanish, and Vietnamese books across 7 Pediatric Sites.

10. Evaluation Summary

Reach Out and Read updated the online training curriculum taking Pediatrician feedback to reduce redundant information that reduce length of training. Pediatricians reported the streamlining of the training, and the

reduction of time has allowed them to participate within reasonable time and resulted in increasing completion rate to 70%.

VMC foundation continues to work with community networks to acquire book donations to secure literature for children older than 6. Securing funding and partnerships may contribute to increase access to reading for multiple family members in the home that aim towards the program goals that encourage parent/guardian involvement in their child's academic success and strengthen parent/guardian and child's relationship and support a healthy relationship.

Support For Parents Triple P: Positive Parenting Program

PEI Prevention Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The Positive Parenting Program (Tripe P) is a multi-level system of family intervention for parents of children ages birth through 12, who have or are at risk of developing behavior challenges. It is a prevention oriented, early intervention program which aims to promote positive, caring relationships between parents/caregivers and their children, and to help parents/caregivers develop effective management strategies for dealing with a variety of childhood behavior challenges and common developmental issues. Program is designed to assist parents/caregivers reduce challenging behaviors that are disruptive, defiant, aggressive, and other behaviors that parents/caregivers have difficulty managing. Levels 2, 3, 4, and 5 are offered in various formats, group or individual, throughout Santa Clara County.

i. Level 2 Selected Triple P: offers information, guidance, and advice for a specific parenting concern services are approximately 20 min over 2 sessions or 60–90-minute seminars/workshops
ii. Level 3 Primary Care Triple P: a brief targeted intervention program that lasts approximately 80 minutes over 4 sessions providing one to one assistance to parents/caregivers to manage distinct challenging behaviors.
iii. Level 4 Standard Triple P: Intensive training in positive parenting skills, typically targets parents/caregivers of children with more severe behavioral problems. Program variants include individual, group, or self-directed (with or without telephone assistant) options.
iv. Level 5 Enhanced Tripe P: An intensive individually tailored program for families with children with behavior challenges and family dysfunction. Modules include practice sessions to enhance parenting skills, mood management strategies and stress coping skills, and partner support skills over the course of 11, 60–90-minute sessions.

2. Program Indicators

Family support and engagement are intended to prevent or intervene early in the development of emotional and behavioral problems in young children by providing the parents/caregivers with outcome-based parenting strategies, support services, and classes, reducing prolonged suffering and increasing parent/caregiver child relationship. Skills learned through parenting classes and support also supports reduction of child welfare involvement mitigating the removal of children from their home.

3. Program Goals, Objectives & Outcomes

i. Engage and encourage parent/caregiver involvement in their child's academic success and school
ii. Strengthen parent/caregiver and child's relationship and support a healthy relationship
iii. Support maintaining a child at home with parent/ caregiver

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
312*	**Refer to Cover Page**	**Refer to Cover Page**

*Triple P: 275 parents served, and 37 participants trained (312)

5. Evaluation Activities

The Triple P Program is an evidenced-based positive parenting training program offering parents access to a suite of interventions of increasing intensity and delivered in a range of ways including one to one or small and large groups. Outcomes are achieved by creating a supportive learning environment for parents/caregivers and evaluating appropriate level of support. Practitioners must complete an approved active skills training program and demonstrate their knowledge and competence in program delivery through a skills-based accreditation process. Upon completion of training, practitioners gain access to the Triple P Provider Network website, which offers support in providing clinical resources and helpful advice about program delivery. In addition, practitioners are expected to have knowledge of child or adolescent development, experience working with families and regular access to clinical supervision and support.

The County of Santa Clara Behavioral Health Services Department implemented an application process to ensure all practitioners meet Triple P entry-level requirements. Only accredited practitioners can deliver Triple P further enhancing fidelity to the Triple P Program allowing each practitioner to effectively offer parent/caregiver consultation, including active skills coaching, provide specific positive parenting strategies promoting children's development, early detection and effective management of behavior problems and identification of indicators that may require more intervention.

Each Triple P level has a set of resources to be used with families and for practitioners to best determine appropriate program level. Practitioners gather family background, child adjustments and parenting styles through parent questionaries and assessment tools such as the Eyberg Child Behavior Inventory (ECBI), and Parenting Scale. In addition, many of the materials are offered in multiple languages and delivered in the family's preferred language. ECBI and Parenting Scale questionnaires are administered at pre and post completion of the Level 4 and 5 training series to parents/caregivers to gauge their skill acquisition and identify if further supports are required. During this fiscal year, there was an identified need to implement pre and post satisfaction questionnaires to families that participated in level 2 and 3 services to evaluate knowledge acquisition and satisfaction of service delivery.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	32	10.25
16 -25 years	23	7.38

26- 59 years	156	50
60+ years	5	1.60
Prefer not to answer		
Unknown	96	30.77
Unduplicated Total	312	100

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	8	2.56
Asian	55	17.64
Black or African American	3	.96
Native Hawaiian or Other Pacific Islander	3	.96
White/ Caucasian	9	2.88
Other	117	37.5
More than one race	5	1.6
Prefer not to answer		
Unknown	112	35.9
Unduplicated Total	312	100

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		

Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino	106	33.97
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian	21	6.74
Cambodian		
Chinese		
Eastern European		
European		
Filipino	3	.96
Japanese	8	2.56
Korean		
Middle Eastern		
Vietnamese	20	6.41
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer	68	21.80

Unknown	86	27.56
Unduplicated Total	312	100

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	25	8.01
Female	183	58.65
Prefer not to answer		
Unknown	104	33.34
Unduplicated Total	312	100

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	25	8.01
Female	183	58.65
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure	1	.32
Another gender identity		
Prefer not to answer	3	.97
Unknown	100	32.05
Unduplicated Total	312	100

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		

Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	312	100
Unduplicated Total	312	100

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	119	38.14
Spanish	101	32.37
Vietnamese	18	5.77
Chinese		
Tagalog		
Farsi		
Other	6	1.92
Prefer not to answer		
Unknown	68	21.80
Unduplicated Total	312	100

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military		

Prefer not to answer		
Unknown	312	100
Unduplicated Total	312	100

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability		
No Disability		
Prefer not to answer		
Unknown	312	100
Unduplicated Total	312	100

*Participants may choose more than one option for Disability.

7. Referrals

N/A – Triple P programming does not make referrals into higher levels of care. Often families participating in Triple P services are already connected to behavioral health service.

FY 2023				
Unduplicated N = n/a				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
n/a				

8. Group Services Delivered

A method of delivery of Triple P is through small groups and large seminars/workshops. Variance of service delivery is tailored to provide appropriate level of need at the duration and pace that works best for the parent.

FY 2023		
Unduplicated N = n/a		
Number of Groups	Attendance	Average Attendance per Group
n/a		

9. Detailed Outcomes

Triple P services has had a slow return due to various factors such as staffing challenges. Although services have mostly resumed to in-person, there is reported concerns from families related to gatherings in person. Triple P Network continues to provide practitioner guidance in offering services for communities and families impacted by the pandemic and modification to service delivery methods through articles, webinars, and trainings.

Families that did participate in Triple P services during the fiscal year primarily participated in Triple P levels 2 and 3. Pre and post satisfaction surveys were not yet implemented to evaluate outcomes of their knowledge acquisition from participation. Fiscal year 23-24 will begin implementation of the satisfaction survey for families participating in Level 2 and 3 training and will also evaluate data collection for higher levels of service through level 4 and 5 trainings.

10. Evaluation Summary

Triple P service delivery has been slow this fiscal year due to various factors. However, with the slow service delivery it has provided an opportunity to re-evaluate how services may be delivered for the Children, Youth and Family system of care to be able to catch a wider audience and provide prevention supports to families that may managing challenging behaviors from their child. Opportunities around re-evaluation of data collection and outcome measures also presented themselves this fiscal year which resulted in new processes being implemented for next fiscal year.

PROMOTORES

PEI Prevention Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Promotores started is a program of Gardner Family Health Network, Inc. This program is designed to reduce disparities by utilizing a non-clinical networking model among service providers to exchange information about activities and resources that promote economic stability, educational success, access to healthcare, housing, and legal services for families. The target population is Santa Clara County residents, Transitional Aged Youth (TAY) ages 16-25, adults ages 24-59, and older adults ages 60 and older. Unlike the traditional Medi-Cal authorized services, the Promotores program operates with an open-door policy, whereby individuals who are not currently diagnosed with behavioral health-related disorders may receive services.

2. Program Indicators

The Promotores program uses outreach in the county of Santa Clara to providing mental health education to help alleviate prolonged suffering from mental health disorders. Psychoeducation presentations educate and help reduce behavioral health stigma in the communities. Presentations include Mental Health 101, Recognizing Early Signs of Depression and Anxiety, Understanding the Effects of Caring for an Elderly Parent, Understanding Your Youth's Behaviors, Young Adulthood and Mental Health

3. Program Goals, Objectives & Outcomes

❖ Goals

i. Culturally and linguistically targeted outreach within communities and neighborhoods to create enhanced linkages/referrals from and to nearby clinics to community services provided by Peer Mentors.
ii. Increase accessibility to mental health resources and explore innovative outreach efforts.
iii. Increase workforce recruitment, education, and training from TAY communities.
iv. Culture and diversity needs.
v. Examine cultural responsiveness.
vi. Improve adult/older adult workforce recruitment, training, and retention.

❖ Objectives

i. Build capacity for behavioral health prevention and early intervention services at sites where clients go for other routine activities.
ii. Implement strategies to empower traditionally underserved/unserved communities to engage in services prior to the development of SMI or serious emotional disturbances.
iii. Increasing family management skills, including anger management skills refusal and problem-solving skills, teaching skills to their children, and the ability to assist their children with academic success.

iv. Coordinate and link participants with other providers including resources that serve youths, adults and older adults in Santa Clara County.

❖ Outcomes

i. Build Promotores capacity in neighborhoods to create linkages/referrals from and to nearby clinics to community for both adults and teens.
ii. Reduce the barriers to health education and services that are common for native-born and immigrant communities
iii. Empower traditionally underserved/unserved communities to engage in mental health services as needed.
iv. Ensure early access to behavioral and health services to nearby clinics, to lower behavioral health illness and suicide rates, enhance wellness and resilience, and reduce barriers to health education/services, behavioral health stigma, and discrimination that are common for Native born and immigrant communities.
v. Increase the strength and capacity of culturally relevant community programs in Santa Clara County to be a viable and sustainable organization that provides a unique service that supports all residents including the ethnic community within the County.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 3,058		
Number Served	Program Expenditure	Cost per Person
3,058	**$ 641,022.35**	**$209.62**

5. Evaluation Activities

Gardner's Promotores program was developed to provide mental health education to those in Santa Clara County's low-income/no-income individuals and families. Gardner takes a community-based approach. Promotores utilizes community health workers to provide psychoeducation around various aspects of mental health to those individuals who are not currently receiving any type of mental health services. By attending the program, participants can ask staff for help and link them to any needed resources in the community. There is hope that by providing psychoeducation to a broad audience to those who, for whatever reason, maybe struggling with behavioral health issues or in the early stages of mental/behavioral health issues.
Gardner staff is made up of individuals from the community and is a cultural makeup of the community. They have several bilingual staff, Spanish, Mandarin, and Cantonese. The culturally diverse team makes it so that they can provide culturally sensitive information to the communities for outreach.
Gardner's Promotores program is responsible for providing outreach to all of Santa Clara County for the following populations TAY (ages 16 to 25)/Adult (ages 26 to 59)/Older Adult (ages 60+). The Promotores has developed presentations specific to each of these age groups. A pre-test and post-test are given at the beginning and ending with measuring how effective each of the presentations has been. To be considered successful at least 50% of the participants must pass the post-test. Each pre and post-test was tailored to fit with each presentation.

The Promotores program is based on the Community Health Worker Program model is based on a Latin American model that reaches underserved populations through peer education. The model is used to reach hard-to-serve populations and connect them to needed services. Promotores are liaisons, who are trusted members of their community and usually share some of the same or similar life experiences as the community.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	276	9.03%
16 -25 years	294	9.61%
26- 59 years	900	29.43%
60+ years	202	6.61%
Prefer not to answer	60	1.96%
Unknown	1326	43.36%
Unduplicated Total	3058	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	18	0.59%
Asian	213	6.97%
Black or African American	103	3.37%
Native Hawaiian or Other Pacific Islander	25	0.82%
White/ Caucasian	388	12.69%
Other	293	9.58%
More than one race	35	1.14%
Prefer not to answer	399	13.05%
Unknown	1584	51.80%

Unduplicated Total	**3058**	**100.00%**

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	0	0.00%
Central American	0	0.00%
Mexican/ Mexican-American/ Chicano	129	4.22%
Puerto Rican	0	0.00%
South American	0	0.00%
Hispanic/ Latino (undefined)	754	24.66%
Other Hispanic/ Latino	0	0.00%
Hispanic or Latino Subtotal	**883**	**28.88%**
Non-Hispanic or Non-Latino as follows:		
African	20	0.65%
Asian Indian/ South Asian	2	0.07%
Cambodian	0	0.00%
Chinese	3	0.10%
Eastern European	1	0.03%
European	2	0.07%
Filipino	3	0.10%
Japanese	1	0.03%
Korean	0	0.00%

Middle Eastern	1	0.03%
Vietnamese	8	0.26%
Non-Hispanic/ Non-Latino (undefined)	464	15.17%
Other Non-Hispanic/ Non-Latino	45	1.47%
Non-Hispanic or Non-Latino Subtotal	**550**	**17.99%**
More than one ethnicity	0	0.00%
Prefer not to answer	56	1.83%
Unknown	1569	51.31%
Unduplicated Total	**3058**	**100.00%**

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	876	28.65%
Female	796	26.03%
Prefer not to answer	3	0.10%
Unknown	1383	45.23%
Unduplicated Total	**3058**	**100.00%**

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	769	25.15%
Female	728	23.81%
Transgender (Male to Female)	6	0.20%
Transgender (Female to Male)	0	0.00%
Transgender (Undefined)	0	0.00%
Genderqueer	0	0.00%

Questioning or Unsure	0	0.00%
Another gender identity	1	0.03%
Prefer not to answer	36	1.18%
Unknown	1518	49.64%
Unduplicated Total	**3058**	**100.00%**

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	18	0.59%
Heterosexual/ Straight	887	29.01%
Bisexual	16	0.52%
Questioning/ Unsure	4	0.13%
Queer	0	0.00%
Another sexual orientation	4	0.13%
Prefer not to answer	257	8.40%
Unknown	1872	61.22%
Unduplicated Total	**3058**	**100.00%**

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	1622	53.04%
Spanish	59	1.93%
Vietnamese	8	0.26%
Chinese	4	0.13%
Tagalog	0	0.00%
Farsi	1	0.03%
Other	10	0.33%
Prefer not to answer	4	0.13%
Unknown	1350	44.15%

Unduplicated Total	**3058**	**100.00%**

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	1	0.03%
Veteran	6	0.20%
Served in Military	0	0.00%
Family of Military	1	0.03%
No Military	1609	52.62%
Prefer not to answer	6	0.20%
Unknown	1435	46.93%
Unduplicated Total	**3058**	**100.00%**

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	1	0.03%
Difficulty hearing or speaking	4	0.13%
Other communication disability	7	0.23%
Cognitive	7	0.23%
Physical/ Mobility	11	0.36%
Chronic Health Condition	5	0.16%
Other non-communication disability	3	0.10%
No Disability	707	23.12%
Prefer not to answer	2	0.07%
Unknown	2311	75.57%
Unduplicated Total	**3058**	**100.00%**

*Participants may choose more than one option for Disability.

7. Referrals

FY 2023
Unduplicated N =895

Number of individuals with serious mental illness referred to treatment	Kind of treatment to which the individual was referred	Number of individuals who followed through on the referral and engaged in treatment	Average duration of untreated mental illness	Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation
See below for total; 895	Prevention Early Intervention Continuing Other	Unknown, clients are not entered for tracking	Unknown, not tracked	Unknown, not tracked

Numbers of referrals	Q1	Q2	Q3	Q4	Total
Numbers of referrals to a prevention program (educational, workshops, ex. Ethnic Wellness Center)		3	356	41	540
Numbers of referrals to an early intervention program (brief treatment- ex. IPSCC)					0
Numbers of referrals to for county services for continued care (ex. Call Center)	140	211	24	118	353
Number of referrals to non county services (food, housing, legal…)		2			2
TOTAL:	**140**	**216**	**380**	**159**	**895**

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
13	114	8.77

9. Detailed Outcomes

Output: Count of Number of events and time engaged in outreach and promotion activities engaged in and attended by Promotores staff. **Outreach and Psychoeducation Presentations Count**		
Name of Event	# of people outreached to	Total FY23
Barbara Lee Senior Center	7	7
Campbell Presentation	22	22
Goodwill event fair	58	58
LGBTQIA Fair	30	30

Outreach	6	6
Resource Tabling	256	318
Alviso Youth Center		200
Berryessa Community Center Tabling		8
Body Dysmorphia Presentation		3
Buena Vista Midtown Apartments		54
Cardenas		70
Central YMCA		5
Costco		24
Don De Dios Apartments		32
Grocery Outlet Tabling		56
Lion Market		9
Minority Mental Wellness Tabling		32
Monte Alban Apartments		16
National Night Out Tabling		5
Pollard Plaza Apartments		64
Promo Pamphlets Outreach		40
Recovery Café		80
Revelas Apartments		21
San Jose City Hall Tabling		3
San Jose Health Fair Tabling		63
San Jose Pride Festival		15
SAP Center		235
Seven Trees COVID Event Tabling		34
SJ Homeless Event		60
Social Anxiety Presentation in Older Adults		21
Social Media Addiction Presentation		13
Stepping into Puberty Zoom Meeting		8
Story Market		15
Stress Management Presentation		6

10. Evaluation Summary

❖ Implementation Challenges/program barriers

The Promotores Program have been met with a few challenges during this fiscal year that include re-scheduled presentations, tabling areas and pre-post survey engagement. Peer Mentors were able to set up presentations both virtually and in person. During the year, some presentations were rescheduled which made it challenging for Peer Mentors to complete new flyers by the rescheduled date so that the community was aware of the changes. Peer Mentors were also faced with inabilities to table in various locations where the property management denied the tabling space. This led to staff needing to find another location that was readily available. Lastly, while all presentations provided the QR code to access the pre and post survey and the staff reviewed the purpose of the survey, many guests did not complete thus providing the program with minimal data on the outcome of the presentations.

❖ Lessons Learned

The Promotores Program pivoted from the challenge of re-scheduling presentations to implement a guideline to share with agencies requesting presentations so that the process is streamlined to be more effective, and the agencies are aware of the workflow for rescheduling those presentations. The Promotores Program was able to solidify tabling locations where they would be accepted and focusing tabling efforts in South County such as Morgan Hill and Gilroy and North County such as Cupertino and Palo Alto. The Promotores Program learned the importance of encouraging presentation participants to complete surveys and are working towards translating the pre and post survey questions.

❖ Successes (include client stories)

One of the most impactful successes for the Promotores Program was the implementation of the Mental Health Awareness Night with the San Jose Sharks. This opportunity has allowed the Peer Mentors to connect to thousands of Santa Clara County residents through tabling at a game and providing a stress reduction presentation. This opportunity has also allowed us to continue the partnership with the San Jose Sharks for the upcoming season. Another success was increasing the amount of presentations being provided within the county. The Peer Mentors have been able to connect with various agencies, schools and community organizations to provide mental health presentations. The increase of participants and positive feedback from these agencies has allowed the Promotores Program to continue providing presentations at these agencies. The Promotores Program has also taken initiative to incorporate more tabling locations within Santa Clara County and have been diligently working on solidifying accessible spots. Lastly, the Promotores Program has been able to effectively meet the requirements for the unduplicated clients for FY23 with consistent tabling, completing cold calls and providing presentations.

❖ Client stories

DELAC group shared their families enjoyed learning about the topic of bullying. They shared that peer mentor, Graham Burnes, was "so professional and took the time to answer all of their questions".
While tabling there was a lady who approached me thanking me for the services we provided and share stories of how mental health has helped her a lot and now encourages others around her about mental health.
While doing presentation there was a man who was thankful for our services and requested us to come back to make future presentations.

While doing presentations at a facility there was a group of ladies thankful for the services we provided, and they learned a few key points of how to overcome certain topics we provided and found the importance of seeking mental health for themselves and family members.

Following is the text of a letter from Suzy Cortez of the Santa Clara Unified School District Family Resource Center:

“Dear Sheri (Terao), Working closely with Gardner Health Services to organize parent workshops has been a truly collaborative and enriching experience for the Family Resource Center. These workshops have served as invaluable resources, fostering a strong partnership between the families, ultimately empowering parents with valuable insights and tools to support their children's well-being. Looking forward to strengthening this partnership. Sincerely, Susy Cortez”

Older Adult Prevention and Early Intervention

PEI Prevention Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Older adults in Santa Clara County can access Older Adult Prevention and Early Intervention outpatient program designed to enhance their quality of life, address their specific mental health needs, and help them remain in their homes whenever possible rather than needing more intensive care. These programs offer a range of outpatient and intensive outpatient services to adults over the age of 60 who may be experiencing mental health issues such as depression, post-traumatic stress disorder, and anxiety due to various factors such as retirement, financial challenges, the loss of loved ones, social isolation, health problems, and changes in living circumstances.

B. Early Interventions - The program shall offer early interventions that are low-intensity and short-term (up to 120 days) in order to prevent the need for more intensive mental health treatment or to stop a mental health problem from worsening These interventions may include mental health consultations with specific interventions, anger management support, and socialization programs with a focus on mental health for home-bound adults displaying signs of isolation, anxiety, depression, conflict within the family, neglect, and substance abuse.

C. The delivery of all services will be voluntary and based on the preferences of each client. Cultural competency, recovery, and resilience will be key principles guiding the provision of services, with a focus on strengthening the individual's personal assets and connections to the community, family, and peer/social network.

Older adults (age 60 and over) who have mental health concerns, have not received specialized mental health care for over a year, and need various assessments and support services to address unaddressed needs are eligible for the Prevention and Early Intervention (PEI) Outpatient services.

2. Program Indicators

i. **Suicide** – The program assesses for risk management at the beginning and through out services. When necessary, connects client to community crisis services and referral to outpatient services.
ii. **Unemployment** – The program aims to link individuals to community job placement programs.
iii. **Prolonged suffering**: The program aims to assist individuals affected by early signs of mental health symptoms, working to prevent both suicide and prolonged suffering. By meeting clients at their current state and implementing targeted interventions, the program strives to provide the necessary support to help them navigate their daily challenges effectively

3. Program Goals, Objectives & Outcomes

i. Improve access to quality early intervention behavioral health services for the target population, including timely access to services, high-quality care, and effective treatment using empirically validated tools.
ii. Reduce the psycho-social effects of trauma on Older Adult clients.
iii. Decrease and prevent suicide risk for all active Older Adult clients through early intervention for mental health disorders such as depression and its impact on daily functioning, by connecting home-bound clients with appropriate service providers (if not the contractor).

iv. Help Older Adult client's access ongoing supportive community-based services to maintain an active lifestyle.

v. The discharge outcome is documented by filling out a discharge coding form, which assists both the staff and the client in identifying the underlying reasons for the discharge. A successful discharge is reached when a client can independently carry out their daily living tasks, demonstrating improvements in their social skills, employment status, relationships, and emotional/behavioral well-being.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
65	**$ 565,746.34**	**$ 8,703.79**

5. Evaluation Activities

i. Access and Linkage: Clients are continuously evaluated to determine if a referral to county outpatient services is necessary to continue stabilization, medication evaluation, and other adjunctive programs. If yes, clients are supported to be linked to community based outpatient services through the county behavioral health call center.

ii. Improving Timely Access: Monitoring access to ensure clients have access to services within the 10-day NACT to quality early intervention behavioral health services for the older adult target population, including timely access to services, high-quality care, and effective treatment using empirically validated tools

iii. Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory. Through various assessment tools and client collaborative treatment planning, providers help clients decrease stigma to receive mental health services. To improve quality early interventions and prevention quality of care.

Outpatient service programs such as the Prevention and Early Intervention Outpatient Services program provide various services to meet the needs of older adults. These services may include evaluations, therapy, and coordination of care. The aim of these programs is to identify and address the specific needs that older adults may have, which can include psychological, medical, developmental, and social concerns. Services included but not limited to:

i. The assessment process involves determining the psychosocial areas where the client may need support and identifying any mental health diagnoses.

ii. Treatment planning includes setting goals for the client to focus on during their time in treatment and establishing an end goal date.

iii. In case of a crisis, brief intervention measures such as connecting with suicide prevention lines, creating safety plans, and identifying community resources will be provided.

iv. Short-term and longer-term counseling services, lasting up to four months, may be offered, with the possibility of referral to higher levels of care for ongoing mental health support.

v. Case management services involve connecting clients to community resources like affordable housing, food banks, and coordinating primary care, psychiatry, and specialist care.

vi. Clients can take advantage of self-help and peer support opportunities such as learning how to access community resources, joining employment enrichment groups, and participating in groups that focus on increasing knowledge.

vii. Outreach and engagement activities, on the other hand, provide clients with opportunities to socialize, engage in hobbies, participate in community activities, and join support groups.

❖ Measuring/Survey Instrument tools:

i. The AC-OK Co-Occurring Questionnaire aims to identify any co-occurring disorders such as mental health issues, trauma-related mental health issues, and substance abuse. This helps to determine the current mental health challenges and any recent trauma experiences within the past year, as well as any issues related to substance use.

ii. The Milestones of Recovery Scale (MORS) is used during the intake process and on a monthly basis to evaluate a client's level of social and daily functioning. This helps to identify the client's stage of change and level of independence in coordinating their own care and ensuring their safety.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years		
26- 59 years	2	3%
60+ years	63	97%
Prefer not to answer		
Unknown		
Unduplicated Total	65	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	11	18%
Asian	17	26%
Black or African American	2	3%
Native Hawaiian or Other Pacific Islander		

White/ Caucasian	19	29%
Other	10	15%
More than one race	6	9%
Prefer not to answer		
Unknown		
Unduplicated Total	65	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano	14	22%
Puerto Rican	2	3%
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino	1	2%
Hispanic or Latino Subtotal	17	27%
Non-Hispanic or Non-Latino as follows:		
African	1	2%
Asian Indian/ South Asian	12	18%
Cambodian		
Chinese		

Eastern European	7	10%
European	5	7%
Filipino	1	2%
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	2	3%
Non-Hispanic or Non-Latino Subtotal	28	43%
More than one ethnicity	1	2%
Prefer not to answer	14	21%
Unknown	5	7%
Unduplicated Total	65	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	22	34%
Female	43	66%
Prefer not to answer		
Unknown		
Unduplicated Total	65	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**

Male	18	28%
Female	43	66%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer	4	6%
Unknown		
Unduplicated Total	65	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	1	2%
Heterosexual/ Straight	58	89%
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer	6	9%
Unknown		
Unduplicated Total	65	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	37	58%
Spanish	11	17%
Vietnamese	2	3%

Chinese	5	7%
Tagalog	2	3%
Farsi	2	3%
Other	5	7%
Prefer not to answer	1	2%
Unknown		
Unduplicated Total	65	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	55	85%
Veteran		
Served in Military		
Family of Military		
No Military		
Prefer not to answer		
Unknown	10	15%
Unduplicated Total	65	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	1	2%
Difficulty hearing or speaking	2	3%
Other communication disability		
Cognitive		
Physical/ Mobility	7	11%
Chronic Health Condition	6	9%
Other non-communication disability		
No Disability	17	26%
Prefer not to answer	10	15%
Unknown	22	34%
Unduplicated Total	65	100%

*Participants may choose more than one option for Disability.

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
N/A	Psychiatric, medication support services, higher level of mental health care, lower level of mental health care, intensive case management, linkage to essential resources, food, clothing, housing and adjunct services	N/A	Unknown	5 Days

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
N/A	N/A	N/A

9. Detailed Outcomes

In this fiscal year, we marked serving 65 clients and having 15 successful discharges. Clients reported notable improvements in various areas, including emotional/behavioral well-being, employment status, social skills, overall functionality, family and social relationships, as well as physical health.

10. Evaluation Summary

*U*pon referral to the Older Adult Prevention and Early Intervention program, clients are evaluated using self-report, family report, and a multidisciplinary team report. During the intake process, an AC-OK Co-Occurring Questionnaire is used to assess the client's current mental health challenges, potential substance use, and any trauma they may have experienced in the past year.

The Milestones of Recovery Scale (MORS) is also used to evaluate the client's level of social and daily functioning, determine their stage of change, and assess their independence in coordinating their personal, health, and mental health care. Providers review the client's progress on the MORS scale on a monthly basis until a change in the level of care is needed.

The program also provides community referrals and linkages to resources such as affordable housing, food, clothing, homeless shelters, intensive case management, socialization events and programs, group workshops, in-home supportive services for caregivers, and other appropriate resources.

Clinicians employ various methods to effectively monitor progress over a four-month period. These include the utilization of assessment tools and questionnaires conducted during the intake process, periodic reviews of outcomes, and the assessment tools known as AC-OK and MORS, which are typically administered at the time of discharge. Furthermore, clinicians regularly revisit the goals established by the client at the outset of treatment, leveraging these objectives as motivational tools to empower the client to persist in applying the skills they have acquired throughout their therapeutic journey.

❖ Challenges

During the fiscal year, the OA-PEI program faced a range of substantial challenges. To begin with, there was an unforeseen issue of client disengagement, stemming from various factors, including severe cognitive impairments and memory-related issues such as dementia. Additionally, the program had to contend with staffing problems, encompassing both retention and recruitment concerns.
Furthermore, a notable obstacle that persisted throughout the program's operations revolved around the constrained financial resources accessible to both non-legal and legal residents in need of our services. The inadequacy of financial aid, extending to both categories of residents, hindered our capability to fully address the holistic requirements of certain clients. This limitation hindered our capacity to furnish the indispensable care and assistance they necessitated. Acknowledging the critical nature of resolving this challenge, our program is actively engaged in the pursuit of viable remedies. Our aim is to ensure that individuals, regardless of their legal status, who are referred to the PEI-Adult program, receive the caliber of care that they rightly deserve.
The PEI-Older Adult program maintains an unwavering dedication to continuously enhance our services, resolutely striving to tackle the obstacles before us. By harnessing resilience, fostering collaboration, and upholding a client-centric ethos, we are resolute in our mission to elevate the accessibility and efficacy of our program. Our commitment is unwavering - we aim to guarantee that every one of our clients is afforded the compassionate care and support they are rightfully entitled to.
Gardner closely collaborated with the county to engage in discussions and explore potential solutions for the challenges previously mentioned.
Success story:
A heartwarming story involves a 60-year-old woman seeking mental health help for the first time. She contacted the county call center when her relationship with her son strained, causing her to lose her support network. In individual sessions, her provider taught her important social and communication skills. The client actively engaged in her sessions, practiced the skills, and, over four months, transformed. She became better at using her new skills and applied them in conversations with her son, leading to a remarkable reconciliation. Their improved relationship gave her a renewed support system, and she confidently chose to end her treatment, showing the profound impact of her therapeutic journey.

EARLY INTERVENTION PROGRAMS

Raising Early Awareness & Creating Hope (Reach)

Prevention and Early Intervention Program (PEI)

ANNUAL EVALUATION REPORT DATA
REPORTING PERIOD: FY23 (JUL 1, 2022-JUN 30, 2023)

1. Program Description

Raising Early Awareness and Creating Hope (REACH) is a collaborative effort between Momentum for Health (MMH) and Starlight Community Services (SCS). Together, REACH is committed to providing early intervention and prevention services for youth and young adults who are clinically high risk for psychosis (CHR-P) throughout Santa Clara County. REACH's mission is to raise awareness and understanding of mental illness, specifically early signs of psychosis, within the community while offering culturally competent and evidence-informed treatment to underserved youth and young adults, ages 10-25, and their families. Program services include case management, therapy, psychiatry, occupational therapy, education and employment support, peer and parent mentorship, and various groups, including Multi-Family Group.

2. Program Indicators

The current REACH program has designed services in effort to promote improved accessibility of mental health treatment in the early stages for those youth and young adults at CHR-P and focuses on interventions to reduce stigma. The REACH program addresses the following program indicators through targeted interventions:

- **Suicide and attempted suicide**

The REACH program promotes mental health screenings and clinical assessment which has standardized suicide assessment risk for all program participants. The assessment process enables staff to make appropriate referrals and coordination of care for continuous support for program participants and prevent further negative outcomes.

- **Incarceration**

Justice involved youth and young adults often encounter disciplinary measures instead of mental health intervention. The REACH program provides outreach and community education regarding signs and symptoms of CHR-P will also providing linkages to mental health services which can aid in reducing risk of incarceration due to mental illness.

- **School failure or dropout**

Partnerships between schools and families are needed to prevent early school failure such as school dropout. REACH services promote increase in PEI services available to those at CHR-P and to school professionals to support students by early identification and assessment of social, emotional, and health problems that affect the student's achievement, behavior, and attendance.

- **Unemployment**

The REACH program has partnered with County School Linked Services (SLS), which are centralized locations for resources and services to support youth and young adults with education and employment services. REACH services are accessible to youth through the SLS partnership. Outreach and collaboration enable REACH to provide early interventions for youth and young adults at CHR-P and give them tools and coping skills that can help them reduce the long-term impacts of mental health issues, including unemployment.

❖ Prolonged suffering

REACH works to reduce stigma surrounding mental health through extensive outreach within the community with stakeholders and also community members to address mental health concerns. Evidenced based interventions, such as Multi-Family Groups, are offered to families who have experienced a family member affected by mental health issues, specifically psychosis.

❖ Homelessness

Many homeless youth and young adults attend school regularly and have access referrals and resources to support their needs. Youth and young adults at risk for CHR-P are screened through the SLS partnership to enter into REACH services. REACH also screens all youth who receive services through REACH for homelessness indicators and provides supportive care coordination to appropriate housing support in the community.

❖ Removal of children from their home

REACH focuses on the PEI aspect linking youth at an early stage of intervention to mental health services, along with supports to their families, in effort to prevent adverse events leading to removal of children from homes. External prevention services include parent training, increasing parent's understanding of the developmental stages of childhood, and positive parenting.

3. Program Goals, Objectives & Outcomes

❖ Current program goals are to:

i. Reduce stigma and discrimination.
ii. Reduce disparities in access to mental health services.
iii. Reduce the psycho-social impact of trauma.
iv. Increase prevention of suicide risks; and
v. Increase prevention and early intervention for children, youth, and young adult populations at risk of experiencing onset of serious psychiatric illness.

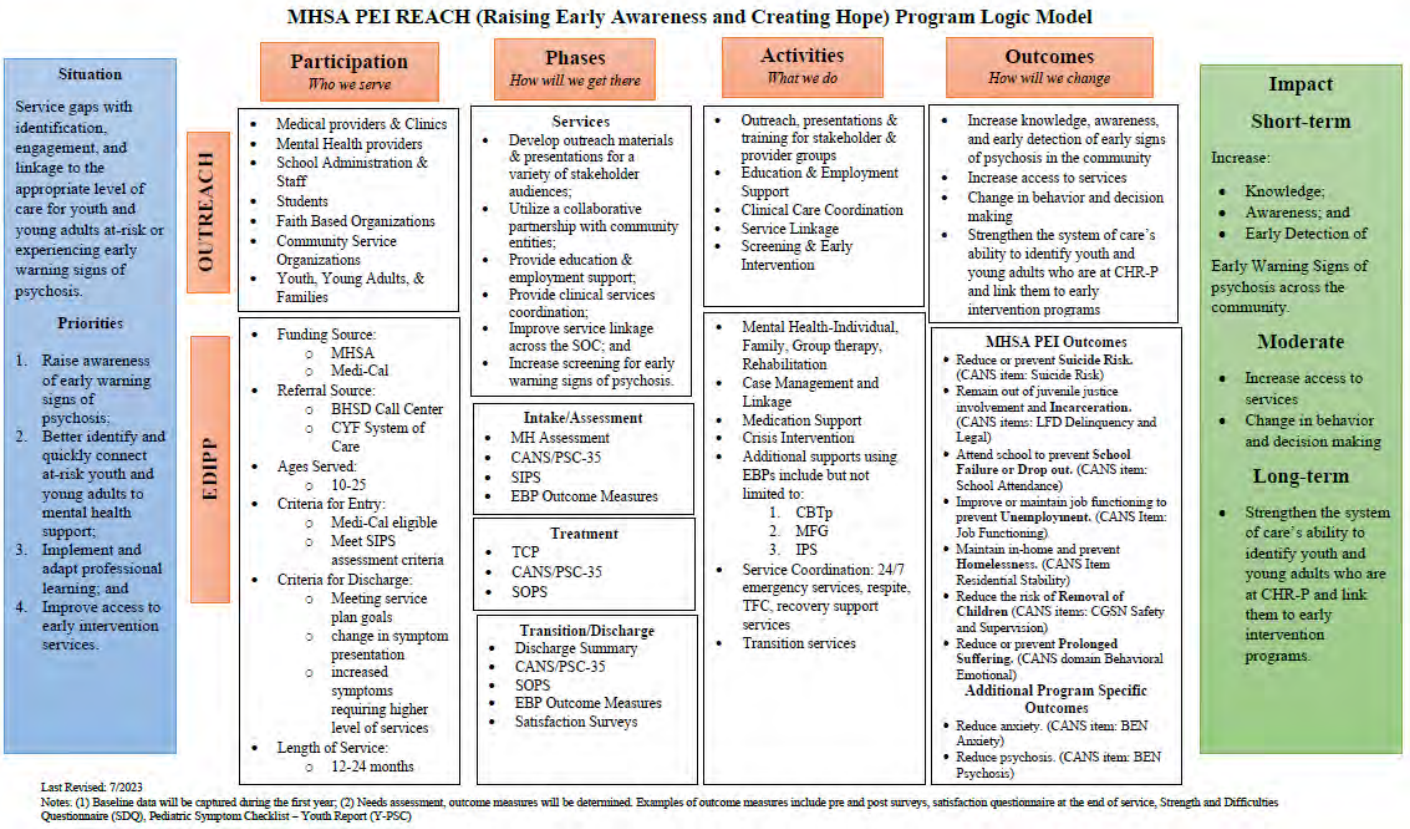
❖ REACH service objectives include:

i. Increase education and training within the provider community, educational system, and child-service systems who might encounter youth experiencing early or active symptoms of serious psychiatric illness;
ii. Reduce psychiatric hospitalizations and admissions;
iii. Increase ability of clients to regain productive lives;
iv. Increase positive family engagement and experience of care;
v. Reduce the duration of untreated psychosis; and
vi. Delay or reduce the severity of the onset of psychosis.

The current REACH program utilizes the PIER Model for program fidelity. All services provided in the REACH program are guided by the practices and requirements as described by the PIER Model. Program components include:

i. Universal Community Education
ii. Targeted Multicultural Outreach and Training
iii. Community-based Interventions
iv. Multi-family Support Groups
v. Peer Support Services
vi. Supported Employment and Supported Education
vii. Benefits Assistance and Social Services Navigation

The REACH program utilizes the logic model listed below:



4. Clients Served & Annual Cost per Client Data

Direct Service Sponsored & Unsponsored Only
All Expenses (Direct Service + Outreach + Cost)

FY 2023		
Unduplicated N = 129		
Number Served	Program Expenditure	Cost per Person
129	**$ 2,116,516.63**	**$ 16,407.11**

5. Evaluation Activities

❖ MHSA PEI Outcomes

i. Consumers will reduce or prevent Suicide Risk. (CANS item: Suicide Risk)
ii. Consumers will remain out of juvenile justice involvement and Incarceration. (CANS items: LFD Delinquency and Legal)
iii. Consumers will attend school to prevent School Failure or Drop out. (CANS item: School Attendance)
iv. Consumers will improve or maintain job functioning to prevent Unemployment. (CANS Item: Job Functioning)
v. Consumers will maintain in-home and prevent Homelessness. (CANS Item Residential Stability)
vi. Caregivers will reduce the risk of Removal of Children (CANS items: CGSN Safety and Supervision)
vii. Consumers will reduce or prevent Prolonged Suffering. (CANS domain Behavioral Emotional)

❖ County Outcomes

i. Decrease the percent of open consumer no shows to 25%
ii. Consumers will discharge successfully.
iii. Consumers will be admitted into program within 7 business days to improve timely access.

❖ Additional Program Specific Outcomes

i. Increase knowledge, awareness, and early detection of early signs of psychosis in the community;
ii. Increase access to services;
iii. Change in behavior and decision making;
iv. Strengthen the system of care's ability to identify youth and young adults who are at CHR-P and link them to early intervention programs;
v. Consumers will reduce Anxiety (CANS item: BEN Anxiety); and
vi. Consumers will reduce Psychosis (CANS item: BEN Psychosis).

6. Demographic Fata FY 2023

(Note: Decision support data indicated information which may differ from the provider level PEI reports)

Age Group	# Served	% of Served
0 – 15 years	50	39%
16 -25 years	77	60%
26- 59 years	2	1%
60+ years	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	129	100%

Race	# Served	% of Served
American Indian or Alaska Native	2	2%
Asian	10	7%
Black or African American	7	5%
Native Hawaiian or Other Pacific Islander	0	0%
White/ Caucasian	15	12%
Other	64	50%
More than one race	0	0%
Prefer not to answer	2	2%
Unknown	29	22%
Unduplicated Total	129	100%

Ethnicity	# Served	% of Served
Hispanic or Latino:		
Caribbean	0	0%
Central American	0	0%
Mexican/ Mexican American/ Chicano	0	0%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	71	56%
Other Hispanic/ Latino	0	0%
Hispanic or Latino Subtotal	71	56%
Non-Hispanic or Non-Latino as follows:		

African	0	0%
Asian Indian/ South Asian	0	0%
Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%
European	0	0%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Non-Hispanic/ Non-Latino (undefined)	0	0%
Other Non-Hispanic/ Non-Latino	29	22%
Non-Hispanic or Non-Latino Subtotal	0	0%
More than one ethnicity	0	0%
Prefer not to answer	0	0%
Unknown	29	22%
Unduplicated Total	129	100%

Gender (Assigned at Birth)	# Served	% of Served
Male	50	39%
Female	79	6%
Prefer not to answer	0	0%
Unknown	0	0%

Unduplicated Total	129	100%

Gender (Current)	# Served	% of Served
Male	0	0%
Female	0	0%
Transgender (Male to Female)	0	0%
Transgender (Female to Male)	0	0%
Transgender (Undefined)	0	0%
Genderqueer	0	0%
Questioning or Unsure	0	0%
Another gender identity	0	0%
Prefer not to answer	0	0%
Unknown	129	100%
Unduplicated Total	129	100%

Sexual Orientation	# Served	% of Served
Gay or Lesbian	0	0%
Heterosexual/ Straight	0	0%
Bisexual	0	0%
Questioning/ Unsure	0	0%
Queer	0	0%
Another sexual orientation	0	0%
Prefer not to answer	0	0%
Unknown	129	100%
Unduplicated Total	129	100%

Primary Language	# Served	% of Served
English	89	69%
Spanish	28	22%
Vietnamese	4	3%
Chinese	1	1%
Tagalog	0	0%
Farsi	0	0%
Other	0	0%
Prefer not to answer	0	0%
Unknown	7	5%
Unduplicated Total	129	100%

Military Status	# Served	% of Served
Active Military	0	0%
Veteran	0	0%
Served in Military	0	0%
Family of Military	0	0%
No Military	23	18%
Prefer not to answer	0	0%
Unknown	106	82%
Unduplicated Total	129	100%

Disability*	# Served	% of Served
Difficulty seeing	0	0%
Difficulty hearing or speaking	0	0%

Other communication disability	0	0%
Cognitive	0	0%
Physical/ Mobility	1	1%
Chronic Health Condition	0	0%
Other non-communication disability	26	20%
No Disability	0	0%
Prefer not to answer	0	0%
Unknown	102	79%
Unduplicated Total	129	100%

*Participants may choose more than one option for Disability.

7. Referrals

Number of individuals with serious mental illness referred to treatment. (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	Kind of treatment to which the individual was referred	Number of individuals who followed through on the referral and engaged in treatment. (for treatment that is provided, funded administered, or overseen by county mental health)	Average duration of untreated mental illness. (for referrals to treatment that are provided by or overseen by county mental health)	Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation. (for referrals to treatment that are provided by or overseen by county mental health)
75	Individual and family therapy, Case management, Medication support, Crisis intervention, Psychoeducation	29	Unknown/Not Identified	5-7 days

8. Group Services Delivered

Unduplicated N= 47		
Number of Groups	Attendance	Average Attendance per Group
36	47	6

9. Detailed Outcomes

❖ CANS Outcome Measures FY 2023

FY 2023 CANS Successful Discharges (Negative % Equals POSITIVE Change and 0% Equals No Change)

CANS								
YBEN First CANS	**YBEN Last CANS**	**YBEN % Change**	**YRB First CANS**	**YRB Last CANS**	**YRB % Change**	**LDF First CANS**	**LDF Last CANS**	**LDF % Change**
33	29	-12%	10	7	-30%	29	26	-10%

Notes: (1) YBEN - Youth Behavioral Emotional Needs, YRB - Youth Risk Factors, LDF - Life Domain Functioning; (2) Source: FY23 Child and Adolescent Needs and Strength Questionnaire (CANS).

i. Consumers demonstrated a 12% improvement in behavioral and emotional well-being as evidenced by the CANS Behavioral and Emotional domain scores.
ii. Consumers demonstrated a 30% improvement of risk factors as evidenced the CANS Youth Risk Factors domain scores.
iii. Consumers demonstrated an 10% improvement in their daily life functions as evidenced by the CANS Life Functioning domain score.

❖ FY2023 Discharges

Unduplicated N=17	
Successful Discharge	76%
Administrative Discharge	0%
Other Discharge	24%

Source: BHSD A&R Dashboard Report

i. During FY2023, there were a total of 17 discharges from the REACH program with 13 total successful discharges, 0 administrative discharges, and 4 other discharges.

10. Evaluation Summary

❖ FY23 Program Successes Included:

i. REACH continued focus on collaboration between both provider agencies to streamline and strengthen support pathways during an increase in staffing vacancies during FY23.
ii. Outreach efforts continued with a focus on engaging local hospital and medical providers, diverse community organizations, education providers, and community based behavioral health providers across the county to increase awareness of the REACH program.
iii. Completion of updated printed materials, marketing videos, website updates, and social media outreach
iv. Addition of housing sustainability funds through a partnership with the Office of Supportive Housing; 21 REACH clients and families received funds for eviction prevention, securing of new housing, and utilities assistance during FY23.
v. Increased participation in group support sessions by clients and families.
vi. Continued use and advocacy for early screening tools to be implemented across different service teams within the System of Care.

❖ FY23 Program Challenges Included:

i. Referrals for program support were overall decreased this FY with many referrals of consumers experiencing either higher or lower level of service need, outside of PEI which required consumer connection to other targeted services within the system of care.
ii. Staffing turnover and vacancies across the behavioral health system of care have impacted consumer wait times when requiring referral to a higher level of care across the SOC. Staff vacancies and turn-over have directly impacted the REACH program capacity during FY23 as well.
iii. System-wide changes relating to payment reform, documentation standards, and staffing certifications were noted as a challenge during FY23.

❖ FY23 lessons learned included:

i. Place importance on relationship building with community partners including expanding outreach to organizations where at-risk youth frequent.
ii. Continue focusing outreach to diverse communities, faith-based organizations, and service providers in under-served communities to increase awareness of both REACH programs and screening tools for CHR-P.
iii. There is a need for maintenance support for consumers post CHR-P program discharge within either the system of care or externally using resources of clients health plan providers.
iv. Development and implementation of a “psychosis support continuum” within the REACH program.

❖ FY23 example of consumer success:

During FY23, a client was referred to REACH with severe suicidal behaviors, problems coping with daily activities, and social/interpersonal problems. The client experienced challenges due to symptoms of depressed mood, excessive anxiety, and psychosis symptoms which got in the way of completing daily tasks, work, and maintaining social relationships. The client often experienced severe hypervigilance and expressed fear of others. The client experienced stressful family dynamics and unstable housing challenges from an early age. Over the course of services, the client worked with therapist, occupational therapist, case manager, and psychiatrist. Through the services offered, the client explored, developed, and practiced use of coping skills when faced with anxious or stressful situations. Skills developed included grounding techniques, sensory self-soothing skills, mindfulness, positive imagery, and progressive muscle relaxation. The client received

occupational therapy support which provided skill development strategies such as scheduling daily plan by using a calendar, creating a home maintenance schedule to provide distraction, exploring relaxation hobbies, and development of self-care activities. The client demonstrated motivation to change along with self-improvement through attending nearly all scheduled appointments with REACH team and using skills developed while working with the team. The REACH team organized a graduation ceremony with client where the team presented a certificate and reflected to the client about growth and accomplishments while involved in REACH. Through the use of skills learned and support of the REACH team, the client was able to reach their goals and shared feeling more positive about the future.

11. Outreach Activities

Type of Setting (i.e. school, community, etc.)	Type of Responders (I,e. principals, teachers, parents, medical staff, etc.)	Number of attendees
Schools	School counselors, superintendents, Wellness center staff,	162
Community mental health – Clinics	Mental health clinicians, program managers	114
Medical (physical) – Clinics	PCPs, pediatricians, social workers, other medical staff	96
Psychiatry – Clinics	Psychiatrists, therapists,	206
County staff – Community	Case managers, social workers, call center staff, peer support workers,	148
Resource fairs – Community	Homeless, low-income community	263

Integrated Prevention Services for Cultural Communities (IPSCC)

PEI Early Intervention Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

IPSCC/Integrated Behavioral Health Program (IBH Program) is integrated within AACI's and Gardner Family Health Federally Qualified Health Center and works collaboratively with primary health care providers to support the wellbeing of patients. The IBH program is based on the IMPACT model, an evidence-based approach to integrated treatment. Also known as the Collaborative Care Model, this approach utilizes a team-based perspective that emphasizes the importance of care coordination in supporting clients struggling with behavioral health challenges. The model also allows us to take a patient-centered perspective that acknowledges clients' complex needs that can include behavioral health, physical health, as well as needs related to social determinants of health. The program also effectively use consultation with primary care providers to ensure they are meeting client's needs for care.

Primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and general healthcare needs. Integrated care offers a systematic coordination of general and behavioral healthcare. This program intends to: 1) Provide outreach and services to people 16 and older; and 2) implement an integrated behavioral health services model within local Federally Qualified Health Centers that serve underserved ethnic minorities building on successes from previous years. In light of new MHSA PEI regulations, programs in this category are now tasked with collecting, analyzing and reporting on actual program impact, referrals to care, and fulfill specific project outcomes based on specific deliverables. The target population for these services is adults/ older adults at risk of mental health issues instead of those already experiencing mental health problems. BHSD proposes six sites for this modified project with the intent to release Requests for Proposal (RFP) in September 2018. The six sites will serve the needs of individuals in the mild to moderate range.

2. Program Indicators

The Integrated Behavioral Health program aims to support clients in accessing services in a timely manner to minimize prolonged suffering related to mental health challenges such as low mood and anxiety. By accessing appropriate services, whether counseling or case management support, early on before challenges become exacerbated, we aim to prevent further decline and help clients to maintain functioning in various areas of their lives. In collaboration with Palo Alto University, the program actively revising and updating our clinical guidelines, policies, and documentation related to suicide screenings, risk assessments, and interventions to include a cultural lens. This can be seen by our incorporation of cultural idioms of suicide distress and application of the Cultural Assess of Risk for Suicide (CARS).

Historically, underserved ethnic minorities do not reach out for assistance to address their mental health needs as stigma has always played a negative role when it comes down to accessing services. For decades the best way to access and decrease stigma has been through the primary care settings especially for the Latinx community where seeking mental health services is often discouraged. This often leads to prolonged suffering as many individuals suffer in silence and only seek out services when they start experiencing psycho somatic

symptoms. By having bilingual/bicultural staff that reflects the populations being served, patients are more likely to open up during their primary care visits. Peer mentors and behavioral health clinicians can help address issues related to stigma by normalizing their reasons for their visit and offering mental health services from a setting that they are already familiar with. While participating in their integrated behavioral health visits, patients can address traumas, learn coping skills, and begin recovery of their prolonged traumas.

3. Program Goals, Objectives & Outcomes

This program intends to 1) Provide outreach and services to people 16 and older; and 2) Implement an integrated behavioral health services model within local Federally Qualified Health Centers that serve underserved ethnic minorities building on successes from previous years
Outcomes 1: Consumers and the members of their support networks are supported in accessing the services they need to support their recovery and wellness.
FY21-FY23

i. Culture and diversity needs
ii. Consider the need for a broader offering of post crisis intervention
iii. Assess points of coordination and collaboration

The goal of the program is to improve access for immigrant, refugee, and cultural communities to behavioral health services by providing them as an integrated part of our Health Center and to improve emotional, physical, and overall wellbeing. By having immediate access to low-intensity mental health services, patients can learn about and use these services in a non-stigmatizing setting, with someone they trust, who understands their culture and speaks their language. Early access to these services also has implications for better overall health outcomes, addressing chronic illness, and identifying and addressing all the patients' needs in a holistic manner. We also aim to remove barriers to primary care and challenges around navigating a complex healthcare system, which can be obstacles to care.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 201		
Number Served	Program Expenditure	Cost per Person
754	**$ 1,345,719.91**	**$ 1,784.77**

*Cost per person is calculated using number of clients served

5. Evaluation Activities

The IBH program aims to increase access for cultural communities and reduce barriers that may exist for patients who may be reluctant or hesitant to engage in services. We utilize several strategies to improve timely access to clinical services for underserved populations. First, we have a screening workflow that aims to screen all incoming referrals within 48 business hours to assess service needs and rule out any existing risk factors. The screening process also includes a brief assessment of immediate case management needs to determine if there are any challenges related to social determinants of health, such as employment, housing, or transportation. For

example, if a client reports a financial challenge that is limiting their ability to access healthy foods, IBH staff may connect clients to local food banks, senior nutrition programs, or provide information on how to connect to CalFresh benefits. The Patient Navigation team helps clients navigate their insurance and health care services as well as provides linkage to community resources, and we have multiple wellness programs for youth and seniors that help to build community and support recovery and growth. Supporting clients to manage their basic needs as well as needs for community and safety contributes to overall wellness for clients.

The current system that is set up for patients to access services is a "no wrong entry" approach which allows patients to be referred from any department within the clinic as well as being self-referred. The approach that tends to create the higher volume of referrals comes from the primary care visits as patients are all screened using the PHQ-2 and PHQ-9 screening tools which stimulates conversation between the provider and the patients about their mental health needs. Currently, patients are also being referred by other departments such as dentistry, chiropractic, optometry, etc. Once a patient agrees to a referral to the behavioral health department a peer partner conducts a warm hand off where patients are explained the scope of services and discuss what they can expect from participating in the behavioral health department. Once a patient meets with a behavioral health clinician for an assessment, together they decide if the patient is a good fit for the program or if the patient needs to be referred to a higher level of care such as specialty mental health services. Whether the patient remains with the IBH services or is referred out to the call center, the clinicians also address the patient's case management needs by providing on the sport linkages to basic needs such as: housing, transportation, shelters, domestic violence resources, legal resources etc. depending on the needs of the patient.

Strategies: Improving Timely Access to Services for Underserved Populations

The program has a policy when it comes to timely access to services which is 10 days from the time that the peer partners receive the referral from which ever referrals source. Currently, the program has been very high success rate in engaging patients to the program. During those 10 days the peer partners must make three attempts to introduce the patient to services which includes: two phone calls and a contact letter. If a patient does not reply within those ten days the referral is closed, however if a patient contacts the peer partner after the ten-day mark the patient will still be seen by one of the IBH providers.

Evidence-based practice standard or promising practice standard

Currently the clinical staff is using an array of evidence-based practice modalities that have been proven to be effective in the primary care setting. These include psycho education, cognitive behavioral therapy, and solution focused brief therapy. The guiding principle is that only evidence-based interventions should be used. Each IBH clinician has the individual responsibility to stay abreast of current research in the field, to obtain continuing education in necessary subjects, and to practice within his/her scope of expertise. IBH clinicians and the IBH program in general should be a shining example of adherence to effective, research-based services; most importantly to provide quality services to our patients, but also to provide accurate education to the PCPs regarding best practices for BH problems.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	*0*	*0%*
16 -25 years	*199*	*26%*
26- 59 years	*426*	*56%*

60+ years	*129*	*17%*
Prefer not to answer	0	0
Unknown	0	0
Unduplicated Total	754	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	*2*	*0%*
Asian	*75*	*10%*
Black or African American	*8*	*1%*
Native Hawaiian or Other Pacific Islander	*2*	*0%*
White/ Caucasian	*188*	*25%*
Other	*224*	*30%*
More than one race	*2*	*0%*
Prefer not to answer	*10*	*1%*
Unknown	*244*	*32%*
Unduplicated Total	*754*	*100%*

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino: (Header)		
Caribbean	*0*	*0%*
Central American	*28*	*4%*
Mexican/ Mexican-American/ Chicano	*295*	*39%*

Puerto Rican	*0*	*0%*
South American	*25*	*3%*
Hispanic/ Latino (undefined)	*47*	*6%*
Other Hispanic/ Latino	*104*	*14%*
Hispanic or Latino Subtotal	*499*	*66%*
Non-Hispanic or Non-Latino as follows:		
African	*2*	*0%*
Asian Indian/ South Asian	*4*	*1%*
Cambodian	*0*	*0%*
Chinese	*1*	*0%*
Eastern European	*1*	*0%*
European	*3*	*0%*
Filipino	*5*	*1%*
Japanese	*0*	*0%*
Korean	*1*	*0%*
Middle Eastern	*3*	*0%*
Vietnamese	*1*	*0%*
Non-Hispanic/ Non-Latino (undefined)	*118*	*16%*
Other Non-Hispanic/ Non-Latino	*29*	*4%*
Non-Hispanic or Non-Latino Subtotal	*168*	*22%*
More than one ethnicity	*0*	*0%*
Prefer not to answer	*2*	*0%*
Unknown	*85*	*11%*

Unduplicated Total	*754*	*100%*

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	*180*	*24%*
Female	*574*	*76%*
Prefer not to answer	*0*	*0%*
Unknown	*0*	*0%*
Unduplicated Total	*754*	*100%*

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	*157*	*21%*
Female	*541*	*72%*
Transgender (Male to Female)	*1*	*0%*
Transgender (Female to Male)	*0*	*0%*
Transgender (Undefined)	*0*	*0%*
Genderqueer	*0*	*0%*
Questioning or Unsure	*0*	*0%*
Another gender identity	*0*	*0%*
Prefer not to answer	*0*	*0%*
Unknown	*55*	*7%*
Unduplicated Total	*754*	*100%*

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	*10*	*1%*
Heterosexual/ Straight	*620*	*82%*

Bisexual	*16*	*2%*
Questioning/ Unsure	*1*	*0%*
Queer	*3*	*0%*
Another sexual orientation	*2*	*0%*
Prefer not to answer	*13*	*2%*
Unknown	*89*	*12%*
Unduplicated Total	*754*	*100%*

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	*363*	*48%*
Spanish	*321*	*43%*
Vietnamese	*5*	*1%*
Chinese	*36*	*5%*
Tagalog	*1*	*0%*
Farsi	*8*	*1%*
Other	*14*	*2%*
Prefer not to answer	*0*	*0%*
Unknown	*6*	*1%*
Unduplicated Total	*754*	*100%*

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	*0*	*0%*
Veteran	*2*	*0%*
Served in Military	*1*	*0%*
Family of Military	*2*	*0%*
No Military	*501*	*66%*
Prefer not to answer	*0*	*0%*
Unknown	*248*	*33%*

Unduplicated Total	*754*	*100%*

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	2	0%
Difficulty hearing or speaking	1	0%
Other communication disability	0	0%
Cognitive	6	1%
Physical/ Mobility	9	1%
Chronic Health Condition	16	2%
Other non-communication disability	19	3%
No Disability	371	49%
Prefer not to answer	1	0%
Unknown	329	44%
Unduplicated Total	754	100%

*Participants may choose more than one option for Disability.

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)

Number of clients referred to treatment overseen by County mental health: 248 1 patient referred to Kaiser 2 patients referred to private therapist	• Santa Clara County Behavioral Health Call Center -Mental Health • Santa Clara County Behavioral Health Call Center – Substance Use Program • Santa Clara Family Health Plan In Network Mental Health Providers • Domestic Violence Shelter and Advocacy Programs • Dietician • Psychiatric Evaluation for Medication Management • Korean American Community Foundation Program	Not available	Not available	Not available

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
8	8	2

9. Detailed Outcomes

AACI:

Outcomes	**Total FY23**
Percentage of unduplicated patients screened for PHQ-9	**81.9%**
Percentage of unduplicated patients screened for Generalized Anxiety Disorder 7 (GAD-7) at intake.	**76.7%**
Percentage of patients who engage in IBH services that show 1 point reduction in score as indicated in PHQ-9 from intake to discharge.	**39%**
Percentage of patients who engage in IBH services that show 1 point reduction in score as indicated in Generalized Anxiety Disorder 7 (GAD-7) from intake to discharge	**40.1%**
Percentage of IBH patients who are prescribed antidepressants or antianxiety medication who also receive care coordination service.	**44%**

Client Satisfaction Survey (Total: 13 responses collected)	Total FY23
AACI Services are easy for me to access	Strongly agree and agree: 92.3%
It is easy for me to schedule or change an appointment	Strongly agree and agree: 100%
I feel like my team (i.e. counselor, PCP, Patient Navigator) works together to support me.	Strongly agree and agree: 92.3%
I receive services in my preferred language.	Strongly agree and agree: 100%
I like the services that I receive.	Strongly agree and agree: 100%
I would recommend this agency to a friend or family member if they needed help or services.	Strongly agree and agree: 100%
The staff respects and understands my cultural background (race, religion, language, etc).	Strongly agree and agree: 100%
I am actively involved in deciding my treatment goals.	Strongly agree and agree: 100%
The services I receive from AACI have helped me to better handle/cope with life.	Strongly agree and agree: 100%
Overall, I feel better as a result of my services at AACI.	Strongly agree and agree: 100%

Gardner: annually: Unduplicated numbers served contracted 200.
Average 6 months length of stay (LOS)
Numbers of unduplicated served FY23: __553__
Numbers of duplicated served FY23: ___743___
During this reporting year July 1, 2022– June 30, 2023, a total of 553 unduplicated patients were served. Please keep in mind that some patients had a length of stay of over 180 days and may have received services for more than one quarter. Some patients may also have chosen to reinitiate IBH services and therefore, these patients may have had an intake and were discharged more than once. Some patients were seen for only one encounter and were referred to a higher level of care. As a result, the total for all four quarters combined and duplicated patients served was 743. In the Detailed Outcomes Tables below, we report the duplicated count to account for having an open door policy, which allows patients to come back and resume services as needed. We also report the unduplicated/unique patient count for comparison.
This summary description will focus on the duplicated count due to the reasons stated above. In FY 23, about 82% of patients had a PHQ-9 screening done at intake and about 76% of patients had a GAD-7 screening done at intake. As mentioned in previous quarters, due to the inconsistent workflow issues, some patients had missing screenings at intake. Please also keep in mind that a GAD-7 screening is only done for patients who present with symptoms of anxiety.
There were a total of 365 discharges throughout the entire year. Out of the 365 discharged, there were 307 unique discharges. Out of the discharges, 100 patients were referred to a higher level of care. Additionally, in FY 23, about 45.2% of discharged patients reported decreased symptoms indicated through at least a one

point reduction in their PHQ-9 score. Furthermore, about 37% of discharged patients reported decreased symptoms indicated through at least a one point reduction in their GAD-7 score at discharge.

This year's data collection was particularly difficult due to our transition to Epic in late September 2022. We had clinicians document their caseload and all patient outcomes manually via an Excel sheet since our workflows and reporting tools in Epic took time to develop and standardize. Overall, it was difficult to keep track and reconcile patient data between two different systems.

Please note that when a patient is discharged successfully, the IBH clinician does not change the diagnosis from intake to discharge. IBH clinicians are trained to keep the same diagnosis even at termination. In reality, these patients were successfully discharged and had a reduction in their screening score. The reasons for a successful discharge can range from the following: the patient is symptom free, the patient has successfully completed their treatment plan goal, the patient has reached their limit of sessions and it was mutually decided that therapy was to be terminated because the patient has shown improvement in their symptoms as indicated by their score. The remaining discharged patients not accounted for in the numerator had either no change in score, did not improve, or had an incomplete score.

Lastly, out of all the IBH patients served in FY 23, about 11.5% of patients were prescribed anti-depressant or anti-anxiety medication and received care coordination services.

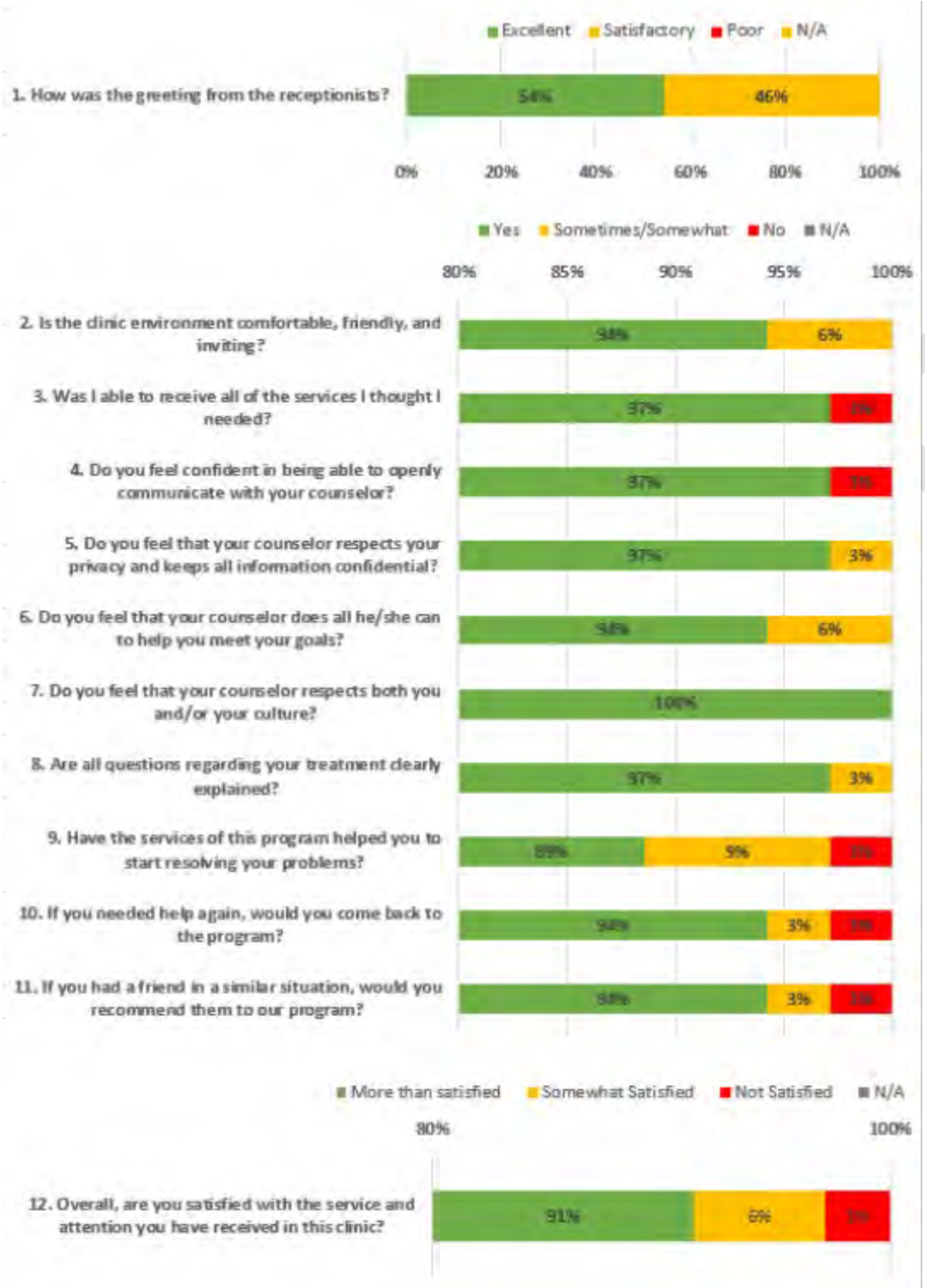
Outcomes	FY 2023 Totals
Number of clients needing referrals to BHSD	***100 clients over 4 quarters*** ****this includes duplicated count due to IBH's Open Door Policy and some clients re-initiating services. Therefore, certain clients may have been referred multiple times.***
Open cases	**743** open cases, but **553** unduplicated patients in total
Number of clients above 180 days	**72 unique clients** ****this is unduplicated***
Number of discharges	**307 unique patient discharges** **365 total discharges**

Detailed Outcomes for FY 23	FY23 (***unduplicated***) total percentage
1. Percentage of unduplicated patients screened for PHQ-9 at intake.	423 **unique** patients had an intake in FY 23. 347 patients had PHQ-9 screening done. 347/423 = **82% patients screened**
1. Percentage of unduplicated patients screened for PHQ-9 at intake.	423 **unique** patients had an intake in FY 23. 347 patients had PHQ-9 screening done. 347/423 = **82% patients screened**

2. Percentage of unduplicated patients screened for Generalized Anxiety Disorder 7 (GAD-7) at intake.	423 **unique** patients had an intake in FY 23. 320 patients had GAD-7 screening done. Note: Patients are only given a GAD-7 screening if they report anxiety symptoms. 320/423 = **76% patients screened**
3. Percentage of patients who engage in IBH services that show 1 point reduction in score as indicated in PHQ-9 from intake to discharge. Numerator -number clients with one point reduction in PHQ-9 Denominator – # of Clients with depression diagnosis who are discharge at that quarter.	307 unique patients were discharged in FY 23. 139/307 = **45.2% improved**
4. Percentage of patients who engage in IBH services that show 1 point reduction in score as indicated in Generalized Anxiety Disorder 7 (GAD-7) from intake to discharge. Numerator -number clients with one point reduction GAD-7 Denominator – # of patients with anxiety diagnosis who are discharge at that quarter.	307 unique patients were discharged in FY 23. 114/307 = **37% improved**
5. Percentage of IBH patients who are prescribed antidepressant or anti-anxiety medication who also receive care coordination service.	553 unique patients served in FY 23. 64 unique patients on AD or AA medication 64/553 = **11.5% patients on AD or AA medication**

For the purposes of evaluating patients' satisfaction with their experience in the IPSCC program a total of 35 patients were contacted during the fourth quarter and a satisfaction questionnaire survey was conducted that consisted of 12 questions and here are the results:

Client Satisfaction Survey Results for St. James, and South County (n = 35)



10. Evaluation Summary

❖ AACI

i. **Program Success (can include client stories/experiences):**

Our two major successes this fiscal year includes our transition to a new electronic health records system, Epic, and our increase in collaboration with our partners within the agency. Since our transition to Epic from November 2023, there has been an increase in care coordination and case consultations amongst the care team. As the

pandemic regulations allowed for more in-person visits, our PEI-IPSCC team members have made themselves available for warm hand-offs with health care providers and participate in on-site team huddles. Our PEI-IPSCC team has been actively involved in utilizing our agency wide care coordination bi-monthly meetings, allowing us to partner with representatives from our domestic violence shelter, housing, and advocacy program, Enhanced Case Management program, and Mental Health and Health Center departments to leverage internal resources to assist with addressing complex needs and provide comprehensive care to our clients.

ii. Program Barriers and implementation challenges:

Our client referrals are predominantly from the health center. Staffing changes within the health center would impact care coordination and referrals. There has been an increase in health acuity with patients referred to PEI-IPSCC during the pandemic this fiscal year. With multiple health complications, there has been an increase in patients' hospitalizations and surgeries that contribute to an increase in missed appointments or delays in resuming services. We engage in continuous quality improvement with our partners in the health center to coordinate the best approach to address these challenges.

- **Success Stories:**

Client 1: Client is an older adult, monolingual Mandarin speaking male with a complicated medical history referred for counseling services for depressive symptoms associated with feeling as a burden on his family. Client presented with symptoms of depressed mood, anxiety, isolation, feelings of hopelessness, and suicidal ideation. Client was paired with a provider who was able match his language and culture, which likely contributed to the development of trust. After a few sessions, the client was able to report steady improvements in his mood, reduced suicidal ideations, and increase in hope. This also translated to the client feeling more motivated to partner with his medical team to address his physical health.

Client 2: Client is 17 year old, monolingual Spanish speaking female referred by her primary care provider for anxiety. Client struggled in school and connecting with peers. After engaging in therapy sessions, she was able to learn healthy coping strategies and have a better understanding of her symptoms. Client has expressed feeling proud of her accomplishments as her grades significantly improved. She has been nominated by two teachers for an annual student award. Her improvement in managing her anxiety skills have also allowed her to build new friendships and feel more satisfied with her social life.

- **Gardner: Implementation Challenges/Program barriers:**

One of the biggest challenges faced during the FY 22-23 that the IPSCC Program faced were systemic changes that were brought upon by the implementation of the new electronic health records system. There was a lot of preparation involved during this time period to organize, train, and practice the new system in preparation for a "go live" date of September 27th, 2022. During the "go live" transition patients experienced longer wait times to be seen as the staff who registered patients were fairly new on the execution of the functions with EPIC which replaced the NextGen System.

During the second quarter the fact that a new system was being used caused minor contretemps for the HIT department and the DATA department to focus on developing work flows for data collection as the focus turned to patient care e.g. developing work flows for different departments in the primary care side. During this time period many meetings took place to discuss ways of improving data collection for reporting purposes. As a result, the information collected for this report was a combined effort between existing work flows for the data department and assistance from the clinicians who recorded data in order to ensure the validity and accuracy of the presented data.

One challenge that the IPSCC Program faced throughout all the quarters is that many patients referred to the call center continue to experience significant delays in accessing outpatient services which ranged from a few

weeks to a few months. The IPSCC clinicians continued to provide services in the interim to ensure that patients were receiving care while they waited and also to prevent patients from losing interest and motivation in continuing their healing process. IPSCC clinicians found themselves having to advocate and make multiple calls to ensure that patients got into the specialty system of care. Often times, patients lost interest and they either requested an extension in working with the IPSCC staff or they dropped out of services as they lost motivation. Another challenge was that the HIT team and the billing team did not solidify a work flow that facilitates the access to My Avatar, which can delay patients being opened in a new outpatient setting while the patients are open in the IPSCC program.

Another challenge that the program continues to face, is that many of the patients being served met medical necessity to participate in the program and had private insurance through The Covered California Program, which limited their ability to access specialty mental health services if these services were warranted. At the discretion of the clinician, if patients in this situation appeared to benefit from a higher level of care, these patients would typically be referred to the call center for a referral to specialty mental health services. But because of their insurance type, the call center turned them down and re-directed them to contact their insurance for a referral. In these instances more often than not, these referrals made through the private insurance were not able to provide them with the appropriate resource as they do not have access to local psychiatrists, local therapists, or access to services in their native language. Thus, many of these patients ended up on the program longer than usual until the peer partners or clinicians were able to secure a referral that met the patient's needs.

- **Lessons Learned:**

It was a top priority for the IPSCC program to prepare for the transition in electronic health records therefore, as a department we were proactive and developed a plan for the switch. All acute and at risk patients were scheduled during this period to ensure that there was no patient disruption in their care. The remainder available time was designated to new cases taking into account their acuity, severity as they were all triaged. In addition, the IPSCC worked in collaboration with the Data Team Department to develop reports of active patients to ensure that all patients were transferred into the new system and that follow up appointments were available to them. This helped minimize any disruptions in patient care and mitigated the risk of patients not receiving follow up care.

Despite the changes in the electronic health records, the IPSCC continued to thrive in meeting productivity as the existing clinicians' schedules slowly filled up with new and existing patients. During the switch the program continued working on providing a "hybrid" model of care that enabled patients to receive services in their preferred mode of service e.g. face to face sessions or tele phone sessions. This allowed the clinicians to meet the patient's mental health needs as many of them have verbalized being grateful for not having to physically come into the sites for services. Many of them verbalized that obstacle like traffic, expensive gas/transportation costs, etc. can often hinder their ability to access mental health services.

Another lesson learned which has been ongoing even before the onset of the pandemic is the need for advocacy from the IPSCC staff and from the patients themselves. Often times, patients present with a plethora of basic needs that can include any of the following: rental assistance, utilities assistance, securing employment or accessing government aid programs. Most often than not, the IPSCC staff needed to advocate by making phone calls with the patients in order for them to access and secure these services. The IPSCC staff is constantly being encouraged to participate in collaboration events and networking opportunities to help enhance the access to the multitude of services available to the patients in the community.

Lastly, another lesson learned during the latter part of the FY 22-23 was that many of the meetings in the clinics became mandatory to be face to face rather than through the use of ZOOM or other platforms. This was very important turning point as the IPSCC staff started connecting with colleagues and started participating in monthly staff meetings with the medical providers which help promote a sense of integration and camaraderie.

During these meetings the clinicians and providers learn about each other and how to best support the overall well-being of the patients and this helped promote a true sense of integration and coordination of services.

- **Successes (include client stories):**

During the first quarter the IPSCC program experienced multiple successes that helped enhance morale during a high stress transition period. For example, the team continued to be fully staffed and many of the staff verbalized feeling supported and having healthy levels of job- satisfaction which helped prevent employee burn out and turn over. Clinicians and peer partners alike verbalized feeling supported by the team's super user, OCHIN consultant, OCHIN trainers, and immediate supervisor which helped promote a positive learning environment. The program supervisor took into account the clinicians and peer partners' learning styles, learning curve and environmental factors that can either hinder or foster learning. Having the OCHIN staff available for the first two weeks of the transition was also very helpful as they helped navigate situations as they arose in the different sites.

Another big success during the transition of systems was the quality of communication that was exchanged during the weekly staff meetings. A reasonable part of the meeting was dedicated to identifying obstacles, identifying solutions and providing a safe place for the staff to verbalize their concerns. A huge part of the meeting was used to problem solve through operational issues that arose during that time frame and immediate supervisor and super user served as conduits between clinical staff, peer partners and the OCHIN team. The team was constantly discussing progress, setbacks and challenges in the field and together brainstormed solutions. Lastly, the team was always discussing ways of improving no shows and cancellations and worked closely with other departments to put into practice the changes discussed in the meetings.

Also during the fiscal year the entire clinical staff in the IPSCC participated in the Brief Solution Focus training which has been proven to be an effective evidence based practice in the primary care setting. The program director has been working with the training manager to provide an advanced training in the same model to help enhance the staff's professional growth. Since then the clinical staff have been using these tools to help patients meet their clinical goals in a short period of time. Additionally, the entire team participated in a Trauma Informed De-escalation Training to help whenever there is a crisis in the clinics or to assist patients in their own caseload. The program director has been advocating for everyone at every level in the entire primary care setting to be trained in Trauma Informed Care to assist patients that may show up dysregulated to their appointments. As a result, the entire primary care staff at all health centers are scheduled to participate in a training in early fall 2023.

Moreover, the satisfaction questionnaires continue to show mainly positive results in most of the different evaluation factors, which shows that patients are very content with the services they received during the fiscal year. There were a few factors that seem to have scored in the middle range however these factors were outside of the IPSCC program's control such as the greeting from the receptionist or the environment of the clinic. This information was shared with the clinic managers who have the ability to use this information for training purposes and create change.

- **Success Stories**

1) Middle aged Pt came to the IPSCC program feeling depressed, feeling there is no reason to live, having suicide ideations with no plans, means or access. At the time of the intake she was experiencing severe anxiety of being alone. Pt reported that she and her children all used to live together but for financial reasons they all had to move to different places, leaving Pt living by herself. At that time the Pt had not recovered from this, and reported having more distant relationships with her children and grandchildren. Pt reported the only way she can be in their lives is if she did whatever they want her to do , such as babysit at the "drop of a dime", and sometimes Pt had to call out of work to babysit to enable the parents to go to work. Pt reported when she

tries to set a boundary, her family would become angry, and distance themselves from her. Pt could not stand the distance, and would usually end up calling and apologizing profusely for setting a boundary with the intention of having her back into their lives.

At the time of discharge Pt learned how to value and respect herself. Pt learned how to see the unhealthy patterns in these relationships, and that those who truly care for her will accept her boundaries. Pt learned how to put this to the test and experienced success in some of her relationships, in which her boundaries were respected and relationships are still intact. Pt reported that she realize she does not deserve to be mistreated by others or manipulated in any way. Pt realized she does not want to continue to put herself in that position and learn how to assert her needs. Pt used to be afraid of the repercussions of this but realized continuing to put herself in abusive situations only caused her to feel worse, and now Pt feels more receptive in establishing boundaries, understanding that others may respond negatively, but that she has to do this for herself. Pt learned to understand that it is a learned behavior and others have learned that their manipulation of her gets them what they want, and Pt learnt to understand this can also be un-learned and by respecting herself they can also learn to respect her.

Elders Storytelling Program

PEI Early Intervention

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The Elders' Storytelling Program at Gardner and Asian American CI Community Contracted Provides serves isolated older adults with mild to moderate depression using the culturally proficient technique of life review and storytelling (reminiscence) and incorporating innovative service components to help reduce the elder client's depressive symptoms and restore their position of social connectedness with their family, friends, caregivers and community.
Status: Continuing
Population: 60+ year old adults who reside in Santa Clara County
Service category: PEI: Early Intervention

2. Program Indicators

i. Suicide – Providers utilize several assessments to determine client's level of depression and the risk for suicide. If there is a concern, providers refer the client to outpatient therapy and psychiatric services provided in the community. If necessary, they can also refer clients to inpatient psychiatric services or request a 5150.
ii. Unemployment - Providers check the employment situation of clients, and when they express a desire for help finding employment, providers can refer them to employment agencies in the community.
iii. Prolonged suffering – Through reminiscence, providers help clients change their focus in order to alleviate some of their suffering. The program helps them dwell on the happy, meaningful, and fulfilling times in their life, rather than the negative experiences and pain of their past that increase their suffering.
iv. Homelessness – Providers maintain awareness of the risk of homelessness for their clients, and when appropriate, they can refer clients to housing resources in the community.

3. Program Goals, Objectives & Outcomes

❖ Goals

The goal of the program is to support elders who are isolated and have mild to moderate depressive symptoms. Integral to the success of the model is the incorporation of the language, culture and life experience of the clients served. Each client shares his/her story as it is elicited and documented by the mental health specialist who whenever possible speaks the client's first language and is knowledgeable of their culture and life experience. The service may include family members, has a pre- and post-treatment test component, and has a service duration of 12 weeks.

The program will produce outcomes of increased awareness and access to services in the community, decreased depressive symptoms, improved quality of life, and decreased isolation, especially for home-bound or monolingual non-English-speaking older adults.

❖ Program Objectives

Timeliness and access: client will be received services within 10 working days.
90 % of clients shall receive weekly face-to-face services from the team
80% of the clients shall receive their first face to face visit from the program team within 3 days of refferral
50% of client shall successfully be linked to outpatient services or rehabilitation and recovery services within the frist 12 months of referral, if clinically appropriate and needed.

❖ Outcomes

i. Reduce the elder client's depressive symptoms
ii. Decrease isolation for home-bound older adults by creating community connections.
iii. Restore their positive social connectedness with their family, friends, caregivers, and community.
iv. Increase self-sufficiency.
v. Participation in meaningful activities.
vi. Reduce subjective suffering from mental health illness.
vii. Develop, increase, and strengthen natural networks of supportive relationships.
viii. Reduce of psychosocial impact of trauma.
ix. Maintain or improve the overall level of functioning and self-sufficiency in the community.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 54		
Number Served	Program Expenditure	Cost per Person
112	**$428,249**	**$3,823.65**

*Cost per person is calculated using number of clients served

5. Evaluation Activities

❖ Strategies include:

i. Access and Linkage – We facilitate information and referrals to support clients' access and linkage to community resources such as mental health therapy, psychiatric services, medical services, housing agencies, support for clients with Alzheimer's or with a disability such as blindness or deafness, senior companion services, employment agencies, etc.
ii. Program helped client linkage to the community resources (e.g., housing, citizenship, etc) and access other services such as medical, dental and vision. Program also doing outreach in the community event, medical setting office and private event to reach out the isolation elder population. Program also

collaboration with other departments across systems (e.g., senior program) for outreach and provide service for diversity population.

iii. The practice's effectiveness is demonstrated according to the practice model and program design by the implementation of pre- and post- treatment assessments that can determine whether there has been an improvement in the client's mood, satisfaction with life and ability to function independently during the time of treatment. The assessment instruments used are the Daily Living Activities (DLA-20), the Patient Health Questionnaire (PHQ-9), the Geriatric Depression Scale (GDS-15), and the Satisfaction with Life scale (SWL).

iv. Services have been provided mainly in-person following health and safety protocols. Services include outreach activities, collaboration with the referral party, coordination with other professionals serving the client, consultation with managers, and meetings with clients and support people when needed. Providers have formed a strong connection and collaboration with other service providers and departments, and the Storytelling program is becoming well known in the community.

v. Improving Timely Access to Services for Underserved Populations: engaged elder immediate into the program and educated the elders about other community resources for prevention.

vi. Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory: the program applied cultural sensitivity when working with client.

The methods of measuring outcomes, should be one or a combination of the following:

i. Evidence-based practice standard or promising practice standard
    a. If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness, explain how the practice's effectiveness has been demonstrated and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program. Psychoeducation

ii. Community and or practice-based evidence standard
    a. If the County used the community and/or practice-based standard to determine the Program's effectiveness, describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program. Psychoeducation

iii. Outreach activities:
    a. Program conducted outreach at different settings, such as community and personal events, classes, presentations, workshops, libraries, women groups, event organized by Vietnamese American Round Table, Vietnam Town, Vietnamese churches, Korean churches, Lunar New Year events, AACI Health Center and Gardner Family Health Network, Senior Nutrition program and Senior Wellness Program, VMC, Samaritan health center, Inn Vision homeless shelter, shelter downtown, Milpitas City Hall, Overfelt school, SJPD safety program, Telehealth program, Stroke Awareness Workshop, event in Rincon Garden, health fair by Sunnyvale Public library, Well Check calls/information & Referral Services, Agency and Program intro services, different internal agency programs, online Zoom meetings, phone calls, etc. to reach out directly and indirectly to targeted population. Through these approaches, we have had opportunities to listen to and understand their stories, experiences, problems, struggles, etc., thus increasing our services' effectiveness. Program works with Promotores and other CCPs to outreach to beneficiaries as well.

iv. Measurements:
    a. The program measures the effectiveness by using PHQ-9 and GDS-15 pre/post assessment questionnaires and based upon clients' satisfaction and their experiences while participated in the program to work on their storybooks, how they will use the books as tools to help improve

understanding, relationship with their families, as well as increase social skills and connection with community.

b. The assessment instruments used are the Daily Living Activities (DLA-20), the Patient Health Questionnaire (PHQ-9), the Geriatric Depression Scale (GDS-15), and the Satisfaction with Life scale (SWL).

❖ Outcomes

i. Reduced the elder client's depressive symptoms.
ii. Decreased isolation for home-bound older adults by creating community connections.
iii. Restored their positive social connectedness with their family, friends, caregivers, and community.
iv. Increased self-sufficiency.
v. Clients participated in meaningful activities of creating storybook.
vi. Reduced subjective suffering from mental health illness.
vii. Increased, and strengthened natural supportive relationships with caregivers, friends, community.
viii. Maintain or improve the overall level of functioning and self-sufficiency in the community.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years		
26- 59 years		
60+ years	112	100%
Prefer not to answer		
Unknown		
Unduplicated Total	112	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	3	3%
Asian	62	55%
Black or African American		

Native Hawaiian or Other Pacific Islander		
White/ Caucasian	18	16%
Other	26	26%
More than one race	3	3%
Prefer not to answer		
Unknown		
Unduplicated Total	112	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano	23	21%
Puerto Rican	1	1%
South American	2	2%
Hispanic/ Latino (undefined)		1%
Other Hispanic/ Latino		2%
Hispanic or Latino Subtotal	26	2%
Non-Hispanic or Non-Latino as follows:		
African	1	1%
Asian Indian/ South Asian	2	7%
Cambodian	2	4%

Thai	1	1%
Chinese	8	1%
Eastern European	4	1%
European	1	1%
Filipino	1	1%
Japanese	1	1%
Korean	13	12%
Middle Eastern		
Vietnamese	32	29%
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal	18	16%
More than one ethnicity		
Prefer not to answer		
Unknown	2	2%
Unduplicated Total	112	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	34	29%
Female	78	66%
Prefer not to answer		
Unknown		
Unduplicated Total	112	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	34	29%
Female	78	66%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	112	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	1	1%
Heterosexual/ Straight	105	94%
Bisexual		
Questioning/ Unsure		
Queer		29%
Another sexual orientation		
Prefer not to answer		
Unknown	6	5%
Unduplicated Total	112	100%

	FY 2023

Primary Language	# Served	% of Served
English	25	22%
Spanish	24	21%
Vietnamese	32	29%
Chinese	9	8%
Tagalog		
Farsi	1	18%
Other	20	1%
Prefer not to answer		
Unknown	1	1%
Unduplicated Total	112	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran	3	3%
Served in Military		3%
Family of Military	3	91%
No Military	102	4%
Prefer not to answer		
Unknown	4	
Unduplicated Total	112	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	4	4%
Difficulty hearing or speaking	9	8%
Other communication disability	2	2%
Cognitive	6	5%
Physical/ Mobility	25	22%
Chronic Health Condition	11	10%
Other non-communication disability		44%

No Disability	49	5%
Prefer not to answer		
Unknown	6	
Unduplicated Total	112	100%

*Participants may choose more than one option for Disability.

7. Referrals

Referrals for the Storytelling program come directly from internal outreach efforts in the community as well as through Community Contracted providers in the area. The Storytelling Program provides 12 sessions. Following the program's model, 10 of those sessions are meant to be individual and 2 of them are meant to take place with a caregiver or a friend.

FY 2023				
Unduplicated N =112				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
4	3 clients were referred to the Older Adult program for mental health therapy and 1 client was referred to the Ethnic and Wellness program.	4	Unknown	5 days

8. Group Services Delivered

FY 2023		
Unduplicated N = N/A		
Number of Groups	Attendance	Average Attendance per Group
N/A	N/A	N/A

9. Detailed Outcomes

This fiscal year we had 112 unduplicated clients take part in the Storytelling program.
Discharge: the program discharged we closed 90 clients that terminated the program successfully. The remaining 22 clients were either open into FY24 and or administratively discharged due to health impairments.
The information for the assessments was gathered mainly by questioning the client directly provided, but providers also use their observation skills and sometimes they gather information from a relative or caregiver (with client's consent) that knows the client well. All clients met discharge goals.
Other factors that may impact outcomes include a sudden and significant deterioration on the client's physical health or the passing away of a close relative may cause the client's symptoms of depression to increase, even if they had been improving until that point.

10. Evaluation Summary

❖ Program Success

i. Outreach, networking – Since the start of the program, our continuously reaching out to community, organizations, attending events, connecting, and collaborating with internal programs, as well as engaging in personal social networks, with former clients, etc., even during the Covid pandemic have helped improve public awareness and outreach efforts, efficiently impacted and created great success to the program with surpassing expected goals.
ii. Staff performance – Program staff has continued to commit and dedicate extra efforts to the program, has kept going with research, assess and develop creatively the outreach methods through engagement with different sources and existing networks, community contacts, and enlistment of community support, has focused on increasing community's understanding about the benefits of the program, reinforced connection and establish trust with targeted population, identified seniors' needs to refine and tailor program staff's work, clarified realistic expectations, provided good guidance for sharing and collecting of photos, consulted with collaborative colleagues from different cultures, listened and stayed flexible, thus has been able to produce great quality services with meaningful information and storybooks.
iii. Internal collaboration, coordination for referrals of diverse clients – As part of the program staff's work plan, it is always essential to develop a sense of good and mutual respectful collaboration. Program staff has continued to focus on cultural competency when working with diverse colleagues and clients from various cultures, provide good teamwork, establish trust with partners and interpreters, solicit their suggestions to help avoid false move and misunderstanding as the process develops, listen to their advices so the midcourse corrections can be conducted as needed, always open to feedback and stay proactive with effective messages to clients via help from partners.
iv. Availability and capacity limitations (diverse languages) – With our current capacity, the program has been able to serve Vietnamese, Chinese, Cambodian, Korean, Japanese, Farsi, and English-speaking seniors, and other language thresholds.

❖ Challenges and barriers

Goals, participation, administrative discharges: As shared in our quarterly reports, the outreach activities and engagement level had encountered lots of obstacles and setbacks due to community and seniors' stress and anxiety about their health and social issues impacted by the Covid-19 pandemic and its prolonged times. At the same time, they were disheartened by continuing violence against them and communities of various cultures

during post-Covid, felt isolated and concerned over their own safety and families', worried about the cost of living and dismayed by inflation levels and high commodities prices as well as by many other stressors.
Generally, seniors are impacted physically, mentally, socially, emotionally, and financially in their daily living by those factors during the Covid pandemic and post-Covid periods. Their lives had been disrupted and suffered by considerable health, social and economic hardships. They have engaged in very limited activities, have not felt interested in any social programs and activities, cancelled or postponed plans to participate in events, programs, services, etc. These challenges have affected our outreach activities as well as participation level.

i. Internal coordination – Program has continued to collaborate closely with internal programs, must stay flexible and continuously put more efforts in adapting to collaborative colleagues' and clients' schedules, constantly focus on improving good cross-cultural understanding, share honest and clear communication to avoid conflicts to ensure smooth coordination for referrals and intake.
ii. Clients' overly demanding – Program staff has continued to put extra efforts in dealing with and accommodating many overly demanding and difficult clients. Program staff must continuously keep positive attitude, open conversations, clarify, and build up trust with clients to make them fully comfortable with collaborating and sharing instead of holding back their thoughts.
iii. Clients' diverse behaviors – It's challenging to serve seniors from diverse communities on how to work together to achieve the goals. As previously shared, non-Vietnamese clients tended to have some unrealistic expectations and provide more photos than needed despite program staff's guidance and explanations about the goals and limited capacity of the program. This not only creates obstacles and slows down the process but also creates stress and drain staff's energy in managing clients' expectations and timelines. Program staff must continuously work on setting goals collaboratively with clients through communication and interpersonal partnership.
iv. Referrals and level of engagement – Program staff must continuously reach out to internal programs, community, and former clients, and encourage collaboration opportunities and support for referrals. As shared, clients who are currently attending some internal programs are more likely to join than others as they have built relationships and trust with the organization and their counselors. Generally, seniors are seriously impacted by the pandemic, financial and social disturbances, and other stressors mentioned above, thus the level of participation have been affected.

❖ Success stories:

The program has provided me with good times reminiscing, focusing, capturing, re-writing my story. My meaningful storybook with collection of photos, highlight of major life events and poignant moments will become a legacy to be shared with my loved ones, and to inspire others. My storybook has also created opportunities to understand and reconcile family disputes.
The program has effectively taught me on how to communicate, how to access, prioritize and select resources which aligned the best with my needs, how to contact efficaciously service providers and resources via different methods, reduce challenges of using technology to search for resources, get updated news, learn how to apply and fill out online applications, stay connected with others, thus helped boost up my confidence, reduce my incompetent feelings as well as avoid overwhelmed feelings.
Program progress: The goal for the year is to serve 100 clients; we were able to surpass the goal and serve 112 clients this year. Not only that, but we also got abundant praise from our clients as well as their families and caregivers for the work that we do. Our services are very much appreciated and needed. As the daughter of a new referral recently said to me when I was explaining the program to her over the phone: "you are bringing me to tears because this is exactly what my mom needs". Older Adults who live by themselves but have lost some of their independence feel very isolated even when they have family close by because typically their children are busy with work and with their own children. Our clients deeply appreciate our visits, having someone to talk to and with whom they can re-live their happy memories, life adventures, and achievements. The companionship

we provide our clients helps them feel valued and through verbal validation and praise we promote their positive feelings and mood. The Storytelling program also strengthens the connection between the client and their family as it allows them to hear some of the client's stories and cultural traditions, sometimes for the first time.

One successful case we had this year was that of a 63 year old Latino female who emigrated from Mexico. When she was referred to us she lacked family and social support. She was divorced and her children were all in Mexico; only one of her children was in touch with her. She had a brother but he offered her no support. She only had one friend and she had quarreled with her recently. She also had various other stressors – she had been sexually abused by her boss two years earlier, which made her quit her job suddenly and she had been struggling to find other steady work since. Not long afterwards, she was diagnosed with cancer and had to undergo treatment, which made her feel more isolated and depressed. Through the Storytelling services, the client started to open up; previously she had only talked to one other person about her sexual abuse trauma. Our program was able to link her to other services that could support her, such as the Ethnic and Wellness program, which helped her with therapy and finding legal support. Our sessions, by focusing on the good things she had experienced, her achievements and her strengths, helped her slowly come out of her persistent negative perspective. The sessions helped her recover the self-esteem she had lost due to the sexual attack. She started appreciating the positive things in her life and regained joy, energy and motivation. She also found a way to start her own business and sustain herself. Furthermore, our sessions encouraged her to communicate openly with her one and only friend, which resulted in their reconciliation and a stronger friendship.

Community Outreach Partners:

i. Our clients are referred to us by different community services/agencies including:
ii. Behavioral health centers
iii. Health clinics
iv. Home care and nursing care services
v. Case management community agencies
vi. Associations for older adults and for various illnesses/disabilities
vii. Senior centers and adult day health care centers
viii. Senior apartment complexes
ix. Health insurance plans
x. Churches
xi. Health fairs

At the beginning of this fiscal year we were still receiving referrals in waves, but in the last few months the flow of referrals has been continuous and has exceeded our expectations. Our program is becoming better known in the community and that has significantly diminished the need for us to do outreach. We currently have a full caseload and a wait list of 7 clients, which we hope to open within the next two months. If/when the wait list reduces to 3 or 4 clients we will engage in outreach activities. The most common ways for us to do outreach are by (1) having a presence at various fairs, which allows us to talk directly to potential clients, and (2) reaching out via phone or email to community agencies like the ones mentioned above.

We have experienced several challenges during the year. Our current and only provider in the Storytelling program joined GHS last August and therefore there was a learning curve that affected the program at the beginning of the year. Then, in December and for most of January, the Storytelling program provider was on sick leave, which caused us to temporarily stop all new openings as we struggled to care for our clients without him. Fortunately the provider worked really hard and was able to make up for it in later months. Another challenge that we have experienced this year is not having a female provider in Storytelling. We have lost 5 or 6 potential

clients who were interested in the program but did not want to have a male provider. If we could expand the program and hire another person, even if part time, it would help us navigate these challenges with more ease.

School Linked Services

The School Linked Services program in Santa Clara County covers 6 different programs.

1. Behavioral Health (BH)
2. Family Engagement (FE)
3. Unconditional Education (UE)
4. Strengthening Families & Children Project
5. Universal Health Screening Services
6. Based Behavioral Health Wellness Center Grant Program

The total cost per person, across all programs in this category can be found below. The following pages are detailed reports for each individual program in this category.

FY 2023		
Number Served	Program Expenditure	Cost per Person
9,479	**17,063,425.72**	**$1,800.13**

School Linked Services Behavioral Health (SLS BH)

PREVENTION & EARLY INTERVENTION (PEI)

ANNUAL EVALUATION REPORT DATA
REPORTING PERIOD: FY23 (JUL 1, 2023-JUN 30, 2023)

1. Program Description

The School Linked Services (SLS) Program provides mental health treatment services by master level clinicians, including access to child psychiatry services, if needed. Services are provided primarily in the school setting, although may be also accessed at the clinic, home, and community agencies as needed by clients. Services are individualized and tailored to the needs of the youth based upon age, developmental functioning level, history of trauma, cultural values, family environment and physical health. Services target students ages 6-18 with Medi-Cal and who reside within High-Risk Areas (HRAs) of Santa Clara County in designated SLS schools. HRAs were determined by a County commissioned study on zip codes with high levels of poverty, substance abuse, child removals, juvenile justice involvement, mental health clients, school dropout rates, single parent households, felony arrests, teen mothers, low state-wide test scores, and low birth weight.

2. Program Indicators

i. **Suicide** – SLS provides ongoing risk assessments throughout treatment for clients. When an SLS clinician provides an intake for a client they assess for suicidal ideation (thoughts, plan, intent, access to plan), self-harm and/or other risk factors. If a clinician finds that there is some level of risk, a safety plan will be created with the client and family to address concerns immediately. A safety plan will include crisis telephone numbers, identified support people, identified crisis/concern, triggers, proactive and reactive strategies that the client and family can use to prevent crisis as well as to manage crisis. The family is then coached to use this plan if the identified concern were to arise. Throughout treatment, a clinician will monitor for concerns and provide ongoing safety planning. If a client does present with suicidal ideation and is unable to stay safe at home/community, the clinician will contact the Mobile Crisis and Stabilization Services (MRSS) Program which performs a 51/50 (or 5858 for a minor) evaluation and will determine if the youth need to be placed under a 72-hour hold. If a client does get placed on a 72- hour hold, the clinician will determine if further referrals are needed such as a higher level of care program, psychiatry, etc.

ii. **Incarcerations** – By providing mental health services, clients are stabilized and are to reduce risky behaviors which would otherwise lead to involvement in juvenile justice.

iii. **School failure or dropout**- SLS provides services to help support clients so they can be successful in school. This can include direct support in the classroom and playground to work on improving behavioral concerns, attention, organization, and mental health issues which may be creating obstacles towards learning. SLS also supports teachers through observations, in-class support and assistance with creating behavioral plans. SLS supports parents and caregivers through collateral services to improve behavioral issues in the home, behavioral support to help with school-based themes like homework, a bedtime routine and a morning routine.

iv. **Unemployment –** SLS Clinicians provide services to high school aged youth and support their overall well- being while in school so they can be successful academically as well as in the community. As a

result, youth are able to complete academic expectations and pursue workforce opportunities. The program also supports parents who are unemployed by linking them to different resources so that they can get access to job opportunities, employment trainings, etc. By providing mental health services to stabilize clients, this allows parents to stay in the workforce.

v. **Prolonged suffering -**SLS strives to provide services as quickly as possible to lessen any suffering that clients are experiencing. SLS does this by contacting families the same day a case is assigned to a Clinician. SLS will meet the family wherever they prefer to complete an intake and will start assessing for safety and needs. SLS Clinicians will immediately begin linking families to resources to ensure safety.

vi. **Homelessness –** SLS provides services to homeless clients and their families by ensuring that the client and family has access to community resources that will meet their basic needs. SLS clinicians will determine if further referrals are needed to a higher level of care. Clinicians support clients by connecting them to the McKinney Vento program at their identified schools to ensure the client is getting access to their educational rights and protections.

vii. **Removal of children from their home -** SLS provides support for caregivers to improve functioning and skills to lessen incidents of removal. This includes coaching and training for caregivers, family therapy, and the addition of ancillary support through other programs, if needed.

3. Program Goals, Objectives & Outcomes

The SLS BH Program utilizes the following logic model:

MHSA PEI School Linked Services Behavioral Health (SLS BH)

Situation

Serious mental health problems are on the rise amongst our children and youth, particularly within the school setting.

Priorities

1. To identify barriers to access to treatment for students.

2. To implement EBP treatment to reduce mental health symptoms that impede learning or social functioning.

3. To involve partners, such as school admin, parents, teachers in service delivery.

Participation
Who we serve

Description: School based mental health services for children and youth

Funding Source: MHSA PEI; Medi-Cal

Referral Source:

- SLS School Districts/ Schools
- BHSD Call Center
- CYF System of Care
- Self-Referral

Age: School age 6-18

Criteria for Entry: Meets medical necessity and has full-scope Medi-Cal

Criteria for Discharge: Upon mutual agreement (client and therapist) that the goals of treatment have been met. Upon parent or guardian's unilateral decision to terminate treatment. Upon transfer out of Santa Clara County to another mental health. Determined by clinician. Change in beneficiary status.

Total Capacity: 495

Dosage: 4.5 hours/month/consumer

Length of Service: 8 months

Phases
How will we get there

Intake/Assessment
- MH Assessment
- Narrative Summary
- CANS/PSC-35
- EBP Outcome Measures

Treatment
- TCP
- CANS/PSC-35

Transition/Discharge
- Discharge Summary
- CANS/PSC-35
- EBP Outcome Measures
- Satisfaction Survey

Activities
What do we do

- Mental Health- Individual, Family, Group therapy, Collateral, Peer Discussion Groups, Rehabilitation (86%)
- Case Management and Linkage (11%)
- Medication Support (3%)
- Crisis Intervention (0%)
- Additional Supports:
  - Staff training to ensure fidelity to EBP.
  - Classroom observations
  - Classroom support
- EBPs include but not limited to:
  1. TF-CBT
  2. CBT
  3. BSFT
  4. Triple P
  5. 7 Challenges
  6. Seek Safety

Consumer Outcomes
How will we change

MHSA PEI Outcomes

- Consumers will reduce or prevent **Suicide Risk.** (CANS item: Suicide Risk)
- Consumers will remain out of juvenile justice involvement and **Incarceration.** (CANS items: LFD Delinquency and Legal)
- Consumers will attend school to prevent **School Failure or Drop out.** (CANS item: School Attendance)
- Consumers will improve or maintain job functioning to prevent **Unemployment.** (CANS Item: Job Functioning)
- Consumers will maintain in-home and prevent **Homelessness.** (CANS Item Residential Stability)
- Caregivers will reduce the risk of **Removal of Children** (CANS items: CGSN Safety and Supervision)
- Consumers will reduce or prevent **Prolonged Suffering.** (CANS domain Behavioral Emotional)

County Outcomes

- Decrease the percent of open consumer no shows to 25%
- Consumers will discharge successfully.
- Consumers will be admitted into program within 7 business days to improve timely access.

Additional Program Specific Outcomes

- Consumers will improve school behavior. (CANS item: LFD School Behavior)
- Consumers will maintain or improve school achievement. (CANS item: LFD School Achievement)
- Consumers will maintain or improve their psychosocial. (PSC-35 total score)
- Consumers and families will be satisfied with services

Impact

Short-term

- Provide students with new skills to reduce mental health symptoms and improve school performance

Moderate

- Improve students' ability to maintain the use of coping skills so that student is able to promote.

Long-term

- Student can fully utilize coping mechanisms to reduce mental health symptoms so that they can achieve overall wellness and success. Achievement of life goals
- Gainful employment.
- Higher education.
- Vocational achievements

Last Revised: 9/16/21

Notes: (1) Baseline data will be captured during the first year; (2) Examples of outcome measures include pre and post EBP surveys, satisfaction questionnaire at the end of service, CANS and PSC-35; (3) CANS outcomes definition: Prevention = CANS Item rating maintained at non-actionable (rating 0,1), Improvement = CANS Item rating score changed from actionable (rating 2, 3) to non-actionable rating; (4) PSC-35 prevention=maintain total score <28; Improvement=change in total score from >28 to <28.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 882		
Number Served	Program Expenditure	Cost per Person
882	Refer to Cover Page	Refer to Cover Page

5. Evaluation Activities

❖ SLS BH Program Strategies included

i. **Access and Linkage:** SLS clinicians provide coaching to the client and the caregiver regarding utilizing strengths to access services, accompanying the client and family to identify resources or having the clinician secure a release of information and initiating additional community services on behalf of the client and family (examples of this include linking family to a primary care physician, providing referrals to additional community based organizations, assisting the family with applying for guardianship, accompanying the family to meetings with a psychiatrist or meetings with school district, the juvenile justice system or child welfare). Assessing the needs and strengths in a family is critical in determining the level of support they need to provide care coordination. The SLS clinician works with the family to identify these services or other more appropriate community- based services and assist with placing a referral and linking them to the needed service.

ii. **Improving Timely Access to Services for Underserved Populations:** The referral process is streamlined to ensure timely access for all students referred. This includes contacting referred families within 72 hours of receipt of the referral and offering the most convenient possible time and place for completing the paperwork. If there is any difficulty in reaching the family with three attempts via phone, the school is contacted within one week to assist with making the connection.

iii. **Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory:** Based on the results of the mental health assessment, ongoing CANS assessments, the treatment plan, and contacts with the family, the clinician assists in identifying areas of strength and areas that need action across all settings in the client's life, using non-stigmatizing and non-discriminatory practice. Services are always individualized, family centered while being culturally sensitive. If there are areas of need that are identified, the SLS clinician will collaborate with the family to address the need(s) and ensure that prompt and consistent support services are secured. This plan of action is documented in the treatment plan and outlines the partnership between the SLS clinician and the family working together to achieve treatment plan goals and wellness. Needs would be documented in the plan with potential action steps by the family and the SLS clinician. SLS provides community-based outreach to promote SLS services to different schools and community events for families to be able to access services.

iv. **Assessment tools**: The SLS Providers use assessment tools at the start of services and at the of end services. Clients and their parents (or caregivers) are presented with the following assessment tools: The Child and Adolescent Needs and Strengths (CANS) Tool. The CANS provide supports with looking at client's life domains to help drive client's treatment. The CANS Tool also assesses the parents (or caregivers) needs as well. The Pediatric Symptom Checklist (PSC-35) tool assess the emotional and behavioral needs, based on the parental perspective.

v. **Evidence-Based Practices (EBPs)**: Although the SLS Program does not require any specific EBPs, it does require that EBPs are utilized in the program. Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy, Trauma-Focused CBT, and Motivational Interviewing techniques are frequently used EBPs.

6. Demographic Data FY 2023

Age Group	# Served	% of Served
0 – 15 years	739	84%
16 -25 years	142	16%
26- 59 years	0	0%
60+ years	0	0%
Prefer not to answer	0	0%
Unknown	1	>.1%
Unduplicated Total	882	100%

Race	# Served	% of Served
American Indian or Alaska Native	3	>.1%
Asian	9	1%
Black or African American	16	2%
Native Hawaiian or Other Pacific Islander	1	>.1%
White/ Caucasian	34	4%
Other	405	46%
More than one race	0	0%
Prefer not to answer	4	>.1%
Unknown	410	46%
Unduplicated Total	882	100%

Ethnicity	# Served	% of Served

Hispanic or Latino:		
Caribbean	0	0%
Central American	0	0%
Mexican/ Mexican American/ Chicano	0	0%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	499	57%
Other Hispanic/ Latino	0	0%
Hispanic or Latino Subtotal	499	56%
Non-Hispanic or Non-Latino as follows:		
African	0	0%
Asian Indian/ South Asian	0	0%
Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%
European	0	0%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Non-Hispanic/ Non-Latino (undefined)	54	6%
Other Non-Hispanic/ Non-Latino	0	0%

Non-Hispanic or Non-Latino Subtotal	0	0%
More than one ethnicity	0	0%
Prefer not to answer	0	0%
Unknown	329	37%
Unduplicated Total	882	100%

Gender (Assigned at Birth)	# Served	% of Served
Male	395	45%
Female	463	52%
Prefer not to answer	0	0%
Unknown	24	3%
Unduplicated Total	882	100%

Gender (Current)	# Served	% of Served
Male	0	0%
Female	0	0%
Transgender (Male to Female)	0	0%
Transgender (Female to Male)	0	0%
Transgender (Undefined)	0	0%
Genderqueer	0	0%
Questioning or Unsure	0	0%
Another gender identity	0	0%
Prefer not to answer	0	0%
Unknown	882	100%

Unduplicated Total	882	100%

Sexual Orientation	# Served	% of Served
Gay or Lesbian	0	0%
Heterosexual/ Straight	0	0%
Bisexual	0	0%
Questioning/ Unsure	0	0%
Queer	0	0%
Another sexual orientation	0	0%
Prefer not to answer	0	0%
Unknown	882	100%
Unduplicated Total	882	100%

Primary Language	# Served	% of Served
English	333	38%
Spanish	230	26%
Vietnamese	2	>1%
Chinese	1	>1%
Tagalog	0	0%
Farsi	2	>1%
Other	1	>1%
Prefer not to answer	0	0%
Unknown	311	35%
Unduplicated Total	882	100%

Military Status	# Served	% of Served
Active Military	0	0%

Veteran	2	>1%
Served in Military	0	0%
Family of Military	0	0%
No Military	245	28%
Prefer not to answer	0	0%
Unknown	635	72%
Unduplicated Total	882	100%

Disability*	# Served	% of Served
Difficulty seeing	0	0%
Difficulty hearing or speaking	0	0%
Other communication disability	0	0%
Cognitive	84	9.5%
Physical/ Mobility	0	0%
Chronic Health Condition	0	0%
Other non-communication disability	130	14.7%
No Disability	0	0%
Prefer not to answer	0	0%
Unknown	668	75.7%
Unduplicated Total	882	100%

*Participants may choose more than one option for Disability.

7. Referrals

Number of individuals with serious mental illness referred to treatment	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and**	**Average duration of untreated mental illness (for referrals to treatment that are**	**Average interval between the referral and participants in treatment (defined**

(Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)		engaged in treatment (for treatment that is provided, funded administered, or overseen by county mental health)	provided by or overseen by county mental health)	as participating at least once in the treatment to which referred) and standard deviation (for referrals to treatment that are provided by or overseen by county mental health)
882	Individual, family, group therapy Case Management, Medication Support Crisis support CYF SOC	N/A	N/A	N/A

8. Group Services Delivered

A variety of groups for students were delivered focusing on improving their emotional regulation skills, building and maintaining relationships, practicing mindfulness, social skills, and other topics held during school breaks, including summer, winter, and spring breaks. The group titles and activities were designed to appeal to students of all ages at designated SLS schools (elementary, middle, and high schools), while incorporating therapeutic strategies. When available, groups were provided on school sites. The target population was students ages 6-18 years old at designated schools in high-risk neighborhoods who met the SLS Program eligibility criteria.
This past year, Skill streaming was provided at districts that previously did not have access. This greatly increased the number of groups that were held and students that benefited from them.

Number of Groups	Attendance	Average Attendance per Group
336	2481	7

9. Detailed Outcomes

❖ CANS Outcome Measures FY 2023

YBEN First CANS	YBEN Last CANS	YBEN % Change	YRB First CANS	YRB Last CANS	YRB % Change	LDF First CANS	LDF Last CANS	LDF % Change
118	76	36%	6	5	17%	100	73	27%

YBEN - Youth Behavioral Emotional Needs, **YRB** - Youth Risk Factors, **LDF** - Life Domain Functioning
Negative % indicates positive change
Zero % indicates no change

Notes: (1) YBEN - Youth Behavioral Emotional Needs, YRB - Youth Risk Factors, LDF - Life Domain Functioning; (2) Source: YTD (March FY22) Child and Adolescent Needs and Strength Questionnaire (CANS).

i. Consumers improved their behavioral and emotional well-being as evidence by a 36% reduction in CANS Behavioral and Emotional domain score.
ii. Consumers demonstrated an improvement in risk factors as evidenced by a 17% decrease in CANS Youth Risk Factors domain score.
iii. Consumers demonstrated an improvement in their daily life functions as evidenced by a 27% decrease in CANS Life Functioning domain score.

10. Evaluation Summary

Successes and Challenges

❖ Program success:

School Linked Services (SLS) continues to work on making its best efforts to provide high quality services to clients, families and community partners (Schools/Schools Districts). This is achieved in through multiple collaborative efforts.

i. Client and Family care: SLS focuses in meeting the family's and youth where they are at, working towards helping them improve their emotional needs, building upon their strengths, and being culturally sensitive. SLS assists the families with additional services including but not limited to medication support, case management and direct services. Collateral therapy for parents to help them supporting their youth. This helps to help youth to get as much support as possible to meet their emotional needs.
ii. Staff wellbeing: SLS program managers dedicate as much time needed to support their staff to make sure they can provide best quality services possible. Management advocates for the wellbeing of the team.
iii. Collaboration with sister program (PEI) and other programs: School Linked Services partnered with PEI to provide collaborative services and a wide array of group experiences for our clients during breaks and summer vacation. Group topics were centered on social skills, coping skills, managing anxiety, mindfulness, physical activity, and team building and more. School Linked Services prepares for summer capacity and referrals by communicating and meeting frequently with school district point people and created a plan to keep capacity high throughout the Summer.
iv. Collaboration with School and Schools districts: SLS has regular meetings with County, District and School representatives. This secures communication flow, timely problem solving, and access to services.
v. Collaborative discussions are occurring on a bi-monthly basis with community providers to improve services to better meet the needs of the population served. SLS is ready to assist with crisis intervention, as needed.
vi. SLS is successfully implementing Cal-Aim changes and prepared for the SLS re-design. Although SLS has already been providing services to higher needs families, SLS is ready to increase dosages, length of stay, and access to paraprofessionals within our program.

❖ Program Barriers and Challenges:

Every year, summer brings challenges with family disengagement from services. Many families are away on vacation, do not respond, and naturally, referrals drop as schools are on break. This makes is challenging for clinicians to keep up with maintaining services and productivity. SLS makes all efforts to continue services to all open cases and successfully run multiple summer groups.

Success story: A client was referred due to worrying a lot, especially over his family who have experienced multiple tragedies and traumatic events. The client would call mom from school to make sure she was okay,

had a very low self-esteem, and low mood. Soon after starting services in the SLS program, client was able to receive a diagnosis of PTSD. Client's therapist supported client as he processed his anger towards the tragedies that the family has experienced. Throughout the services, client's therapist supported client as he explored his anger triggers, body signals related to his anger, and supported client to learn and develop grounding skills he could use when experiencing a trigger. The therapist worked with the client to improve the client's ability to self-soothe and regulate his emotions. Therapist utilized CBT to bring awareness to client's negative schemas to provide client a different perspective of the world, so that the client could begin to develop positive friendship traits to assist client to improve his ability to build strong relationships with people that embody the positive characteristics the client valued. By the end of services, client expressed his ability to self-soothe when experiencing feelings of anger after experiencing stressors or triggering events at school or at home, through utilizing his learned grounding skills. Client's mother shared that she also saw a huge improvement in client's behavior as he was starting to communicate more with her. Client's world had turned positively as he expressed excitement for his first job over the summer, and client was wanting to take a "pause" on services so that he could continue to independently grow with the skills he had learned from the program.

11. Outreach Activities

Type of Setting (i.e., school, community, etc.)	Type of Responders (I,e. principals, teachers, parents, medical staff, etc.)	Number of attendees
Schools	Families, school staff and administration, and Wellness Center staff	350 (estimated)
Community	Students, families, school staff and administration, and community members	60 (estimated)

School Linked Services Family Engagement (SLS FE)

PREVENTION & EARLY INTERVENTION (PEI)

ANNUAL EVALUATION REPORT DATA
REPORTING PERIOD: FY23 (JUL 1, 2022-JUN 30, 2023)

1. Program Description

School Linked Services (SLS) Family Engagement (FE) program is a partnership with school districts to comprehensively integrate and streamline coordinated services for students and families. The SLS FE program encompasses service coordination through SLS Coordinators to school-based behavioral health programs such as Prevention and Early Intervention (PEI) services and SLS behavioral health (SLS BH) services in addition to county and community resources. SLS Coordinators provide light case management and linkage. Additionally, the program provides family engagement events, workshops, and series to engage and welcome families and to increase their knowledge on mental health and community resources. SLS FE services are conducted through a community participatory approach, through which partnerships between schools, public agencies, and community-based organizations are developed in Santa Clara County.

SLS initiative and the FE program strides to provide culturally sensitive and evidence-based behavioral and mental health services using a service delivery approach that promotes prevention and early intervention. To do so, SLS FE focuses on four essential elements.

i. **Coordination of Resource Linkage/Service Referrals:** Coordination of services and resources encompasses a range of responsibilities, from engaging families and implementing parent-involved activities at the schools to integrating services and coordinating resource linkages at the school site. SLS Coordinators plan, implement and evaluate these coordinated services and programs in partnership with school staff, administrators, families, and community-based organizations. The plans and activities at the school sites, such as educational workshops, are informed by families and parents of students during the Campus Collaborative meetings.

ii. **Family Engagement:** Family engagement is a shared responsibility in which schools and community agencies are committed to reaching out to engage families in their children's health and academic wellbeing; and in which families are committed to actively supporting their children's learning and development. Family engagement refers to any events that bring caregivers and family members on the school campus, and includes, but not limited to, parent-teacher meetings, school-based parenting education (e.g., one-time class or series-based workshops), back-to-school events, coffee with the principal (cafecitos), parent volunteering opportunities at the school and any other activity that supports mental health awareness and early prevention services.

iii. **Campus Collaborative:** Campus Collaborative facilitates an opportunity for parents, teachers, students, community organizations, service providers, and school staff to meet and discuss SLS priority areas in addressing the needs of students and families at the campus. The Campus Collaborative group members will champion and support the planning, implementation, and evaluation of the SLS plan, which is informed through the group meetings. This 'community and school level' partnership is an essential foundation of the overall SLS initiative. These efforts should establish a connection between the needs of the community and the resources supported by SLS Coordinators through family engagement and service linkage resources.

iv. **Co-Investment:** Co-investment, through a community participatory approach, will yield shared responsibility, commitment, and support in the SLS initiative. Through co-investment, the public, private and civic sectors come together to enable and empower communities to achieve successful wellbeing outcomes. This means a cross-systems approach to leverage resources, provide advocacy for the health and wellbeing of children and families, and engage diverse community stakeholders in the SLS initiative.

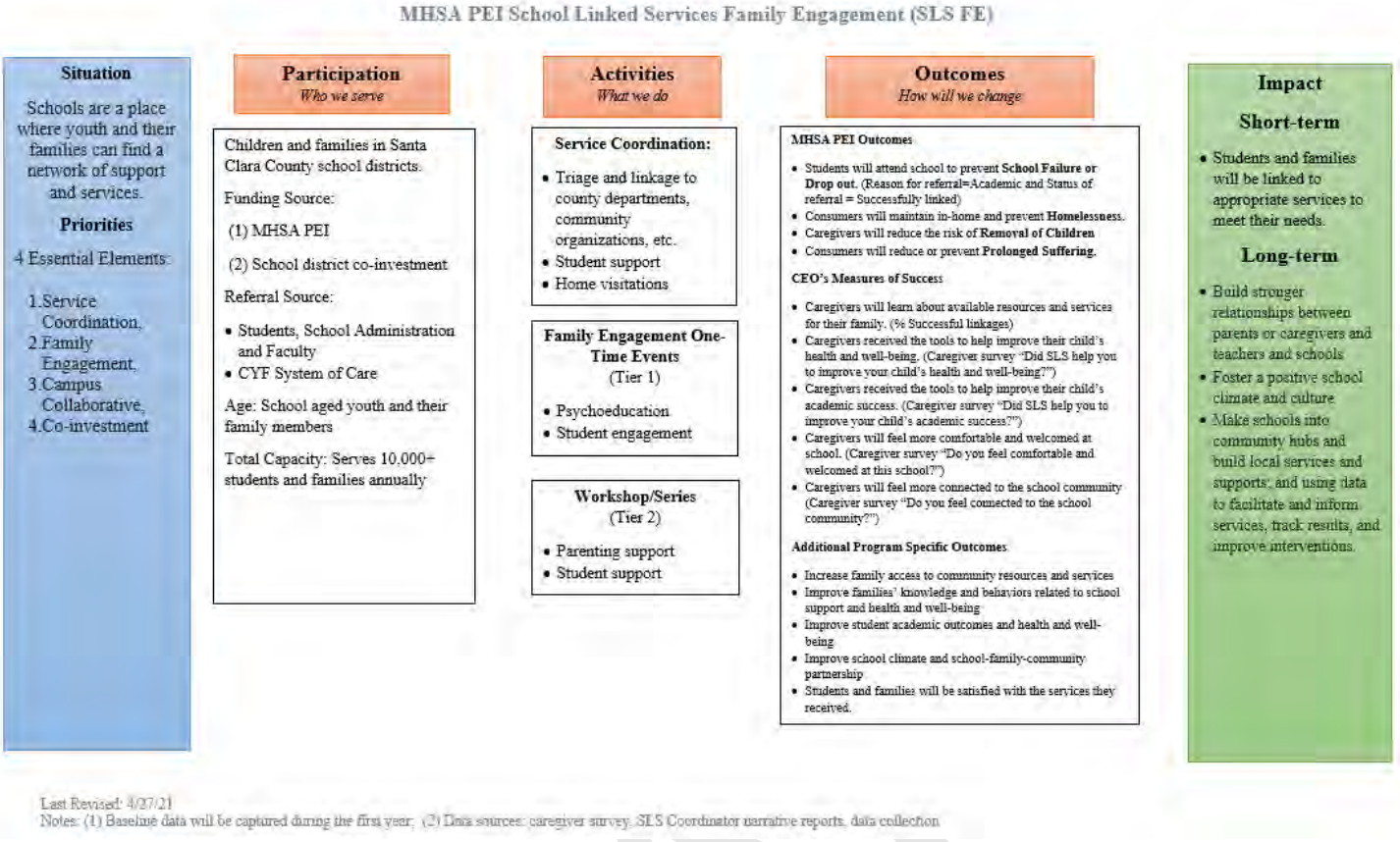
In FY23, SLS FE program expanded to 22 school districts throughout the County. Those school districts include: Alum Rock Union School District, Campbell Union School District, Campbell Union High School District, East Side Union High School District, Franklin- McKinley School District, Fremont Union High School District, Gilroy Unified School District, Los Altos School District, Loma Prieta Joint Union School District, Los Gatos Unified School District, Luther Burbank School District, Milpitas Unified School District, Moreland School District, Morgan Hill School District, Mount Pleasant Elementary School District, Mountain View Whisman School District, Oak Grove School District, Orchard School District, Palo Alto School District, Santa Clara County Office of Education, Santa Clara Unified School District and San Jose Unified School District.

2. Program Indicators

Santa Clara County school districts utilize the Multi-Tiered System of Supports (MTSS) framework to provide interventions and supports designed to address behavioral and academic challenges. The MTSS framework has three tiers of support. Tier 1, the largest tier, serves the majority (75%-90%) of students by providing core instructions and basic interventions, such as psychoeducation, skills streaming, touch and refer (light case management), and outreach to the entire school. Students who do not respond to these interventions may move into Tier 2. Tier 2 serves 10-25% of students in which additional interventions and supports, such as skill building groups, parenting workshops, reading groups, case management and navigation, and Check-In/Check-Out interventions are delivered to students in individually and small groups. Tier 3 serves less than 10% of students. Students who need services beyond Tier 1 and Tier 2, are provided individualized supports, Tier 3, such as individual, group, and/or family therapy based on their level of need. Tier 3 also includes crisis interventions and targeted case management.

The SLS FE program aims to reduce prolonged suffering in students by providing service coordination and family engagement activities, including events that build awareness through psychoeducation activities and workshops that support skill building. The SLS FE program also addresses the domain of school dropout through the referrals of students to academic support services, as well as SLS Coordinators organizing events and workshops like the Parent Project and Strengthening Families.

3. Program Goals, Objectives & Outcomes



4. Clients Served & Annual Cost per Client Data

FY 2022		
Unduplicated Number Served	Program Expenditure	Cost per Person
6,634	**Refer to Cover Page**	**Refer to Cover Page**

5. Evaluation Activities

The SLS FE program evaluates program's effectiveness through successful linkages for referrals, caregiver satisfaction, school district satisfaction, and increase knowledge and skills. Satisfaction surveys are administered to all caregivers and school districts, in addition capturing qualitative data through focus groups with the SLS Coordinators. Outcomes include:

❖ MHSA PEI Outcomes

i. Students will attend school to prevent **School Failure or Drop out.**
ii. Consumers will maintain in-home and prevent **Homelessness.**
iii. Caregivers will reduce the risk of **Removal of Children**
iv. Consumers will reduce or prevent **Prolonged Suffering.**

❖ CEO's Measures of Success

i. Caregivers will learn about available resources and services for their family.
ii. Caregivers received the tools to help improve their child's health and well-being.
iii. Caregivers received the tools to help improve their child's academic success.
iv. Caregivers will feel more comfortable and welcomed at school.
v. Caregivers will feel more connected to the school community.

❖ Additional Program Specific Outcomes

i. Increase family access to community resources and services
ii. Improve families' knowledge and behaviors related to school support and health and well-being
iii. Improve student academic outcomes and health and well-being.
iv. Improve school climate and school-family-community partnership.
v. Students and families will be satisfied with the services they received.

6. Demographic Data FY 2023

(Note: Decision support data indicated information which differs from the provider level PEI reports)

Race	# Served	% of Served
American Indian or Alaska Native	0	0%
Asian	783	11.8%
Black or African American	166	2.5%
Native Hawaiian or Other Pacific Islander	0	0%
White/ Caucasian	587	8.9%
Other	4,739	71.4%
More than one race	306	4.6%
Prefer not to answer	0	0%
Unknown	53	0.8%
Unduplicated Total	6,634	100%

Ethnicity	# Served	% of Served
Hispanic or Latino:		

Caribbean	0	0%
Central American	0	0%
Mexican/ Mexican American/ Chicano	0	0%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	0	0%
Other Hispanic/ Latino	4,739	100%
Hispanic or Latino Subtotal	4,739	100%
Non-Hispanic or Non-Latino as follows:		
African	166	10.8%
Asian Indian/ South Asian	0	0%
Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%
European	587	38.2%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Non-Hispanic/ Non-Latino (undefined)	0	0%
Other Non-Hispanic/ Non-Latino	783	51%
Non-Hispanic or Non-Latino Subtotal	1,536	100%

More than one ethnicity	306	85.2%
Prefer not to answer	0	0
Unknown	53	14.8%
Unduplicated Total	6,634	100%

Gender (Assigned at Birth)	# Served	% of Served
Male	3,424	51.6%
Female	3,193	48.1%
Prefer not to answer	0	0%
Unknown	17	0.3%
Unduplicated Total	6,634	100%

Gender (Current)	# Served	% of Served
Male	0	0%
Female	0	0%
Transgender (Male to Female)	0	0%
Transgender (Female to Male)	0	0%
Transgender (Undefined)	0	0%
Genderqueer	0	0%
Questioning or Unsure	0	0%
Another gender identity	0	0%
Prefer not to answer	0	0%
Unknown	6,634	100%
Unduplicated Total	6,634	100%

Sexual Orientation	# Served	% of Served
Gay or Lesbian	0	0%
Heterosexual/ Straight	0	0%
Bisexual	0	0%
Questioning/ Unsure	0	0%
Queer	6	0.1%
Another sexual orientation	0	0%
Prefer not to answer	0	0%
Unknown	6,628	99.9%
Unduplicated Total	6,634	100%

Primary Language	# Served	% of Served
English	3,161	47.65%
Spanish	2,789	42.04%
Vietnamese	303	4.57%
Chinese	0	0%
Tagalog	37	.56%
Farsi	0	0%
Other	334	5.03%
Prefer not to answer	0	0%
Unknown	10	.15%
Unduplicated Total	6,634	100%

Military Status	# Served	% of Served
Active Military	0	0%
Veteran	0	0%
Served in Military	0	0%

Family of Military	0	0%
No Military	0	0%
Prefer not to answer	0	0%
Unknown	6,634	100%
Unduplicated Total	6,634	100%

Disability*	# Served	% of Served
Difficulty seeing	0	0%
Difficulty hearing or speaking	0	0%
Other communication disability	0	0%
Cognitive	0	0%
Physical/ Mobility	0	0%
Chronic Health Condition	0	0%
Other non-communication disability	0	0%
No Disability	0	0%
Prefer not to answer	0	0%
Unknown	6,634	100%
Unduplicated Total	6,634	100%

*Participants may choose more than one option for Disability.

7. Referrals

Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment (for treatment that is provided, funded administered, or overseen by**	**Average duration of untreated mental illness (for referrals to treatment that are provided by or overseen by county mental health)**	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation (for referrals to treatment that are provided by or**

versus treatment that is not)		county mental health)		overseen by county mental health)
2,403	Individual and family therapy, Case management, Medication support, Crisis intervention, Psychoeducation	Unknown/Not Identified	Unknown/Not Identified	Unknown/Not Identified

8. Group Services Delivered

Unduplicated		
Number of Groups	Attendance	Average Attendance per Group
148	13,971	94

Note: SLS Family Engagement Workshop Series

9. Detailed Outcomes

❖ Caregiver Feedback Survey

BHSD measured the outcomes of the SLS FE program through the administration of the Caregiver Feedback Survey at the end of Q2 and Q4. For caregivers who received services coordination and referrals, including referrals to Family Engagement one-time events and workshop series.

❖ Measure of Success Outcomes

i. 87% learned about available resources and services for their family
ii. 90% received tools to help improve their child's health and wellbeing
iii. 90% received tools to help improve their child's academic success
iv. 88% parents felt more comfortable and welcomed at school
v. 78% parents felt more connected to the school community

❖ Service Coordination and Linkage Outcomes

During FY 2023 SLS Coordinators submitted 8,260 referrals and served 6,634 students. A total of 7,820 (94.7%) referrals were closed in FY 2023. Of the closed referrals, 80.4% were successfully linked.

❖ Family Engagement Events and Series

During FY 2023 SLS Coordinators organized 721 one-time events, which compared to FY 2022 was an increase of 23.9% (582 to 721 events), The number of students and families that attended the one-time events in FY 2023 was 63,505, which was an increase of 39.1% (45,651 to 63,505) compared to FY 2022.

SLS Coordinators organized 148 series that were attended by 13,971 students and families during FY 2023. Compared to FY 2022, the number of series increased by 12.1% (132 to 148), and the number of students and families attending the series increased by 208.3% (6,707 to 13,971).

10. Evaluation Summary

❖ Success Story –

SLS Coordinators at Alum Rock Union Elementary School District worked to improve school climate as students returned to campus. In FY23, they noted a need to reengagement services with students and caregivers. The SLS Coordinators at ARUESD strategized to improve student academic outcomes, health, and well-being through a partnership with different school-family-community organizations to improve their continuum of services and accessibility of in-person services. ARUESD revitalized their menu of services for students and families this year with in-person services. This year ARUESD provider Alum Rock Counseling Center reengaged families by offering Strengthen Families workshops. Families found this in-person workshop to be productive. SLS Coordinators at ARUSD worked on securing additional resources for families and students through their partnerships with other community service providers. ARUESD SLS Coordinator partnered with Rebekah Children's Services to develop a streamline of services with Differential Response. Similarly, SLS Coordinators worked throughout this year to support develop new partnerships such as their collaboration with Amigos de Guadalupe Center for Empowerment to services McKinney Vento families. These new partners provided families with ongoing social-emotional supports at ARUESD school sites.

❖ Program Successes

The SBBH Programs continue to provide invaluable resources to the community with early detection of mental health needs, crisis support and grief counseling. When students returned to campus, staff and SLS Coordinators highlighted a need for additional behavioral health services with Outpatient Services. This need geared BHSD and SLS Coordinator to provide additional supports to students and families with our new BHSD Navigator Program training.
In FY23, SLS Coordinators were trained to utilize our BHSD Family and Children continuum of care services to address the need for additional therapeutic services and support systems offered to families who reach the BHSD Call Center. BHSD Navigator Program shared a in depth view on the services and programming offered to families with personalized services in different languages. School districts were also provided a detailed training on the resources and services that families can access when they reach the BHSD Navigator Program to secure their connection to our continuum of care services with BHSD Children's and Family Division.

❖ Program Barriers and Challenges / Implementation Challenges

The return of students to in-person learning has highlighted the need for additional behavioral support services across all tiers. SLS Coordinators have identified a need for psycho-education and prevention services, such as workshops on how to best support students at home with programs like positive parenting, triple p, and parent project. School districts have also experienced an increase in prevention services, particularly in substance use services. These surges in demand have affected the delivery of SLS services among SLS Coordinators and CBO providers, who have experienced severe staff shortages, limiting their capacity to provide in-person services. As a result, in-person services for these types of services have been limited. New school districts have encountered barriers in implementing SLS Initiative services, particularly the Loma Prieta Joint Union School District. This district faced challenges implementing SLS Initiative services. The Loma Prieta Joint Union School District found accessing services difficult due to its remote location.

11. Outreach Activities

Type of Setting (i.e. school, community, etc.)	Type of Responders (I,e. principals, teachers, parents, medical staff, etc.)	Number of attendees
School, district office, community.	Students, caregivers, and school staff.	63,505

School Linked Services Unconditional Education (SLS UE))

PREVENTION & EARLY INTERVENTION (PEI)

ANNUAL EVALUATION REPORT DATA
REPORTING PERIOD: FY23 (JUL 1, 2022-JUN 30, 2023)

1. Program Description

The Unconditional Education (UE) program is grounded in a Multi-Tiered System of Supports (MTSS) framework that fully integrates trauma-informed prevention and early intervention within the provision of academic, behavioral, and social-emotional interventions for students. In partnership with school communities, the UE program works to build the capacity of teachers and caregivers to identify and respond to behavioral health needs, while providing coordinated and universally accessible behavioral health supports for students. The primary result is improved academic performance and social-emotional well-being for the most struggling students, including students with disabilities, students who experience chronic stress and trauma, students who are English language learners, students in foster care, and systems-involved youth, as well as a safer and more engaging culture and climate for schools. The UE Program uniquely provides a UE Coach who works to build the capacity of teachers and caregivers to identify and respond to behavioral health needs, while providing coordinated and universally accessible behavioral health supports for students.

2. Program Indicators

School failure or dropout: The UE Program recognizes that some students will struggle with the demands of school. The UE Program focuses on addressing school failure and dropout by bringing in a team of providers, supporting access to networks of community resources, and the coordination of appropriate services for each student. Given each student, family, teacher and school is unique, the program engages in relentless curiosity to revise previous notions of what a student needs and develop creative and data informed solutions when initial efforts have not produced the desired effects.
Prolonged suffering: UE supports the reduction of prolonged suffering by creating a positive culture and climate at school and using trauma-informed, healing centered practices. When a student's struggles are at their greatest, UE holds an endless capacity for hope and the belief that existing barriers can be overcome, even when they seem insurmountable. UE recognizes that letting go of past trauma and learning new things takes time, so it intentionally focuses on building strengths, commending success, recognizing effort and engaging in celebrations to revive the persistence needed to sustain the work of bringing about lasting change.

3. Program Goals, Objectives & Outcomes

❖ TIERS OF INTERVENTION

i. **Tier 1**: As part of high-quality instruction, in a climate of positive classroom culture, students receive interventions at many points throughout the day through UE. The goal of strong Tier 1 systems is to build capacity of all stakeholders on campus to implement trauma-informed interventions and create a safe, supportive, and inclusive learning environment where all students are welcome and can thrive. The UE coach supports the implementation of the Positive Behavior Interventions and Supports (PBIS) –

conducting school-wide assemblies to explicitly teach behavior expectations and organizing weekly positive reinforcement awards. The UE Coach also leads the implementation of a school-wide social-emotional curriculum, including modeling lessons for teachers in the classroom, coaching and observations to ensure fidelity. Additionally at Tier 1 UE provides School-wide training to all staff on a variety of topics, including crisis prevention and understanding and addressing the symptoms of trauma. UE also works with teachers to understand the effects of vicarious trauma and develop practices of self-care.

ii. **Tier 2:** The goal of Tier 2 is to provide targeted small group interventions to students with similar needs and minimize referrals to a higher level of care. The behavior specialists provide push-in classroom support to both the identified students and teacher around classroom management strategies and interventions for building community and managing behaviors in the classroom. UE also helps implement Individualized Behavior support plans (BSPs) to effectively address undesirable behaviors in the classroom and engages stakeholders in monitoring and supporting behavior change. The UE team supports various stakeholders on campus working with students' behavior support plan to develop targeted behavior tracking, student contracting, and utilizing Check-in/Check-out. Based on the presenting needs of students, staff provide pull-out social skills groups utilizing evidence-based group interventions such as Zones of Regulation and Mindfulness. These groups are provided in 6-to-8-week cycles and include goal setting and progress monitoring with the student and teachers.

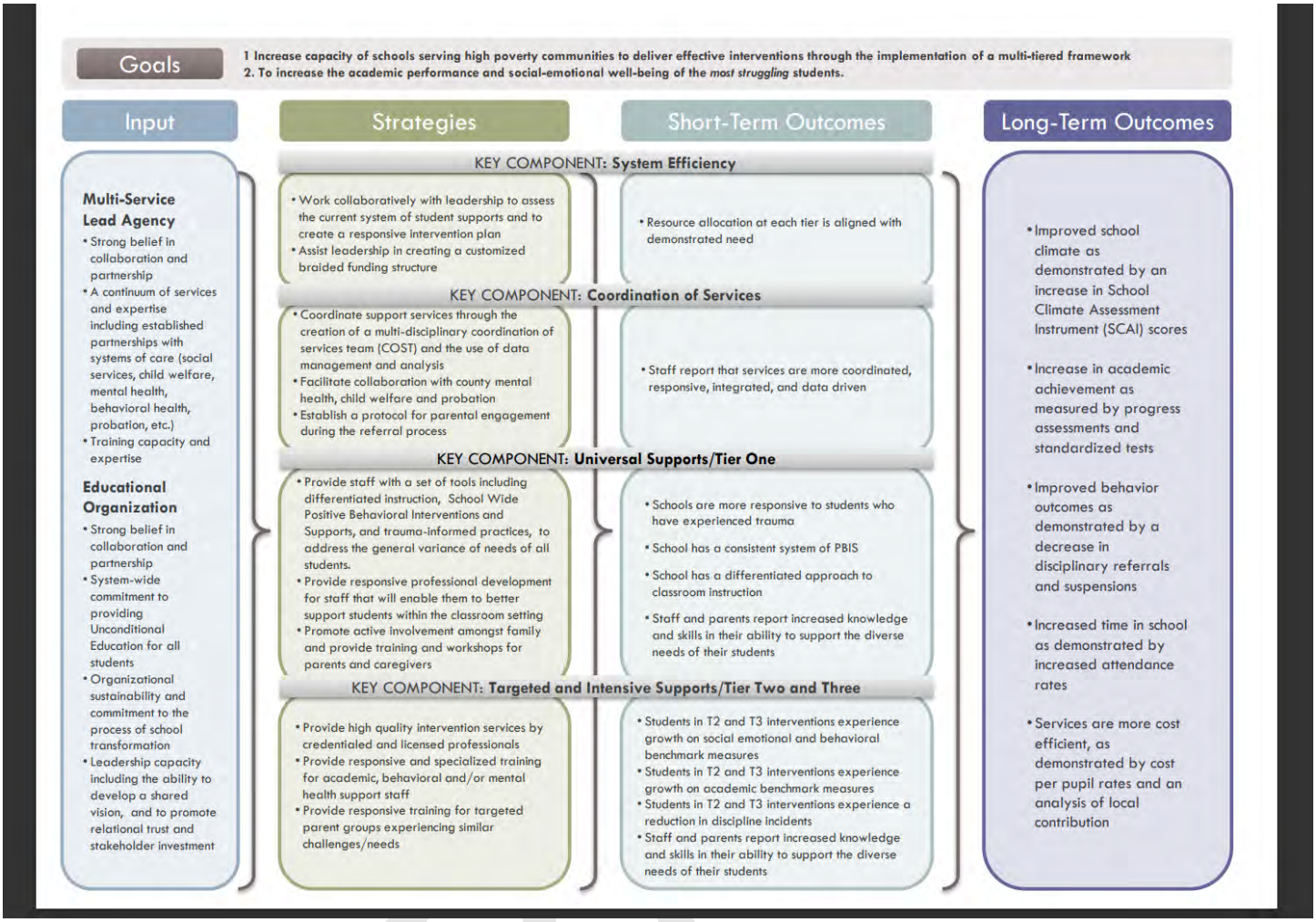
iii. **Tier 3:** As the most intensive of all three tiers, the goal of Tier 3 interventions is to provide individualized support to help students develop healthy skills to manage anger, cope with anxiety, and build a sense of internal self-worth, all of which are protective factors shown to strengthen resilience, reduce violence, and improve educational outcomes. These services include weekly individual therapy sessions to help students address their unique mental health needs and learn effective coping skills to increase engagement and achievement in the classroom. UE staff also help to create personalized structured learning spaces on campus for students to access when they need more individualized academic, behavioral, and social-emotional supports to complete their assignments. For students impacted by poverty and trauma, a sound and responsive culture and climate lays the foundation for student achievement. By promoting safety, student and family voice, and the healthy development of relationships, students are able to become active agents of their social and academic success.

❖ Program priorities include

i. Increase capacity of schools serving high poverty communities to deliver effective interventions through the implementation of a multi-tiered framework.

ii. Increase the academic performance and social-emotional well-being of the struggling students.

The UE Program utilizes the following logic model:



4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 50		
Number Served	Program Expenditure	Cost per Person
50	**Refer to Cover Page**	**Refer to Cover Page**

5. Evaluation Activities

❖ MHSA PEI Outcomes

i. Consumers will reduce or prevent Suicide Risk. (CANS item: Suicide Risk)
ii. Consumers will remain out of juvenile justice involvement and Incarceration. (CANS items: LFD Delinquency and Legal)
iii. Consumers will attend school to prevent School Failure or Drop out. (CANS item: School Attendance)

iv. Consumers will improve or maintain job functioning to prevent Unemployment. (CANS Item: Job Functioning)
v. Consumers will maintain in-home and prevent Homelessness. (CANS Item Residential Stability)
vi. Caregivers will reduce the risk of Removal of Children (CANS items: CGSN Safety and Supervision)
vii. Consumers will reduce or prevent Prolonged Suffering. (CANS domain Behavioral Emotional)

❖ County Outcomes

i. Decrease the percent of open consumer no shows to 25%
ii. Consumers will discharge successfully.
iii. Consumers will be admitted into program within 7 business days to improve timely access.

❖ Additional Program Specific Outcomes

i. Consumers will improve school behavior. (CANS item: LFD School Behavior)
ii. Consumers will maintain or improve school achievement. (CANS item: LFD School Achievement)
iii. Consumers will be satisfied with services they received. (Satisfaction questionnaire)
iv. Reduce school suspensions, chronic absenteeism
v. Increase academic achievement, family involvement and participation in child's education.

The SLS UE program utilizes a Multi-tiered Support Services (MTSS) framework to provide different tiers of supports. For clinical services, the program utilizes the Pediatric Symptom Checklist (PSC 35) and the Child Adolescent Needs and Strength questionnaire (CANS). Additionally, school administrations and faculty are also surveyed along with parents and students.
Access and Linkage: All Tier 3 referrals for the UE Program went through the coordinators on site at the schools. As the UE team is embedded within the school community, new clients were enrolled into the program within 7 business days.

6. Demographic Data FY 2023

Age Group	# Served	% of Served
0 – 15 years	28	56%
16 -25 years	22	44%
26- 59 years	0	0%
60+ years	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	50	100%

Race	# Served	% of Served

American Indian or Alaska Native	1	2%
Asian	1	2%
Black or African American	1	2%
Native Hawaiian or Other Pacific Islander	0	0%
White/ Caucasian	6	12%
Other	24	48%
More than one race	0	0%
Prefer not to answer	0	0%
Unknown	17	34%
Unduplicated Total	50	100%

Ethnicity	# Served	% of Served
Hispanic or Latino:		
Caribbean	0	0%
Central American	0	0%
Mexican/ Mexican American/ Chicano	0	0%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	43	86%
Other Hispanic/ Latino	0	0%
Hispanic or Latino Subtotal	43	86%
Non-Hispanic or Non-Latino as follows:		
African	0	0%

Asian Indian/ South Asian	0	0%
Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%
European	0	0%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Non-Hispanic/ Non-Latino (undefined)	0	0%
Other Non-Hispanic/ Non-Latino	3	6%
Non-Hispanic or Non-Latino Subtotal	0	0%
More than one ethnicity	0	0%
Prefer not to answer	0	0%
Unknown	4	8%
Unduplicated Total	50	100%

Gender (Assigned at Birth)	# Served	% of Served
Male	20	40%
Female	30	60%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	50	100%

Gender (Current)	# Served	% of Served
Male	0	0%
Female	0	0%
Transgender (Male to Female)	0	0%
Transgender (Female to Male)	0	0%
Transgender (Undefined)	0	0%
Genderqueer	0	0%
Questioning or Unsure	0	0%
Another gender identity	0	0%
Prefer not to answer	0	0%
Unknown	50	100%
Unduplicated Total	50	100%

Sexual Orientation	# Served	% of Served
Gay or Lesbian	0	0%
Heterosexual/ Straight	0	0%
Bisexual	0	0%
Questioning/ Unsure	0	0%
Queer	0	0%
Another sexual orientation	0	0%
Prefer not to answer	0	0%
Unknown	50	100%
Unduplicated Total	50	100%

Primary Language	# Served	% of Served
English	13	26%
Spanish	10	20%
Vietnamese	0	0%
Chinese	0	0%
Tagalog	0	0%
Farsi	0	0%
Other	0	0%
Prefer not to answer	0	0%
Unknown	27	54%
Unduplicated Total	50	100%

Military Status	# Served	% of Served
Active Military	0	0%
Veteran	0	0%
Served in Military	0	0%
Family of Military	0	0%
No Military	0	0%
Prefer not to answer	0	0%
Unknown	50	100%
Unduplicated Total	50	100%

Disability*	# Served	% of Served
Difficulty seeing	0	0%
Difficulty hearing or speaking	0	0%
Other communication disability	0	0%

Cognitive	0	0%
Physical/ Mobility	0	0%
Chronic Health Condition	0	0%
Other non-communication disability	0	0%
No Disability	0	0%
Prefer not to answer	0	0%
Unknown	50	100%
Unduplicated Total	50	100%

*Participants may choose more than one option for Disability.

7. Referrals

Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment (for treatment that is provided, funded administered, or overseen by county mental health)**	**Average duration of untreated mental illness (for referrals to treatment that are provided by or overseen by county mental health)**	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation (for referrals to treatment that are provided by or overseen by county mental health)**
50	Behavior support, individual therapy, case management, collateral, crisis intervention, school staff coaching	N/A	N/A	N/A

8. Group Services Delivered

Number of Groups	**Attendance**	**Average Attendance per Group**
0	0	N/A

9. Detailed Outcomes

❖ CANS Outcome Measures FY 2023

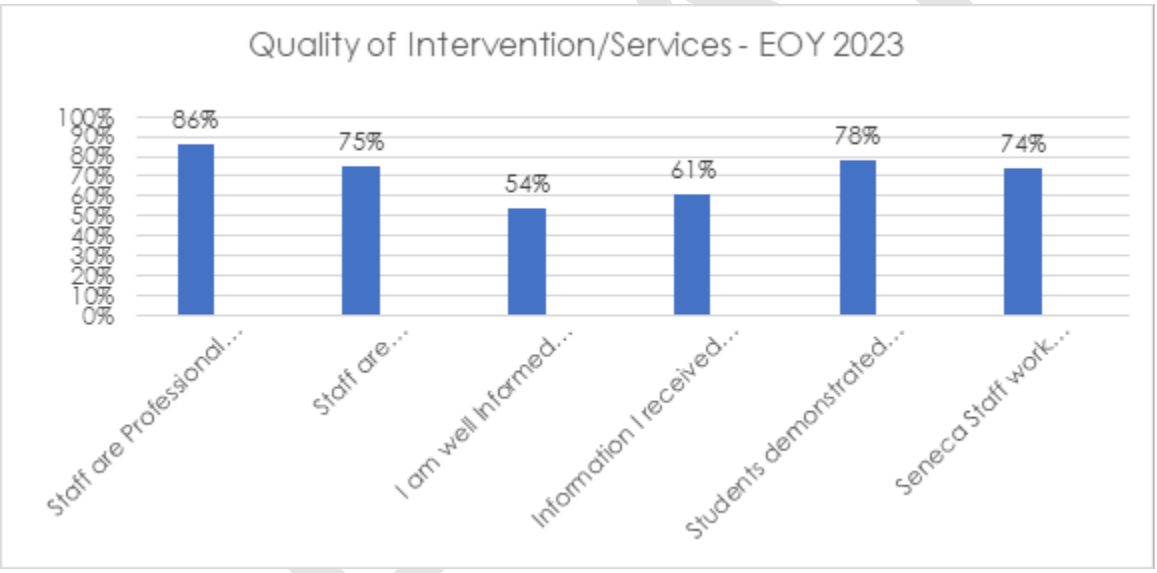
YBEN First CANS	YBEN Last CANS	YBEN % Change	YRB First CANS	YRB Last CANS	YRB % Change	LDF First CANS	LDF Last CANS	LDF % Change
5.0	3.1	38%	0.3	0.4	33%	6.9	3.9	44%

YBEN - Youth Behavioral Emotional Needs, **YRB** - Youth Risk Factors, **LDF** - Life Domain Functioning
Negative % indicates positive change
Zero % indicates no change

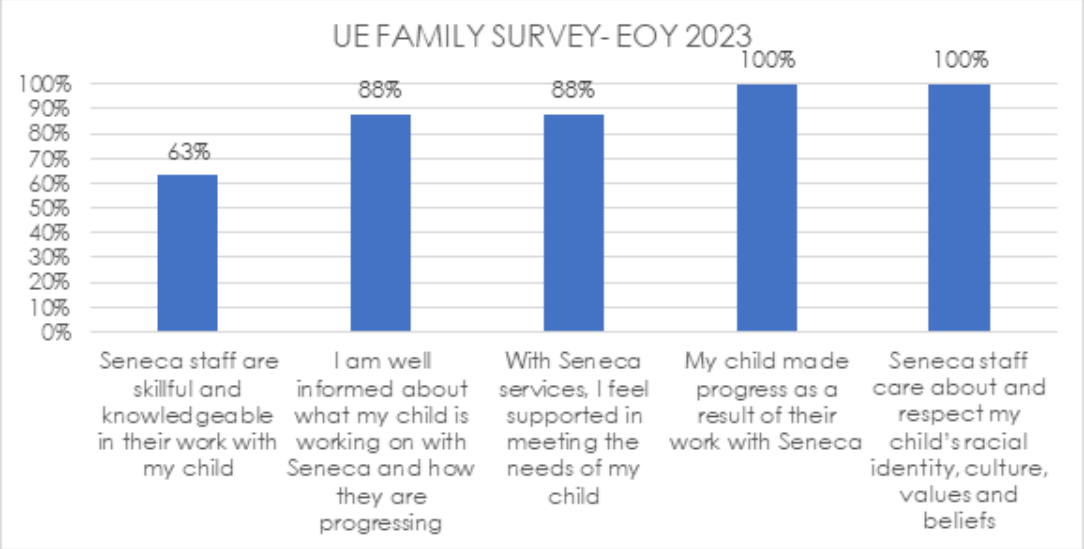
Notes: (1) YBEN - Youth Behavioral Emotional Needs, YRB - Youth Risk Factors, LDF - Life Domain Functioning; (2) Source: FY22 Child and Adolescent Needs and Strength Questionnaire (CANS).

i. Consumers improved their behavioral and emotional well-being as demonstrated by a 38% decrease in the CANS Behavioral and Emotional domain score.
ii. Consumers demonstrated an improvement in their daily life functions as evidenced by a 44% decrease in the CANS Life Functioning domain score.
iii. For the youth Risk Behaviors we had one youth with significant risk factors who was transferred to a higher level of care, and hence it appropriately reflects the increase in score.

UE Fremont/Monroe/Rosemary End of Year (EOY) Partnership Survey Results



UE Fremont/ Rosemary End of Year (EOY) Family/Caregiver Survey Results



❖ Highlights from the End of Year Feedback from School Partners and Parent Surveys:

i. Across all schools 86% of staff agreed that UE Staff are Professional and Collaborative
ii. 75% of staff responded positively and agree that UE staff were knowledgeable and skillful in helping them implement interventions in the classroom and that students demonstrated growth as a result of receiving UE Support.
iii. 78% of teachers reported that students demonstrated growth as a result of receiving UE Support.
iv. In the Family/Caregiver Survey for both Rosemary and Fremont, 88% of the Parents reported that they were well informed about the services that their child was receiving and felt supported by the UE team to meet the needs of their child at home.
v. In our Family/Caregiver Survey, 100% of the Parents agreed that their child made progress as a result of their work with UE and also that UE staff care about and respect their child's racial identity, culture, values and beliefs.
vi. Consumers showed a significant decrease in the Behavioral and Emotional Needs, and Life Functioning domains, indicating that the students made progress on their goals and increased their ability to have a positive school experience.

10. Evaluation Summary

❖ Successes

UE started a new partnership with Monroe Middle School to implement the UE model and expand services within Campbell Union School district. They launched the partnership in December 2022 and staff have hit the ground running establishing strong relationships and alignment with the school team and providing essential social-emotional and behavioral support to students both inside and outside the classroom. While awaiting the Medi-Cal Site Certification visit, the team was on the ground supporting students, classrooms, and teachers as they responded to calls from teachers and staff regarding behavioral challenges occurring on campus. The staff has greatly appreciated this additional level of support UE is able to provide, thereby allowing the students to get the help needed within the classroom and continue to access their academic curriculum. Additionally, they also provided an All Staff training on "Building Resilience and Self-Care for Educators", which was well attended and well-received by all.

The UE Coach at Rosemary Elementary School in partnership with the culture and climate committee was able to make significant progress towards the Tier 1 goal of creating consistent discipline practices across campus

and implementing regular social-emotional lessons within classrooms. Another key highlight this year was the work the UE team did in collaboration with the MTSS/Instructional Leadership team around addressing issues of implicit bias among staff in order to create an inclusive and safe learning environment for all students to thrive.
At Fremont High School, UE continues to provide intensive Tier 3 mental health services to students with complex social-emotional, behavioral and academic needs. With the UE partnerships focus on prevention and early intervention services UE continues to see a decline in the number of students referred for IEP testing thereby allowing them the opportunity to achieve their academic goals in the least restrictive environment. The services provided under the Unconditional Education Partnership are fully integrated in the classroom and include close collaboration with the teachers and academic counselors, and as a result the students report feeling extremely supported and experience a higher level of success in meeting their goals.

❖ Challenges

At Monroe Middle School, since UE launched the Partnership in the middle of the school year, there were some difficulties effectively collaborating with the teachers and integrating supports within the classroom. Through collaborative meetings and frequent communication, these issues were resolved.
Despite multiple attempts to contact the families to gather feedback for our End of year Family Survey, there was a very low response rate across the three schools. The UE team will continue to implement creative strategies to engage families in the treatment process and increase collaboration.
At Fremont high school there were multiple staff transitions in the middle of the year, which briefly impacted the ability to enroll new students into the program for services. Since then, staff have stabilized, and capacity was available.

❖ Success story

DC is a 9 yr.-old male currently attending 4th grade at Rosemary Elementary. DC was originally referred to Seneca as he had a difficult time in the classroom engaging in academic work and frequent conflicts with peers. During unstructured time at recess, he would often be referred to the office due to engaging in inappropriate and unsafe behaviors. DC lives with his mom and 2 younger siblings at home. He also experienced a long history of trauma and multiple referrals to CPS due to allegations of abuse and neglect. With Seneca support DC received Behavioral Intervention Services from a support counselor, who really provided in vivo behavior coaching and skills-building to help DC better manage his impulses and focus on the tasks at hand. DC also received individual and family therapy once a week to help him process his feelings and strengthen his relationship with mom. The Seneca team continued to collaborate with DCs teacher to ensure that they were providing consistent positive reinforcement to DC and monitoring progress towards his goals. DC's behavior began to diminish as he became more comfortable with his environment and built strong relationships with staff who cared about him. Being integrated in the school and Seneca staff being more readily available to provide support was key to prevent many escalations, thereby allowing DC to stay in the classroom and not miss out on academic instruction. Maintaining consistent communication and collaborating with both the family and the teachers was instrumental in helping DC achieve his goals and have a positive school experience. DC was recently discharged from the Seneca program as he no longer needed behavior support and had met his therapy goals. DC also has made many friends at school who he enjoys playing with and can function independently in the classroom.

11. Outreach Activities

Type of Setting (i.e. school, community, etc.)	Type of Responders (I,e. principals, teachers, parents, medical staff, etc.)	Number of attendees
N/A	N/A	N/A

School Linked Services Strengthening Families (PEI SF) & Children Project

PREVENTION & EARLY INTERVENTION (PEI)

ANNUAL EVALUATION REPORT DATA
REPORTING PERIOD: FY23 (JUL 1, 2022-JUN 30, 2023)

1. Program Description

The Prevention and Early Intervention (PEI) Program Strengthening Families and Children Project provides an array of services, which includes a multi-level school-based prevention approach. PEI provides outreach services that are aimed to educate the community about mental health issues and how to access services. It also provides early intervention services that include mental health treatment, case management, classroom observation, classroom interactive presentations (SkillStreaming), linkage to other resources, individual, family and/or group therapeutic services, and parenting workshops (Strengthening Families Program and Triple P – Positive Parenting Program). The County Contracted Providers (CCPs) work in partnership with the school districts and SLS Coordinators to tailor services to the individual school and school district's needs. One of the main goals of the program is to target students and their families that are experiencing behavioral concerns and need support with mental health challenges, as well as providing universal prevention services. The PEI Program serves students and their families at school, home or community, according to what the family needs and the most clinically appropriate setting for the family. PEI services are culturally sensitive, trauma informed, and easy to access.

2. Program Indicators

❖ Suicide

PEI provides ongoing risk assessments throughout treatment for clients. When a clinician provides an intake for a client they assess for suicidal ideation (thoughts, plan, intent, access to plan), self-harm and/or other risk factors. If a clinician finds that there is some level of risk, a safety plan will be created with the client and family to address concerns immediately. Throughout treatment, a clinician will monitor for concerns and provide ongoing safety planning. If a client does present with suicidal ideation and is unable to stay safe at home/community, the clinician will contact the Mobile Crisis and Stabilization Services (MRSS) Program which performs a 51/50 (or 5858 for a minor) evaluation and will determine if the youth needs to be placed under a 72 hour hold. If a client does get placed on a 72- hour hold, the clinician will determine if further referrals are needed such as a higher level of care program, psychiatry, etc.

❖ Incarcerations

By providing mental health services, clients are stabilized and less likely to engage in risky behaviors which could otherwise lead to involvement in juvenile justice.

❖ School failure or dropout

PEI provides services to help support clients so they can be successful in school. This can include direct support in the classroom and playground to work on improving behavioral concerns, attention, organization, and mental

health issues which may be creating obstacles towards learning. PEI also supports teachers through observations, in-class support and assistance with creating behavioral plans. PEI supports parents and caregivers through collateral services to improve behavioral issues in the home, behavioral support to help with school-based themes like homework, a bedtime routine and a morning routine.

- **Unemployment**

PEI provides services to some high school aged youth and support their overall well- being while in school so they can be successful there as well as in the community. As a result, youth will be able to complete academic expectations and pursue workforce opportunities. The program also supports caregivers who are unemployed by linking them to different resources so that they can get access to job opportunities, employment trainings, etc. By providing mental health services to stabilize clients, this allows parents to stay in the workforce.

- **Prolonged suffering**

PEI strives to provide services as quickly as possible so as to lessen any suffering that our clients are experiencing. PEI does this by contacting families the same day a case is assigned to a clinician. PEI clinicians will immediately begin linking families to resources to ensure safety.

- **Homelessness**

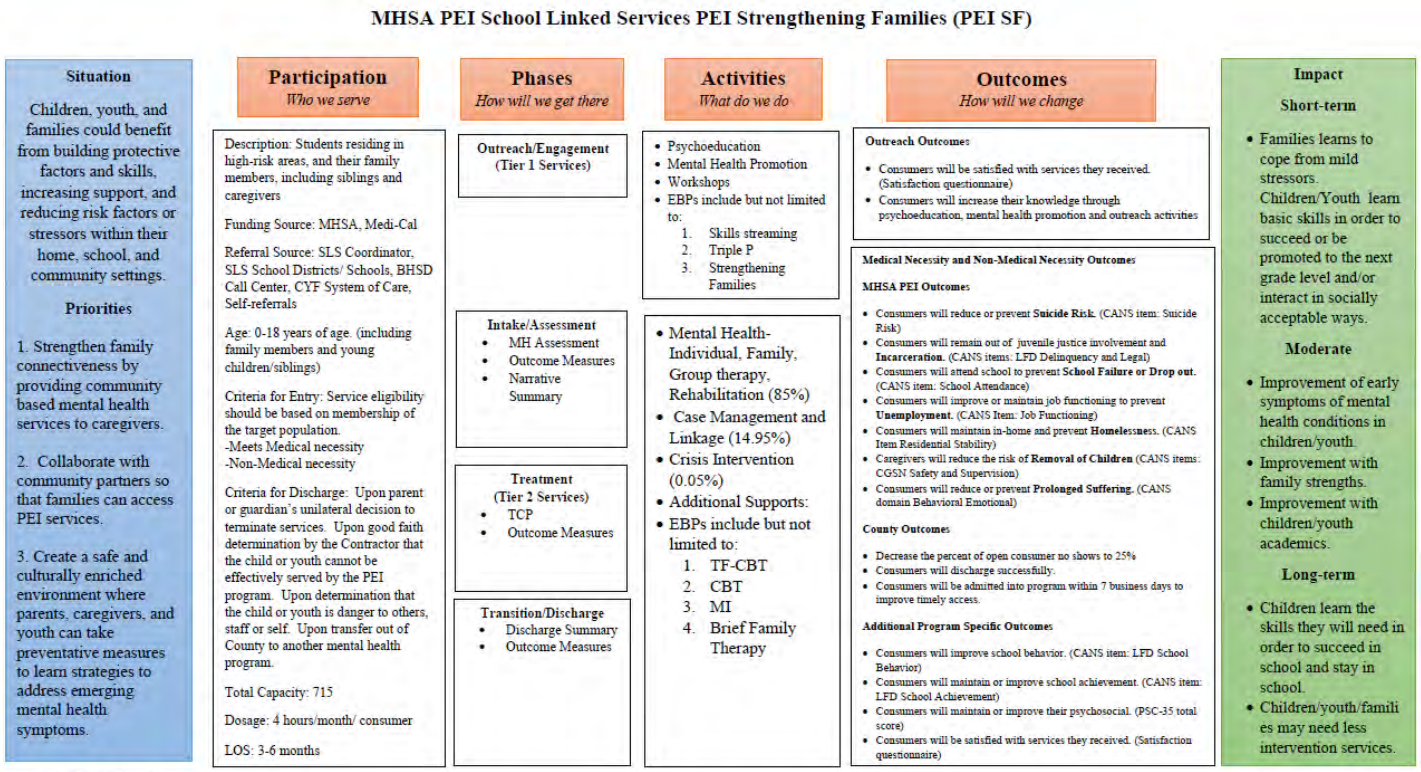
PEI provides services to homeless clients and their families by ensuring that the client and family has access to community resources that will meet their basic needs. PEI has flexible funding that is utilized whenever there is a need for a family including but not limited to support paying for rent, utilities, food, clothing, etc.

- **Removal of children from their home**

PEI provides support to caregivers to improve functioning and parenting skills in order to decrease incidents of child removal.

3. Program Goals, Objectives & Outcomes

The PEI SF program utilizes the following logic model:



Last Revised: 9/16/21
Notes: (1) Baseline data will be captured during the first year; (2) Examples of outcome measures include pre and post EBP surveys, satisfaction questionnaire at the end of service, CANS and PSC-35; (3) CANS outcomes definition: Prevention = CANS Item rating maintained at non-actionable (rating 0,1), Improvement = CANS Item rating score changed from actionable (rating 2, 3) to non-actionable rating. (4) PSC-35 prevention=maintain total score <28; Improvement=change in total score from >28 to <28.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 750		
Number Served	Program Expenditure	Cost per Person
750	**Refer to Cover Page**	**Refer to Cover Page**

5. Evaluation Activities

i. **Access and Linkage:** PEI has utilized access and linkage by providing families with connections to resources (food banks, housing, recreational activities, food stamps, bus passes, social supports, churches, immigration supports and services, legal support, etc., depending on families need). PEI also has access to interpretation services to communicate, coordinate, and link families with resources by communicating needs in their language.

ii. **Improving Timely Access to Services for Underserved Populations:** PEI calls families within 24-72 hours of referral receipt to initiate an intake process. After attempting to contact the family with no response, PEI contacts the school point person assist in reaching the family. As for overall access to services, PEI can meet with families in their house to provide services such as collateral support or meet them at school or in the community. PEI also provides telehealth services for families to assist them in accessing services as conveniently as possible.

iii. **Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory:** PEI delivers responsive and appropriate services that honor and welcome the values, preferences, beliefs, and racial and cultural identity of children, youth and families. PEI staff are trained to deliver culturally sensitive and respectful practices and services. The trainings that are provided are created according to Licensing, Federal State, and County Laws and Regulations and standards.

iv. **Assessment tools:** The Pediatric Symptom Checklist-35 (PSC-35) use used as a general measure of youth mental health functioning. The Eyberg Child Behavior Inventory (ECBI) is used as a measure of child behavior. It is a comprehensive, behaviorally specific rating scales that assesses the current frequency and severity of disruptive behaviors in the home, as well as the extent to which parents/caregivers find the behavior troublesome. The Child and Adolescent Needs and Strengths (CANS) Comprehensive is used with all clients who require a treatment plan. The CANS is administered during the assessment phase at the beginning of treatment, 6 months into treatment, and at discharge. It is a standardized assessment that can be used to assist in treatment planning and support decision making regarding intensity of service. The University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA-PTSD RI) is used at baseline and at service completion with all clients receiving TF-CBT. It is a screening instrument for the assessment of trauma exposure and post-traumatic stress disorder symptoms that corresponds to the DSM-IV criteria and can be used as part of a clinical assessment and as an outcome measure.

v. **Practice effectiveness:** Effectiveness has been demonstrated by using SFP and Triple P which both are evidence-based practice using models and strategies that help families build on family strength. All evidence-based practices (EBP) were designated in the initial PEI planning process based on the California Institute of Behavioral Health Services EBP clearinghouse, with an evaluation plan modeled after Los Angeles County.

vi. Evidence-Based practices that are required in PEI include:

   a. Strengthening Families Program (SFP), which teaches parenting skills and children's life skills in a positive environment to increase family strengths and resilience. SFP helps to improve social skills, school performance and increase positive family interactions. It has been shown to significantly reduce problem behaviors such as aggression and non-compliance to encourage a stronger sense of family and support.

   b. Triple P (Positive Parenting Program) is one of the most effective evidence-based parenting programs in the world, backed up by more than 30 years of ongoing research. Triple P gives parents simple and practical strategies to help them confidently manage their children's behavior, prevent problems developing and build strong, healthy relationships. Triple P is currently used in 25 countries and has been shown to work across cultures, socio-economic groups and in all kinds of family structures.

   c. Trauma-Focused Cognitive Behavioral Services (TF-CBT) is utilized to address severe emerging behavioral/emotional difficulties and/or depression resulting from exposure to trauma. TF-CBT supports the development of skills necessary to prepare the youth for processing their trauma and reducing its impact on their life and functioning. TF-CBT is demonstrated to be the most effective treatment for PTSD in children.

   d. SkillStreaming employs a four-part training approach-modeling, role-playing, performance feedback, and generalization to teach essential prosocial skills to elementary school students in a group setting. Skills areas presented to classes on classroom survival skills, friendship-making skills, skills for dealing with feelings, skill alternative to aggression and skills for dealing with stress.

6. Demographic Data FY 2023

Age Group	# Served	% of Served
0 – 15 years	721	95.1%
16 -25 years	28	4.8%
26- 59 years	1	>1%
60+ years	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	750	100%

Race	# Served	% of Served
American Indian or Alaska Native	0	0%
Asian	21	4%
Black or African American	12	2%
Native Hawaiian or Other Pacific Islander	2	>1%
White/ Caucasian	32	5%
Other	241	41%
More than one race	0	.5%
Prefer not to answer	1	0%
Unknown	399	48%
Unduplicated Total	750	100%

Ethnicity	# Served	% of Served
Hispanic or Latino:		
Caribbean	0	0%
Central American	0	0%

Mexican/ Mexican American/ Chicano	0	0%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	363	55%
Other Hispanic/ Latino	0	0%
Hispanic or Latino Subtotal	363	55%
Non-Hispanic or Non-Latino as follows:		
African	0	0%
Asian Indian/ South Asian	0	0%
Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%
European	0	0%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Non-Hispanic/ Non-Latino (undefined)	49	8%
Other Non-Hispanic/ Non-Latino	0	0%
Non-Hispanic or Non-Latino Subtotal	0	0%
More than one ethnicity	0	0%
Prefer not to answer	0	0%

Unknown	217	37%
Unduplicated Total	750	100%

Gender (Assigned at Birth)	# Served	% of Served
Male	419	59%
Female	326	41%
Prefer not to answer	0	0%
Unknown	5	>1%
Unduplicated Total	750	100%

Gender (Current)	# Served	% of Served
Male	0	0%
Female	0	0%
Transgender (Male to Female)	0	0%
Transgender (Female to Male)	0	0%
Transgender (Undefined)	0	0%
Genderqueer	0	0%
Questioning or Unsure	0	0%
Another gender identity	0	0%
Prefer not to answer	0	0%
Unknown	750	100%
Unduplicated Total	750	100%

Sexual Orientation	# Served	% of Served

Gay or Lesbian	0	0%
Heterosexual/ Straight	0	0%
Bisexual	0	0%
Questioning/ Unsure	0	0%
Queer	0	0%
Another sexual orientation	0	0%
Prefer not to answer	0	0%
Unknown	750	100%
Unduplicated Total	750	100%

Primary Language	# Served	% of Served
English	313	49%
Spanish	157	23%
Vietnamese	4	>1%
Chinese	1	>1%
Tagalog	0	0%
Farsi	0	0%
Other	2	>1%
Prefer not to answer	0	0%
Unknown	273	27%
Unduplicated Total	750	100%

Military Status	# Served	% of Served
Active Military	0	0%
Veteran	0	0%
Served in Military	0	0%

Family of Military	0	0%
No Military	172	26%
Prefer not to answer	0	0%
Unknown	578	74%
Unduplicated Total	750	100%

Disability*	# Served	% of Served
Difficulty seeing	0	0%
Difficulty hearing or speaking	1	>.1%
Other communication disability	0	0%
Cognitive	11	1.5%
Physical/ Mobility	0	0%
Chronic Health Condition	0	0%
Other non-communication disability	165	26%
No Disability	0	0%
Prefer not to answer	0	0%
Unknown	424	72%
Unduplicated Total	750	100%

*Participants may choose more than one option for Disability.

7. Referrals

Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment (for treatment that is provided, funded administered, or**	**Average duration of untreated mental illness (for referrals to treatment that are provided by or overseen by county mental health)**	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which**

overseen by county mental health versus treatment that is not)		overseen by county mental health)		referred) and standard deviation (for referrals to treatment that are provided by or overseen by county mental health)
750	Case Management; individual, family and group therapy; Skill building groups; parenting workshops; Strengthening Families, Skills groups, Triple P	N/A	N/A	N/A

8. Group Services Delivered

There were a variety of groups for students provided during the school day, as well as during school breaks. Groups included drop-in groups for anxiety and depression, social skills building groups, Skillstreaming groups, groups targeted to the specific needs of schools by request, and others. There were also groups for caregivers, such as Positive Parenting Program (Triple P) groups. Details are provided in the EBP descriptions above.
This year, the EBP Skillstreaming was particularly popular, which increased the number of groups (classroom-wide sessions for Skillstreaming) and attendance over previous years.

Number of Groups	Attendance	Average Attendance per Group
465	4686	10

9. Detailed Outcomes

❖ CANS Outcome Measures FY 2023

YBEN First CANS	YBEN Last CANS	YBEN % Change	YRB First CANS	YRB Last CANS	YRB % Change	LDF First CANS	LDF Last CANS	LDF % Change
83	49	41%	5	3	40%	71	60	15%

YBEN - Youth Behavioral Emotional Needs, **YRB** - Youth Risk Factors, **LDF** - Life Domain Functioning
Negative % indicates positive change
Zero % indicates no change

Notes: (1) YBEN - Youth Behavioral Emotional Needs, YRB - Youth Risk Factors, LDF - Life Domain Functioning; (2) Source: YTD (March FY22) Child and Adolescent Needs and Strength Questionnaire (CANS).

i. Consumers improved their behavioral and emotional well-being as evidence by a 41% reduction in CANS Behavioral and Emotional domain score.
ii. Consumers demonstrated an improvement in risk factors as evidenced by a 40% decrease in CANS Youth Risk Factors domain score.

iii. Consumers demonstrated an improvement in their daily life functions as evidenced by a 15% decrease in CANS Life Functioning domain score.

10. Evaluation Summary

❖ Client Success Story

Client was referred by school staff due to client acting out at school and at home. Client has experienced health concerns in the past which led to client not being able to sit still in class and not get along with his peers. After a warm hand-off, provider and client's mother worked together to create a behavior plan that focused on skills to build self-confidence and self-regulation skills to support client to overcome barriers that client was struggling with. During rehabilitation sessions, client was educated and trained on mindfulness skills and prosocial skills to support client's interactions in school and home life, as well as techniques for managing stress. Working collaboratively, client and client's provider explored anger triggers and stressors to help client recognize when client needs to self-reflect and use positive self-talk when they have disagreements with others or are experiencing distress. Client was provided with grounding skills to improve their ability to self-regulate, recognize when they need to take deep breaths, and notice signs that they are becoming overwhelmed. By the time of services ending, client was now able to practice and model prosocial behavior with their peers, as they continue their educational path into middle school. Client was now equipped with tools and skills to be successful in building strong relationships and value their family. Teachers reported at the end of the school year that client was a "joy to work with" in the classroom now, and there were also positive changes observed at home with client now completing chores and homework and having a positive attitude. Client could now control their anger and overcome stressors in the school and home settings by utilizing their learned skills. Client was excited to start middle school and had a stronger mindset and sense of their goals and values in life.

Successes and Challenges

❖ Program success:

Staff continued to focus on broadening service offerings and reaching more students in need. The program successfully offered Triple P (Positive Parenting Program) Level 2 seminars and receive positive feedback from the parents and school about the seminars and ease of access. Seeing trends on campus with multiple students having similar needs, providers were able to use group curriculums to offer during the school year to better meet the needs of more students. They were able to offer various social skills groups, teen groups, and other groups this year.

The PEI Program piloted a universal mental health screening project combined with offering a SkillStreaming intervention and curriculum for third graders at Blackford Elementary School in the Campbell Union School District. Lessons learned from the pilot included the need for additional one-on-one support to be provided to a small number of students to complete the assessment, while most could complete it independently. At this particular school, Spanish speaking staff were needed to support some students to complete the form. Successes included the large number of families who opted into the screening, the smooth process for pulling students out 10 at a time to complete the screening, and the teacher and school staff support for the process.

❖ Program Barriers and Challenges:

There have been challenges with many families referred for support who were monolingual Spanish speaking and recently immigrated, including the youth. The need for therapy continued to be high and with the shortage of therapists it was difficult to hire. There was an increase of higher acuity cases being referred that were out of

the scope for PEI. With other programs facing the same challenge of demand and staffing, it has been a struggle to connect higher acuity clients to programs that would better meet their needs.

To address the needs of higher acuity clients, PEI Programs are co-located with SLS BH Programs and can refer students with higher level needs to that program. The SLS BH Program has been recently expanded to serve an intensive outpatient level of care, which allows most students to stay in the school-based programs without needing to be transferred to other programs based on their needs. The students who are still being transferred typically need more home-based services or services focused on TAY, gang prevention, or other specialty areas.

To address the staffing shortage, the providers have been given the opportunity to expand staffing to increase their capacity. They have introduced creative ways to recruit new staff, as well as hired recruiters in some cases. The number of paraprofessionals in the program has been increased, which helps compensate for clinician vacancies. Paraprofessionals are historically easier to higher and are retained longer.

11. Outreach Activities

Type of Setting (i.e. school, community, etc.)	Type of Responders (I,e. principals, teachers, parents, medical staff, etc.)	Number of attendees
Schools and community	Students, families, school staff, administration, and community members.	29,083 (estimated)

Universal Health Screening Services

PREVENTION & EARLY INTERVENTION (PEI)

ANNUAL EVALUATION REPORT DATA:
REPORTING PERIOD: FY23 (JUL 1, 2022-JUN 30, 2023)

1. Program Description

Healthier Kids Foundation provides prevention and early intervention services through universal health screening to 5th grade students at Franklin McKinley School District (FMSD). Health screenings include mental health, vision, dental, and hearing.

i. Mental health screening identifies children for social-emotional and behavioral issues, using licensed physicians and social workers, then connects them with appropriate community resources.
ii. Vision screening identifies children for vision issues using a high-tech, photo optic scan camera, then connects them to vision services and treatment.
iii. Dental screening identifies children for dental issues, using a licensed dentist, then connects them to dental care through care coordination.
iv. Hearing screening identifies children for hearing issues using the AuDX Pro OAE screening device, then connects them to appropriate services and treatment.

The Universal Health Screening Services activities include outreach and coordination of screening to Santa Clara County school districts, completing screening of the targeted population, and providing the appropriate case management and referrals for identified needs by collaborating with programs, insurers, providers, and advocates. Universal screening provides short term outcomes including knowledge of current health needs by early detection of symptoms, providing access and linkage to services, providing relevant parent/caregiver health related tips and resources. Further, medium outcomes provided by universal screening include determining the health needs and capacity of the targeted population, prevention of health crises, and improved access services. Lastly, long term outcomes provided by universal screening include health wellness curriculum, increased wellness and understanding of the whole child, improved school attendance, school performance, and systemic changes to reduce barriers to care and improve access to services.

The Healthier Kids Foundation Parent Advocates continue their efforts of outreach to parents and caregivers to ensure connection to services were made for students with identifying health needs. The coordination of services has been affected, most likely the cause has been due to the pandemic; providers have less availability in the schedule, harder to schedule appointments a due to less staffing, and parents/caregivers cancelling for various reasons.

2. Program Indicators

Depression, anxiety, and stress are common mental health problems among adolescents that tend to manifest school and social problems. Early detection of children who are at risk of behavioral or emotional problems is possible through universal mental health screening in the school setting. A brief screener, applied universally, appears to be an effective solution for identifying students at mild risk of behavioral and emotional problems and acting early prevents these problems from worsening.

Universal screening for health-related issues prevents prolonged suffering by identifying specific needs and improving outcomes by connecting identified students with services to help alleviate the need. Students meeting

below the clinical range may attend skill groups to increase awareness to mental health and build strategies to help cope when needs emerge.

3. Program Goals, Objectives & Outcomes

❖ Goals of the program include:

i. Increase access to early detection of both physical and mental health concerns for students.
ii. Improve students' knowledge and behaviors related to school support, health, and overall well-being.
iii. Improve students' school engagement, academic outcomes, and well-being.
iv. Increase support and engage parents.
v. Increase family access to community resources and services.
vi. Reduce disparities in access to services by providing support systems and follow-up services to unserved and/or underserved populations.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 1,212		
Number Served (n)	Program Expenditure	Cost per Person
1,163	**Refer to Cover Page**	**Refer to Cover Page**

5. Evaluation Activities

Healthier Kids Foundation provides universal, school-based wellness checks to 5th grade students which includes screenings for vision, dental, hearing, and emotional wellness. This suite of preventive screenings ensures a whole child approach because we know a student's emotional and physical health is critical to their ability to learn in and outside the classroom.

Healthier Kids Foundation uses practice-based evidence standards using the Wellness Check for universal, school-based screening. The proprietary tool combines Kaiser's POQ2, which has been used in Northern California well check appointments for years, with Project Cornerstone's Developmental Asset Questions.

Healthier Kids Foundation's programming is designed to be nondiscriminatory and destigmatize mental health needs by screening all 5th graders at all schools in underserved districts. The tool used has been validated as an effective screening tool for all children in this age range. Parent Advocates follow-up with parents whose children have unmet need. They are from the community, hold a college degree and speak English and Spanish or English and Vietnamese.

Established partnerships with school district staff, school linked services, and parents allows programming to improve access to effective services, linking families as efficiently as possible. We stay with the family until the services are completed.

6. Demographic Data

Age Group	# Served	% of Served
0 – 15 years	1,163	100%
16 -25 years	0	0%

26- 59 years	0	0%
60+ years	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	1,163	100%

Race	**# Served**	**% of Served**
American Indian or Alaska Native	126	11%
Asian	280	24%
Black or African American	30	3%
Native Hawaiian or Other Pacific Islander	15	1%
White/ Caucasian	286	25%
Other	301	26%
More than one race	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	1,163	100%

Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	0	0%
Central American	0	0%
Mexican/ Mexican-American/ Chicano	0	0%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	0	0%

Other Hispanic/ Latino	0	0%
Hispanic or Latino Subtotal	714	61%
Non-Hispanic or Non-Latino as follows:		
African	0	0%
Asian Indian/ South Asian	0	0%
Cambodian	0	0%
Chinese	0	0%
Eastern European	0	0%
European	0	0%
Filipino	0	0%
Japanese	0	0%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Non-Hispanic/ Non-Latino (undefined)	0	0%
Other Non-Hispanic/ Non-Latino	0	0%
Non-Hispanic or Non-Latino Subtotal	436	37%
More than one ethnicity	0	0%
Prefer not to answer	0	0%
Unknown	13	1%
Unduplicated Total	1,163	100%

Gender (Assigned at Birth)	# Served	% of Served

Male	572	49%
Female	591	51%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	1,163	100%

Gender (Current)	# Served	% of Served
Male	0	0%
Female	0	0%
Transgender (Male to Female)	0	0%
Transgender (Female to Male)	0	0%
Transgender (Undefined)	0	0%
Genderqueer	0	0%
Questioning or Unsure	0	0%
Another gender identity	0	0%
Prefer not to answer	0	0%
Unknown	1,163	100%
Unduplicated Total	1,163	100%

Sexual Orientation	# Served	% of Served
Gay or Lesbian	0	0%
Heterosexual/ Straight	0	0%
Bisexual	0	0%
Questioning/ Unsure	0	0%

Queer	0	0%
Another sexual orientation	0	0%
Prefer not to answer	0	0%
Unknown	1,163	100%
Unduplicated Total	1,163	100%

Primary Language	# Served	% of Served
English	913	79%
Spanish	180	16%
Vietnamese	28	2%
Chinese	0	0%
Tagalog	0	0%
Farsi	0	0%
Other	5	<1%
Prefer not to answer	0	0%
Unknown	37	3%
Unduplicated Total	1,163	100%

Military Status	# Served	% of Served
Active Military	0	0%
Veteran	0	0%
Served in Military	0	0%
Family of Military	0	0%
No Military	0	0%
Prefer not to answer	0	0%
Unknown	1,163	100%
Unduplicated Total	1,163	100%

Disability*	# Served	% of Served
Difficulty seeing	0	0%
Difficulty hearing or speaking	0	0%
Other communication disability	0	0%
Cognitive	0	0%
Physical/ Mobility	0	0%
Chronic Health Condition	0	0%
Other non-communication disability	0	0%
No Disability	0	0%
Prefer not to answer	0	0%
Unknown	1,163	100%
Unduplicated Total	1,163	100%

*Participants may choose more than one option for Disability.

7. Referrals

Unduplicated N = 1,163				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
Healthier Kids Foundation's services are non-diagnostic. The	Parent advocates are still working with 16 of the 498 total cases. To	80	N/A	N/A

screening identified 498 students as having unmet emotional need. 25 were in imminent risk. Parent advocates speak to the students' parents and parents decide whether or not to proceed with a referral to behavioral health.	date, 27 students were already receiving services. 29 Successfully accessed Behavioral Health services and 51 successfully accessed basic needs resources. Basic needs resources include: 1 employment, 6 housing, 31 food, 5 toiletries, 3 child care, 6 kid's activities, 8 tutoring, 5 family stress, 1 Health, 6 other, 4 financial assistance.			

8. Group Services Delivered

Unduplicated N = N/A		
Number of Groups	Attendance	Average Attendance per Group

9. Detailed Outcomes

Healthier Kids Foundation had completed 1,163 inclusive screenings for 5th graders this fiscal year. Students that screened and required follow-up were assigned a parent advocate to start outreach to the parent/caregiver. If the parent/caregiver agreed to further assessment, a referral to either the school SLS Coordinator or to the behavioral health call center was made to connect to the appropriate assessment. A total of 498 students were identified and were assigned to parent advocate. Out of those, 29 students were successfully connected to service for further assessment, and 27 students were already receiving behavioral health services. Cases are considered closed after outreach to parent/caregiver was successful and referral was completed to behavioral health provider for an assessment, or after 9 outreach attempts to the parent/caregiver were unsuccessful.

i. Emotional Wellness: 43% (497) out of range and supported with follow-up. To date, parent advocates have successfully supported 368 students in getting what services they need. There were 114 cases that have been closed as unsuccessful because the parent was unable to be reached and/or refused support.
ii. Vision: 17% (196) out of range and supported with follow-up. To date, parent advocates have successfully supported 145 students in getting to the optometrist for appropriate treatment, of which 63 received glasses.
iii. Dental: 34% (400) out of range and supported with follow-up. To date, parent advocates have successfully supported 236 students in getting to the dentist for appropriate treatment.
iv. Hearing: 2% (28) out of range and supported with follow-up. To date, parent advocates have successfully supported 3 students in getting into appropriate treatment, 16 students passed their second hearing screening.

A note on successful vs. unsuccessful outcomes: Healthier Kids Foundation only reports outcomes based on cases that have been closed. Parent advocates will make up to 8 attempts to reach the parent. Typically, the success rate for the year is 65%.

10. Evaluation Summary

❖ Program success

Healthier Kids Foundation successfully screened 1,163 5th grade students at Franklin McKinley, Luther Burbank, Morgan Hill Unified and Eliot Elementary for unmet vision, dental, hearing, and emotional needs. Not only were students connected to the physical and behavioral health service providers, Healthier Kids Foundation also connected students and their families to community resources for basic needs such as employment services, housing services, food, toiletries, childcare, tutoring, kid's activities, family stress, and financial assistance.
Other program successes include, but are not limited to:

v. Increased efficiency in screening process
vi. Partnerships with local school districts
vii. Data collection and sharing capabilities
viii. Feedback from parents

❖ Program Barriers and Challenges

Accessing behavioral health services takes a minimum of 5 weeks when the referral goes smoothly. Many school districts have a waitlist. Healthier Kids Foundation is identifying ways to reduce bottlenecks and increase accessibility for families, the team is finding that coordinating care directly with the call center has increased access for students identified with behavioral health needs.
Franklin McKinley School District was unable to staff days of onsite screening in accordance with the My HealthFirst Wellness Check screening model. Alternatively, the FMSD school social worker team stood in as the screening team so that they could screen students over several days at each site, instead of completing one site a day.
Due to reduced enrollment and high absenteeism across districts, it was difficult to reach the remainder of the students required to meet the contract goal of 1,212 students screened. Healthier Kids Foundation returned to school sites to screen the 2-10 students that were absent the day of the initial screening(s).

11. Outreach Activities

Type of Setting (i.e. school, community, etc)	Type of Responders (I,e. principals, teachers, parents, medical staff, etc)	Number of attendees
School	School staff and parent/caregivers	40

School-Based Behavioral Health Wellness Center Grant Program

PREVENTION & EARLY INTERVENTION (PEI)

ANNUAL EVALUATION REPORT DATA:
REPORTING PERIOD: FY23 (JUL 1, 2022 – JUN 30, 2023)

1. Program Description

The School-Based Behavioral Health Wellness Center Grant Program will support County school districts to implement a broad continuum of prevention, early intervention, and service needs and the necessary infrastructure, technology, and training that effectively support the public behavioral health system. K-12 school districts have been looking for sustainable efforts to address and prioritize the mental health and well-being needs of students. The school-based behavioral health wellness center model is one of many important mechanisms to bringing necessary mental health and other complementary services to schools. Funds from MHSA, American Rescue Plan Act of 2021 (ARPA), and Juvenile Justice Crime Prevention Act and the Youthful Offender Block Grant Program (JJCPA-YOBG) will provide funding to implement new wellness centers, enhance existing wellness centers and/or support with infrastructure to improve the students' emotional and behavioral needs. Wellness centers will be accessible to all middle and high school students regardless of insurance coverage. Program services include screening, assessment, brief solution focused treatment for individuals or groups, crisis intervention, and referrals to external providers and resources.

Grant program development and application design activities include the creation of a workgroup that will focus on developing a letter of intent (LOI) process for all Santa Clara County School Districts in Santa Clara County and the development of the grant application.

2. Program Indicators

The grant program intends to provide funds to school districts to utilize for the prevention and early intervention needs identified of their students through a wellness center program. The purpose of a wellness center on school campus is to have staff provide screening, direct and indirect services, and other engagement activities that will refer students to community resources or the appropriate level of clinical care to address or treat negative outcomes through targeted outcomes:

i. **Suicide and attempted suicide** Wellness Centers promote mental health screenings and clinical assessment for all program participants. The assessment process enables staff to make appropriate referrals and coordination of care for continuous support for program participants and prevent further negative outcomes.
ii. **Incarceration:** Justice involved youth and young adults often encounter disciplinary measures instead of mental health intervention. Wellness Centers provide outreach and community education regarding signs and symptoms and provide linkages to mental health services, which can aid in reducing risk of incarceration due to mental illness.
iii. **School failure or dropout**: Partnerships between schools and families are needed to prevent early school failure such as school dropout. Wellness Center services promote increase in PEI services available to support students by early identification and assessment of social, emotional, and health problems that affect the student's achievement, behavior, and attendance.

iv. **Prolonged suffering:** Wellness centers work to reduce stigma surrounding mental health through extensive outreach within the school community, with stakeholders, and community members to address mental health concerns.

v. **Homelessness:** Many homeless youth attend school regularly and have access to referrals and resources to support their housing needs. Wellness Center staff can provide supportive care coordination to appropriate housing support in the family when homelessness presents.

vi. **Removal of children from their home:** Wellness Centers focus on PEI, linking youth at an early stage of intervention to mental health services, along with providing supports to their families, in an effort to prevent adverse events leading to removal of children from homes. External prevention services include parent training, increasing parent's understanding of the developmental stages of childhood, and positive parenting.

3. Program Goals, Objectives & Outcomes

❖ FY2023 program goals are to:

i. **Goal 1** – Support expanding access to school-based behavioral health services in middle schools (including K-8) and high schools, establishing new on-campus wellness centers, and enhancing existing wellness centers.

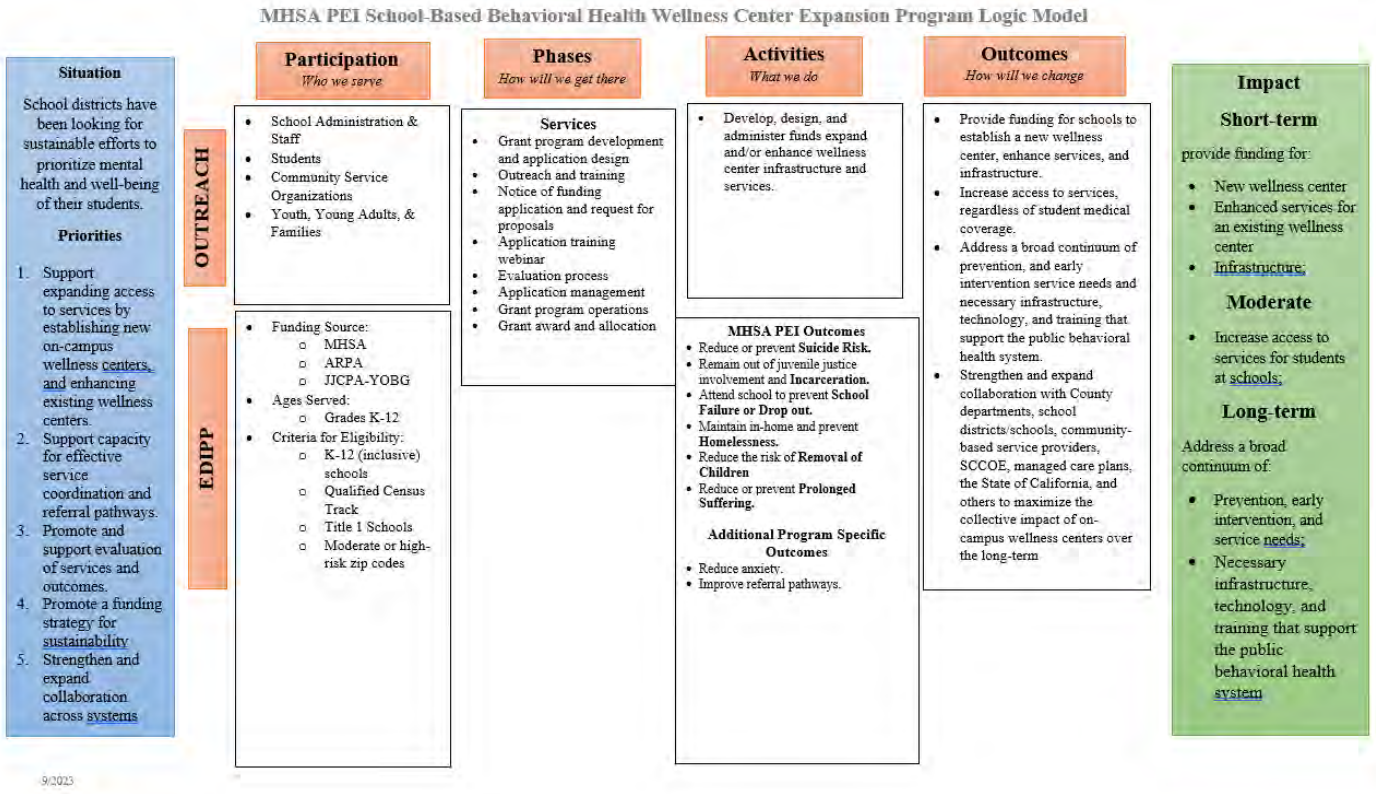
ii. **Goal 2** - Support on-campus wellness center capacity for effective service coordination and referral pathways to maximize access to a continuum of services.

iii. **Goal 3** - Promote and support the evaluation of on-campus wellness center services and outcomes.

iv. **Goal 4** – Propose a multi-pronged funding strategy to sustain on-campus wellness centers.

v. **Goal 5** – Strengthen and expand collaboration with County departments, school districts/schools, community-based service providers, SCCOE, managed care plans, the State of California, and others to maximize the collective impact of on-campus wellness centers over the long-term.

The School Based Behavioral Health Wellness Center Expansion Program uses the following logic model listed below:



4. Clients Served & Annual Cost per Client Data

Not Applicable. The program did not serve clients in FY 2023.

5. Evaluation Activities

Not Applicable. The School-Based Behavioral Health Wellness Center Grant Program does not have evaluation activities to report for this year.

6. Demographic Data

Not Applicable. The program did not serve clients in FY 2023.

7. Referrals

Not Applicable. The program did not serve clients in FY 2023.

8. Group Services Delivered

Not Applicable. The program did not provide group services in FY 2023.

9. Detailed Outcomes

Not Applicable. The School-Based Behavioral Health Wellness Center Grant Program had not provided services to individuals and does not have detailed outcomes to report.

10. Evaluation Summary

The School-Based Behavioral Health Wellness Center Grant Program started pre-development activities for this reporting year in May 2023. These activities included designing a communication plan, letter of interest, application, and evaluation metrics. A weekly workgroup was established between BHSD and Valley Health Foundation (VHF) to collaborate on program goals, eligibility criteria, and deliverables. It has been a successful partnership and collaboration. The workgroup has been successful in meeting the expected timelines for pre-development activities.

Communication with school district staff has been a challenge because the program did not start until May 2023, almost at the end of the academic year. School district staff were occupied with end of the year activities and did not have capacity to discuss the following academic year's needs. Communication was initiated not only with the superintendent, but also with the identified administrative staff member and the Director of Student Services, if known.

The School-Based Behavioral Wellness Center Grant Program was approved with a very short timeline to establish the workgroup, initiate the creation of the application and grant materials, and outreach to eligible school districts. A lesson learned was to maintain organization and to make collaborative decisions. Maintaining detailed notes and due dates of deliverables during the workgroup meetings were vital to prevent confusion on the quick timeline. Another lesson learned is the importance of understanding specific reporting requirements of funding sources, especially when there are more than one funding source supporting a collaborative initiative.

For this reporting period, the School-Based Behavioral Health Wellness Center Grant Program includes only pre-development activities. BHSD and VHF will maintain collaboration next fiscal year and additional supports will be provided to school districts for the implementation of their wellness center projects.

11. Outreach Activities

NOT APPLICABLE

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS PROGRAMS

In Home Peer Respite Program

PEI Outreach for Increasing Recognition of Early Signs Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Description: The Older Adult In-Home Peer Respite Program provides supportive counseling, visitation, and respite services. Peer respite providers offer companionship and supervision as well as peer counseling services for older adults who may be troubled by loneliness, depression, loss of loved ones, illness, or other concerns of aging. Simultaneously, the program provides caregivers of older adults a break from caregiving. Additionally, the respite support offered to caregivers will in turn reduce stress and mental health needs that may arise from providing ongoing caregiving.

The program serves adults aged 60 and older who have a caregiver. Services are voluntary, consumer-directed, and strengths based. In-home respite care takes place in the home.

Status: Continuing

Population: 60+ year old adults who reside in Santa Clara County that have a caregiver (formal or informal)
Service category: PEI: Outreach for Increasing Recognition of Early Signs of Mental Illness

2. Program Indicators

i. **Suicide** – Providers utilize several assessments to determine the client's and the caregiver's level of depression and the risk for suicide. If there is a concern, providers refer them to outpatient therapy and psychiatric services provided in the community. If necessary, they can also refer them to inpatient psychiatric services or request a 5150.
ii. **Prolonged suffering** – Providers help clients engage in activities that give them pleasure and help distract them from their suffering. Through counseling, staff support clients and caregivers by providing them with rehabilitation techniques that will help them manage their stressors.
iii. **Homelessness** – Providers maintain awareness of the risk of homelessness for their clients, and when appropriate, they can refer clients to housing resources in the community.

3. Program Goals, Objectives & Outcomes

The goal of the program is to address the specific need for support of the dyad of older adults and their caregivers. By providing psychosocial support to consumers and respite support to caregivers, the program assists older adults to live in the community for as long as reasonably possible and to age in place in their homes. Additionally, the respite support offered to caregivers will in turn reduce stress and mental health needs that may arise from providing ongoing caregiving.
The program will produce outcomes of improved support and wellness for caregivers of older adults, early identification of mental health symptoms, increased social connection and prolonged healthy and safe

independent living for older adults, plus increased service access to community services for both caregivers and older adults.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 47		
Number Served	Program Expenditure	Cost per Person
47	**$540,154.79**	**$ 11,492.66**

5. Evaluation Activities

❖ Strategies:

i. **Access and Linkage** – We facilitate information and referrals to support clients' access and linkage to community resources such as mental health therapy, psychiatric services, medical services, housing agencies, support for clients with Alzheimer's or with a disability such as blindness or deafness, senior companion services, employment agencies, etc.

ii. The practice's effectiveness is demonstrated according to the practice model and program design by the implementation of pre- and post- treatment assessments that can determine whether there has been an improvement in the client's and the caregiver's mood, satisfaction with life and ability to function independently during the time of treatment. The assessment instruments used are the Daily Living Activities (DLA-20), the Patient Health Questionnaire (PHQ-9), the Geriatric Depression Scale (GDS-15), and the Satisfaction with Life scale (SWL).

iii. Services are provided mainly in-person following health and safety protocols. Services include outreach activities, collaboration with the referral party, coordination with other professionals serving the client, consultation with managers, and meetings with clients and caregivers. Providers have formed a strong connection and collaboration with other service providers and departments and the In-Home Peer Respite program is becoming well known in the community.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years		
26- 59 years	2	4.2
60+ years	45	95.8

Prefer not to answer		
Unknown		
Unduplicated Total	47	100

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	2	4.2
Asian	9	19.2
Black or African American	1	2.1
Native Hawaiian or Other Pacific Islander	2	4.2
White/ Caucasian	11	23.5
Other	19	40.4
More than one race	3	6.3
Prefer not to answer		
Unknown		
Unduplicated Total	47	100

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American	3	6.3
Mexican/ Mexican-American/ Chicano	13	27.7
Puerto Rican	1	2.1

South American	5	10.6
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino	1	2.1
Hispanic or Latino Subtotal	23	49
Non-Hispanic or Non-Latino as follows:		
African	1	2.1
Asian Indian/ South Asian	3	6.3
Cambodian		
Chinese	5	10.6
Eastern European		
European	4	8.5
Filipino		
Japanese		
Korean		
Middle Eastern	1	2.1
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)	1	2.1
Other Non-Hispanic/ Non-Latino	5	10.6
Non-Hispanic or Non-Latino Subtotal	20	42.5
More than one ethnicity		
Prefer not to answer		
Unknown	4	8.5
Unduplicated Total	47	100

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	16	34
Female	31	66
Prefer not to answer		
Unknown		
Unduplicated Total	47	100

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	15	32
Female	32	68
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown		
Unduplicated Total	47	100

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	1	2.1
Heterosexual/ Straight	39	83
Bisexual		
Questioning/ Unsure		

Queer		
Another sexual orientation		
Prefer not to answer	4	8.5
Unknown	3	6.3
Unduplicated Total	47	100

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	21	44.7
Spanish	16	34
Vietnamese		
Chinese	5	10.6
Tagalog	1	2.1
Farsi		
Other	4	8.5
Prefer not to answer		
Unknown		
Unduplicated Total	47	100

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran	3	6.4
Served in Military	1	2.1
Family of Military	4	8.5
No Military	32	68
Prefer not to answer		
Unknown	7	15
Unduplicated Total	47	100

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	6	12.8
Difficulty hearing or speaking	7	15
Other communication disability	1	2.1
Cognitive	14	30
Physical/ Mobility	21	44.7
Chronic Health Condition	7	15
Other non-communication disability		
No Disability		
Prefer not to answer		
Unknown	3	6.3
Unduplicated Total	47	100

*Participants may choose more than one option for Disability.

7. Potential Responders

FY 2023		
Unduplicated N = 47		
Number of Potential Responders	**Types of Potential Responders (ex: teachers, nurses, family, etc.)**	**Examples of settings (ex: family resources centers, schools, etc.)**
The target is to serve 40 clients a year, which means maintaining a caseload of 20 clients (and their caregivers) at any given time since the services last for 6 months. The goal is to open 10 new clients each quarter.	This year 66% of our clients were female and 34% were male. 4.3% of clients were younger than 60 but had a disability that qualified them for services. Our clients encompassed a variety of races and ethnicities, divided almost equally between Hispanic and non-Hispanic. All the clients were retired or on disability. 8.5% were veterans or served in the military and another 8.5% were family of military. 34% had not finished High School education; 66% had a High School or higher degree. About 65% of the caregivers were female and 35% were male. 62% were younger than 60; 30% were 60+; in 8% of caregivers their age is unknown. Their race encompasses American Indian, Asian, African American, Pacific Islander, White, and other races not included in the questionnaire. Their ethnicities are also	Our clients were referred to us by different community agencies including: -Behavioral health centers -Health clinics -Home care and nursing care services -Case management community agencies -Associations for older adults and for various illnesses/disabilities -Senior centers and adult day health care centers -Senior apartment complexes -Health insurance plans -Churches -Health fairs

	varied. They spoke at least 8 other languages besides English.	

8. Detailed Outcomes

The pre- and post- treatment assessments used to indicate the client's and caregiver's levels of improvement are:

i. Daily Living Activities – 20 (DLA-20) – It measures independent functioning in activities of daily living in adults.
ii. Patient Health Questionnaire – 9 (PHQ-9) – It evaluates depression and its severity in adults. The questions are focused on subjective feelings and objective behaviors.
iii. Geriatric Depression Scale – 15 (GDS-15) – It evaluates depression in the elderly. The questions are focused on the person's subjective feelings.
iv. Satisfaction With Life Scale (SWLS) – It measures life satisfaction.

This year we served a total of 47 unduplicated clients in the In-Home Peer Respite program and we discharged 37 clients that completed the program successfully. The following are the results obtained from the pre- and post- treatment assessments of the clients:

i. The DLA-20 results show that in 76% of clients the score obtained at closing was higher than the score at opening, which is an indication of improvement in at least one of the 20 areas assessed. 24% of clients showed a decrease in the DLA-20 scores.
ii. The PHQ-9 results show that 71% of clients experienced a decrease in symptoms of depression; 19.35% of clients experienced no change in symptoms; 9.65% experienced an increase in symptoms.
iii. The GDS-15 results show that 48.39% of clients experienced a decrease in symptoms of depression; 16.13% experienced no change in symptoms; and 35.48% of clients experienced an increase in symptoms.
iv. The SWL scale results show that 54.5% of clients experienced an increase in their satisfaction with life after treatment; 19% of clients experienced no change; and 26.5% of the clients experienced a decrease in their satisfaction with life.

The following are the results obtained from the pre- and post- treatment assessments done on the caregivers of these clients:

i. The DLA-20 results show that in 62% of caregivers the score obtained at closing was higher than the score at opening, which indicates an improvement; in 24.18% of caregivers their score had not changed; in 13.82% of caregivers the score had decreased.
ii. The PHQ-9 results show that 65.52% of caregivers experienced a decrease in their symptoms of depression; 17.24% of caregivers experienced an increase in symptoms; also 17.24% of caregivers experienced no change in symptoms.
iii. The GDS-15 results show that about 62% of the caregivers were younger than 60 and did not need to complete the Geriatric Depression Scale. Of those that completed it, the GDS-15 results showed that 25% of caregivers experienced a decrease in their symptoms of depression and 75% of caregivers experienced no change in their symptoms of depression (it is likely that many of them did not have depression).
iv. The SWL results show that 73.51% of caregivers experienced an increase in their satisfaction with life after treatment; 15% of caregivers experienced a decrease in satisfaction; 11.49% showed no change in satisfaction.

The information for the assessments was gathered mainly by questioning the client and the caregiver directly, but providers also use their observation skills and sometimes they gather information (with the client's consent) from a relative or another person that knows them well. All clients met the discharge goals.
Other factors that may impact outcomes and are common among our clients include a sudden and significant deterioration on the client's physical health and the passing away of a close relative. Staff has also noticed that at the beginning of the program, when clients and caregivers have not had much chance to bond with the worker yet, they are more reticent to talk about their problems, but by the end of the program, when we do the post-treatment questionnaires, they are much more open about their low mood and other issues. All of these factors may influence the results and should be taken into consideration.

9. Evaluation Summary

The goal for the year in the In-Home Peer Respite program is to serve 40 clients; this fiscal year we managed to serve 47 clients and their caregivers. We have received a steady stream of referrals and right now we are at full capacity and have a wait list of 15 clients. We continue to receive very positive feedback about our services and the clients would love for our services to be continuous, since most of our clients have chronic health issues and their need for services is constant. Our services provide our clients with socialization, brain and physical stimulation, opportunities to be creative, fun times, and activities that support their emotional stability. We give them something to look forward to, sometimes it is an opportunity to forget their problems for a few hours, and we help them create new healthier routines. We provide a safe space for them to talk and we help them feel heard and valued. We also provide the caregivers with the opportunity to take a much needed rest. At the same time we support the caregivers with linkage to community resources and by teaching them coping skills.
As an example of a successful case I would like to share the case of a 74 year old Chinese woman whose family moved to Vietnam when she was very young and then she came to the USA in her mid-20s to escape the Vietnam war. Client is married and has three adult daughters who are very busy with their own families and her husband has moderate to severe Alzheimer's and he needs a great deal of assistance. When client was referred to the Respite program she reported that all her daughters' care and attention was directed to her husband; she felt forgotten and alone. Additionally, even though she had to deal with her own physical difficulties and frailty due to her age, her daughters were expecting her to help taking care of her husband. Client felt overwhelmed by their expectations; she felt they did not understand her own needs; she also felt uncared for and unloved by her own children. She had nobody to confide in and had started to fall into depression. The In-Home Peer Respite program provided client with a listening ear first of all. During the sessions client felt free to talk about her stressors and to cry openly without any judgment. During the visits she found validation of her feelings and her worth was reinstated. Together with the paraprofessional she figured out how to manage her stress and maintain a good relationship with her daughters. She was able to take care of her own needs and not just those of her husband. Client enjoyed the conversations with the paraprofessional as they walked around the neighborhood together; they played card games, built puzzles, learned new songs to play on her piano, painted, read, etc. Client had previously been a very active person with a variety of interests but had to abandon them due to her circumstances, which caused her to be depressed. Thanks to our program she was able to pick up several of these leisure activities again and enjoy life once more in spite of the circumstances.
Our clients are referred to us by different community services/agencies including:

i. Behavioral health centers
ii. Health clinics
iii. Home care and nursing care services
iv. Case management community agencies
v. Associations for older adults and for various illnesses/disabilities
vi. Senior centers and adult day health care centers

vii. Senior apartment complexes
viii. Health insurance plans
ix. Churches
x. Health fairs

Specifically, we have received a good number of referrals from Kaiser, Sourcewise, Santa Clara Family Health Plan, and Sunnyvale Senior Center. Over the last 3 years we have done online presentations, set up tables, sent emails, made phone calls, hang flyers, advertised on social media, etc. The relationships established over time with health care social workers and case managers are producing great results, as well as the word of mouth from our clients. In the last few months we have received a steady stream of referrals.

A challenge we encounter on a continuous basis is the poor health of our clients that causes them to cancel sessions due to having frequent doctor's appointments and hospitalizations, with the consequent disruption of our services. Another challenge we encountered this year was adjusting to serving the same number of clients with two staff instead of the three staff we previously had. We had to increase the staff's caseload in order to serve the same number of clients; that meant having to reduce the dosage per client from three hours to two hours per week. Our clients were disappointed but more so were the caregivers; they expressed that two hours a week was insufficient time for them to carry out errands and/or rest. It also meant that we could no longer offer two short visits a week instead of one longer one to accommodate the clients and caregivers' needs. This was also a cause for disappointment for our clients/caregivers. And a third challenge we have to overcome is maintaining the interest of those who have expressed a desire to participate in our program but who will have to wait close to 6 months before they can be served due to the long wait list. It seems that there is a pressing need to expand the program in order to better serve our community.

Law Enforcement Training and Mobile De-Escalation Response

PEI Outreach for Increasing Recognition of Early Signs Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 - JUNE 30, 2023)

1. Program Description

❖ Law Enforcement Liaison (LEL) and Interactive Video Simulation Training (IVST)

Santa Clara County provides a collection of support mechanisms for police officers, first responder and frontline staff who are often the first to respond to a mental health crisis – because police officers' ability to assess a situation and respond appropriately is critical in creating positive outcomes. The County's Law Enforcement Liaison (LEL) Team provides specialized training, including trauma-informed training, to improve officer responses to people with mental health issues, while also working to enhance relationships with law enforcement through greater collaboration and information sharing so that officers can support individuals, they come into contact with by connecting them with mental health services. Additionally, the LEL Team develops and implements Interactive Video Simulation Trainings (IVST) for officers looking to increase their ability to interact more effectively and safely with those experiencing a mental health related crisis. Once limited to police officers, this training has expanded to other first responders and frontline staff who are often the first point of contact.

❖ Law Enforcement Liaison (LEL) Team

In Santa Clara County, mental health professionals from BHSD provide specialized training to police officers through the LEL Team to improve their responses to a person with a mental health issue. The mission of the LEL Team is to build and enhance teamwork, training, discussion, and collaboration with law enforcement agencies throughout the County. The ultimate goal of the LEL Team is to provide police officers and first responders with the support and tools they need to improve their responses to someone experiencing a mental health crisis. The training is also meant to provide law enforcement departments, fire departments and EMS Staff with information so they can help residents get the mental health services and support they need.

❖ Interactive Video Simulation Training (IVST)

One of the hallmarks of the LEL Team is the ongoing development and implementation of IVST. IVST is a four-hour program that was developed for first responder to increase their ability to interact more effectively and safely with those experiencing a mental health related crisis. The focus is on greater understanding, sensitivity, recognition, and effective de-escalation techniques. As part of the training, participants apply what they have learned in interactive video simulations. These simulations depict people experiencing a myriad of mental health related challenges. This year 10 new simulations were created to continue to remain relevant and incorporate lessons learned.

❖ Trauma-Informed Policing

In order to cultivate and sustain effective relationships with the individuals first responder come into contact with, it is critical for first responder to able to recognize and address trauma. Trauma-Informed trainings present a framework for first responders which acknowledges the prevalence of trauma and its related symptoms and

employs response tactics accordingly. Some of the key elements of trauma-informed first responder training include identifying signs and symptoms of trauma and learning appropriate genera- and situation specific (e.g., interaction with victim of domestic violence) trauma-informed responses.

❖ Mobile Response to a Crisis (De-escalation)

Law enforcement liaisons (LELs) act as liaisons between BHSD, especially the MCRT team and Law Enforcement Agencies to identify services or treatment that are most appropriate to meet the individual's needs. Depending on the level of risk, mobile crisis staff may provide immediate support to stabilize the person and then make a same-day referral to a mental health clinic or arrange transportation for people experiencing crisis to Emergency Psychiatric Services (EPS) or Mental Health Urgent Care (MHUC) as needed. The mobile crisis team may also place 5150 involuntary holds. New programs within BHSD have come online that also address varying levels of individuals in crisis. These programs include TRUST, AOT and PERT. LELs serve as liaison for these newer programs as appropriate with training and facilitation.

2. Program Indicators

Law Enforcement Liaisons (LELs) and Interactive Video Simulation Training (IVST) are designed to:

i. Teach first responder to increase their ability to interact more effectively and safely with those experiencing a mental health related crisis and to reduce suicides. The focus is on greater understanding, sensitivity, recognition, and effective de-escalation techniques.
ii. Inform students/participants about alternatives to incarceration. Using de-escalation techniques to manage crisis situations, individuals can safely be diverted to community resources, housing alternatives such as crisis service, to provide needed support.

3. Program Goals, Objectives & Outcomes

i. **Outcome 1**: Increase collaboration and enhance teamwork between law enforcement, other first responders and Behavioral Health Care Services.
ii. **Outcome 2**: Increase the ability of law enforcement and other first responders to interact more effectively and safely with those experiencing a mental health related crisis.
iii. **Outcome 3**: Connect individuals experiencing mental health crisis to appropriate services.

4. Clients Served & Annual Cost per Client Data

FY 2022		
Unduplicated N =1167		
Number Served	Program Expenditure	Cost per Person
1167	**$ 175,489.33**	**$ 150.38**

5. 5. Evaluation Activities

❖ Strategies used:

i. **Improving Timely Access to Services for Underserved Populations:** Outcomes are measured by tracking the number of 5150 contacts and jail contacts that occur in a month by law enforcement agencies. All law enforcement jurisdictions are scheduled for on-going IVST and CIT trainings each year

to teach officers more effective ways to de-escalate situations and to utilize alternate ways to assist individuals in crisis, out in the field. Law enforcement also works closely with the county's Mobile Crisis Response Team (MCRT). Collaboratively and in partnership, outcomes result in a decrease of emergency behavioral health contacts and Jail contacts and an increase in alternative solutions such as crisis residential, peer respite, community resources, referrals to NAMI.

ii. **Evidence-based practice standard or promising practice standard:** Using IVST and CIT provides hands-on interactive skills training for law enforcement and other first responders. The instructors are county Law Enforcement Liaisons (LELs) with a combined total of 90 + years of experience. The LELs are certified as Peace Officers Standards and Training Program (POST) trainers and regularly update the training curricula to meet POST standards. The results of the training are demonstrated by officers in the filed who use the skills learned. There has been a decrease in officer involved shootings and negative outcomes and an increase in officers calling MCRT for support and assistance for behavioral health calls.

6. Demographic Data

Demographic data of those individuals referred to BHSD by those participants trained in IVST & CIT is captured by the respective programs where the referral is made. The trainers providing the instruction have no way of knowing who will be referred to BHSD by those trained. The demographic data of the police officers and other first responders receiving the training is not collected since it cannot be correlated to referrals made by those trained because the respective programs do not ask for demographic data of those making referrals but rather track data of the client they serve.

7. Potential Responders

July 1, 2022 - June 30, 2023
Total number of potential responders (outreach audience): 1167

Type of Setting(s) (ex: school, community center)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
SCC Sheriff	Deputies
SJ Parks & Rec	Staff, Field Workers, Homeless Outreach Specialists
Las Plumas BH	Staff and Clinicians
SJ Code Enforcement	Code Enforcement Officers
Learning Partnership	Clinicians, Outreach Workers, Peer Support, Frontline Staff
SJ Library	Staff
VMC Safe	Nursing Staff
Bill Wilson Center	Staff, Clinicians, Peers, Supervisors
SCC Sheriff Academy	Officers and Deputies
SCC Adult Probation	Staff and Probation Officers
SCC CIT	Officers and Deputies
SJ CIT	Officers and Staff
Community Solutions	Clinicians, Outreach Workers, Staff
SCC Park Rangers	Rangers
Adult Protective Services	Staff
AOT	Clinician, Frontline Staff, Outreach Workers
Pacific Clinics	Clinicians, Outreach Workers, Staff

8. Detailed Outcomes

July 1, 2022 - June 30, 2023
Number of individuals with SMI or SED referred to BHSD treatment system (includes county and CBO providers): 579
List type(s) of treatment referred to:

i. Mobile Crisis Response Team (MCRT)
ii. Mental Health Urgent Care (MHUC)
iii. Assisted Outpatient Treatment (AOT)
iv. Trusted Response Urgent Support Team (TRUST)
v. Mobile Response Stabilization Services (MRSS)
vi. Outpatient Services
vii. Community Resource
viii. In Home Outreach Teams (IHOT)
ix. Psychiatric Emergency Response Team (PERT)

9. Evaluation Summary

❖ Implementation Challenges:

FY 23
After several years of COVID limitations request for training have ramped up and non-law enforcement sources are requesting IVST instruction in record numbers. De-escalation training is in limited supply for non-law enforcement staff and the IVST program has gained high demand as these individuals are becoming aware of the applicability of the skills and lessons to non-law enforcement staff.

❖ Survey Results:

FY 23
Post class surveys of Law Enforcement asked the following questions (Very Good and Good responses are show as a percentage):

Quality of the Information provided:	99%	
Quality of the debriefing & discussion post exercises:	99%	
Exercises reflected real field situations:	96%	
Student knowledge of de-escalation techniques:	96%	*Pre class 58%
Student recognitions of signs & symptoms of mental illness:	99%	*Pre class 69%
Student recognition of Dual Diagnosis signs and symptoms:	81%	*Pre class 45%

❖ Success:

FY 23
Filming ten new IVST Scenarios that include LGBTQ+ situations, Multi-lingual situations and other more realistic and contemporary situations was a great success. These new training scenarios have been received with great enthusiasm and are the next evolution in providing accurate representation of individuals in crisis.

❖ Relevant Examples of Success/Impact:

FY 23

As a result of the relationship developed during IVST trainings with Law Enforcement and other First Responders, the LELs have become a source to contact when other methods of connecting with BHSD may be lacking or falling through the cracks. As a result, the LELs received 525 direct referrals and consultations on case where Law Enforcement and other First Responders needed assistance connecting clients to BHSD or is navigating the various program options available.

STIGMA AND DISCRIMINATION REDUCTION PROGRAMS

New Refugees Program

PEI Stigma & Discrimination Reduction Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The New Refugee Program's early intervention services aim to reduce stigma and increase awareness of available mental health services for newly arrived refugees and intervene at the early signs of mental health issues. The program provides linguistically and culturally appropriate outreach, engagement, and prevention activities to help refugees successfully settle in the county. One modification of this program will be that the New Refugee program will begin to allow services to children and will serve refugee clients who have lived in the County for seven years or less (instead of five).

The New Refugee program is responsible for bringing together multiple community partners who serve the refugee population. The program fosters collaboration and coordinates referrals, providing and organizing numerous culturally and linguistically appropriate outreach activities and mental health services. Outreach mainly occurs in the refugee's native language, with videos of the refugees' compatriots. Understandably, refugees often distrust government/authority figures, and many have endured public scorn, intense discrimination, and threatening behavior based on their ethnicity or religion. Refugee clients are provided with responsive engagement and intervention services, up to and including torture survivor support services. Additionally, refugee clients are connected to other specialty mental health services that may help them live and thrive in the county.

2. Program Indicators

❖ School failure or dropout

Clients are seeking education and enrolling in English as Second language (ESL) classes.

❖ Prolong suffering

Stigma is an ongoing challenge. Members of refugee communities have become increasingly insular. The clients report that they prefer to keep their stories to themselves and cope independently because of genuine fears regarding the risks of deportation and within the group gossip. The clients with mental health concerns struggle to explain their symptoms to their communities and are therefore reticent even to broach the subject.
To address the stigma in receiving behavioral health, the New Refugee Program provides various outreach strategies to the community to prevent prolonged suffering. Outreach efforts at locations including community centers, worship centers, schools, community-based organizations (Jewish Families, Refugee Forum, Sisters Helping Sisters), English as Second Language (ESL) classes, and AACI Community Vaccinations Events. This program engaged newly refugees and asylum seekers who have resided in the United States within seven years. Early treatment reduces prolonged suffering

3. Program Goals, Objectives & Outcomes

❖ Goals:

The New Refugee program will achieve the below goals:

i. Reduce Stigma
ii. Reduce disparities in access
iii. Reduce Trauma
iv. Prevent Suicide

❖ Objectives:

i. Reduce the stigma against identifying mental health issues and accessing services for those issues.
ii. Reduce trauma, specifically intensity and/or frequency of symptoms, and decrease any negative impact on client's functioning in daily living activities.
iii. Prevent suicide by helping to inform this community of the factors and symptoms of mental health issues, including depression, which can contribute to suicidality.
iv. Reduce stigma in the new refugee community.
v. Provide culturally appropriate prevention and outreach services in appropriate languages and in natural community settings to the target population, by favoring the use of non-threatening layperson terms commonly used to describe mental health symptoms experienced by this population, over clinical terms.
vi. Reduce the negative impact of trauma symptoms through the provision of brief treatment interventions to reduce situational stressors that are characteristic of resettling refugee populations, including trauma-related symptoms, and mitigate the need to seek services in the specialty mental health system. For those requiring specialty mental health services, bridge them into the specialty mental health system.
vii. Reduce the likelihood of suicidality through the improvement of coping skills of refugees and their families during the stressful period of acculturation into the predominant cultural norms.

❖ Outcome:

i. Identify newly settled refugees and increase connectedness to mental health services.
ii. Increase collaboration among community partners who serve refugee clients.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
213	**$750,166.07**	**3,521.91**

*Cost per person is calculated by using number served reported by provider

5. Evaluation Activities

Our new refugee program primarily focuses on the "Access and Linkage" strategy to ensure that individuals can easily connect with the necessary resources and services. Additionally, we emphasize "Improving Timely Access

to Services" for newly arrived refugees to address the specific needs of these underserved and marginalized communities. Furthermore, our program is meticulously designed, implemented, and promoted using non-stigmatizing and non-discriminatory strategies, ensuring an inclusive and supportive environment for all participants and community members.

In our mental health program for newly arrived refugees, we adhere to the evidence-based practice standard of Cultural Competence and Holistic Trauma-Informed Care. This standard effectively addresses the unique mental health needs of refugee populations. This practice's effectiveness is demonstrated through a combination of clinical research, client outcomes, and continuous evaluation of the program's impact on mental health outcomes among newly arrived refugees. Staff are trained extensively in cultural competence and trauma-informed care, ensuring they have the necessary knowledge and skills to provide effective services to this population. Regular supervision and ongoing training are also integral to maintaining fidelity to the practice model.

CST's service delivery approaches clients as survivors who have built-in resilience. We respect that resilience by providing client-centered, trauma-informed, multidisciplinary and culturally competent services to assist clients to heal. Our approach builds on clients' intrinsic motivations and a needs assessment to develop an individualized, holistic, strengths-based wellness plan that prioritizes strategies to address each area of need to improve functioning.

CST staff guide survivors in their recovery and empowerment journeys-typically an intensive 12 month long process that spans initial contact, assessment for psychological, medical, legal, vocational and social service needs, goal identification, intervention, and evaluation. Underlying each step in the process is the belief that all human beings have the capacity for growth and change, knowledge about one's situation, and resilience. Our diverse team of CST psychotherapists, psychiatrists and case managers work with the survivor to co-develop goals and priorities, allowing them to guide the timing and exact complement of services to empower the survivor to make informed decisions that best meet their unique needs.

Also, we know that many of our clients have experienced discrimination and persecution because of their sexual orientation, gender identity, and expression (SOGIE). AACI/CST has worked to ensure a welcoming and safe environment that is sensitive to all. We have our own internal LGBTQIA+ workgroup that assesses all aspects of our services and addresses the needs of staff and clients. Meetings are held monthly and incorporate staff from various departments across the agency. During the last fiscal year, we had an agency wide 3-part LGBTQIA+ sensitivity training provided to us by Dr. Jei Africa which included how to address microaggressions, as well as how to respectfully address client (and staff) pronouns and diverse identities. We required all Behavioral Health staff to participate in the county SOGIE training and had providers complete advanced training and certification through the Recognize Intervene Support Empower (RISE) program as trainers and became an active member of the Transgender Coalition. We meet clients where they are and offer them education, linkage to community social and support groups or to the County Gender Health Clinic as appropriate and based on their comfortability. CST clinicians and staff empower the client to lead in setting goals and are mindful to not make assumptions about what a client may need based on cultural expectations in the U.S. or the provider's world views. We are mindful of where clients are in their identity development and the impact of their cultural views and those of their family and community members. For instance, "coming out" may not be a goal or a desire of an LGBTIA+ client who faces specific pressures in the course of their everyday life.

CST's direct services for refugees PEI program within behavioral health department encompasses a range of individual and group activities and services tailored to address the specific needs of refugee specialized populations, such as LGBTQIA+ or female survivors. These initiatives are crafted to provide culturally sensitive and trauma informed support to these marginalized population and communities.

For LGBTQIA+ survivors, we offer dedicated group therapy sessions that create a safe space for discussing the unique challenges they face due to their sexual orientation or gender identity. Similarly, we offer gender specific support groups that address the intersection of their trauma with the gender-based experiences, fostering a sense of solidarity and understanding among participants. These group activities and services are grounded in a holistic and trauma informed approach that are knowledges in the verse background and experience of refugees survivors within this population. Our objective is to enhance healing and recovery, reduce isolation, and empower participants to rebuild their lives after experiencing a war trauma, and displacement.

An example of a female specific service is our Afghan Women's Group. Our CST team successfully developed and executed a 10-week Afghan Women's Group. The purpose of this group is to assist new arrivals of Afghan women build/restore resilience through engaging in a rehabilitation group build on their strengths and peer support to gain knowledge, understanding, and advocacy and coping skills that will enhance their resettlement and recovery process. Granting Afghan women, a safe place to share their experiences, feelings, and hopes is one positive tool to help them on their journey of recovery. Joining a supportive group consisting of professionals and fellow Afghans enables them to develop skills to manage their family environment. The group also provided the opportunity for participants to build community and peer support with other newly arriving Afghan parents.

We also implemented an Afghan Open Men's Group, which was facilitated by a licensed clinical social worker and a case manager who is also able to provide culturally sensitive support in the language needs of English, Dari, and Pashto. With the increase in demand of group treatment modality, CST was able to incorporate a wide range of clients by improving eligibility criteria to open to a larger pool of clients. We have been able to provide information on benefits, ESL classes, the healthcare system, childcare, adult education, immigration, and getting a driver license and buying a car. We had guest speakers from PARS Equality Center for legal immigration support, USCIS, adult schools in the area, Catholic Charities' IPS Program for vocational and employment support and the San Jose Police Department.

Additionally, we continuously monitor and evaluate the program's effectiveness through client feedback, outcome measurements, and data analysis. This approach allows us to make necessary adjustments to the program design and implementation to ensure that it remains aligned with the evidence-based practice standard and continues to meet the mental health needs of newly arrived refugees in our community.
To ensure access and effective linkage, we diligently monitor to program outcomes as outlined below, which consistently surpasses both standard of care and program expectations. CST's uses a variety of measurement tools to gather client and program outcomes.

- **Program outcomes:**

i. The average length of time between the date the referral was received and the date of the 1st contact for this reporting period (July 2022 – June 2023) was 13.83 days. (SOURCE: Internal Data via Excel)
ii. The average length of engagement period before the initial assessment for this reporting period (July 2022 – June 2023) was 8.6 days. (SOURCE: Internal Data via Excel)

- **Client's Outcome**

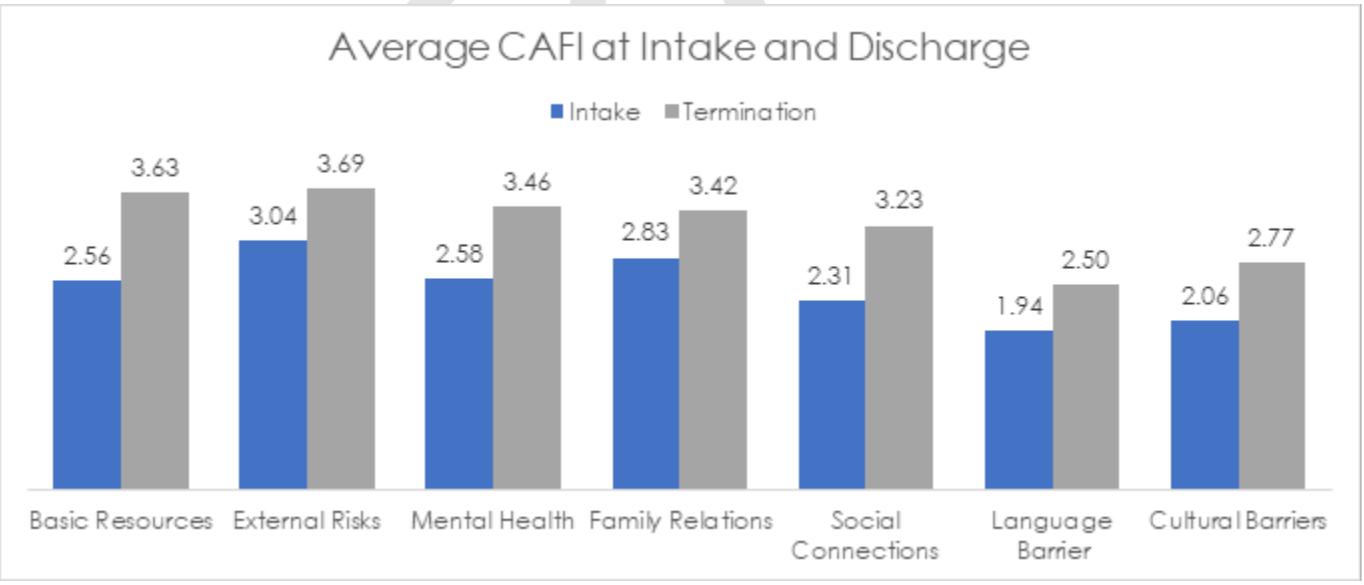
The Current Adaptive Functioning Index - Cross-Cultural Version (CAFI), and Client Satisfaction Survey are the measures that we use to measure client outcomes.

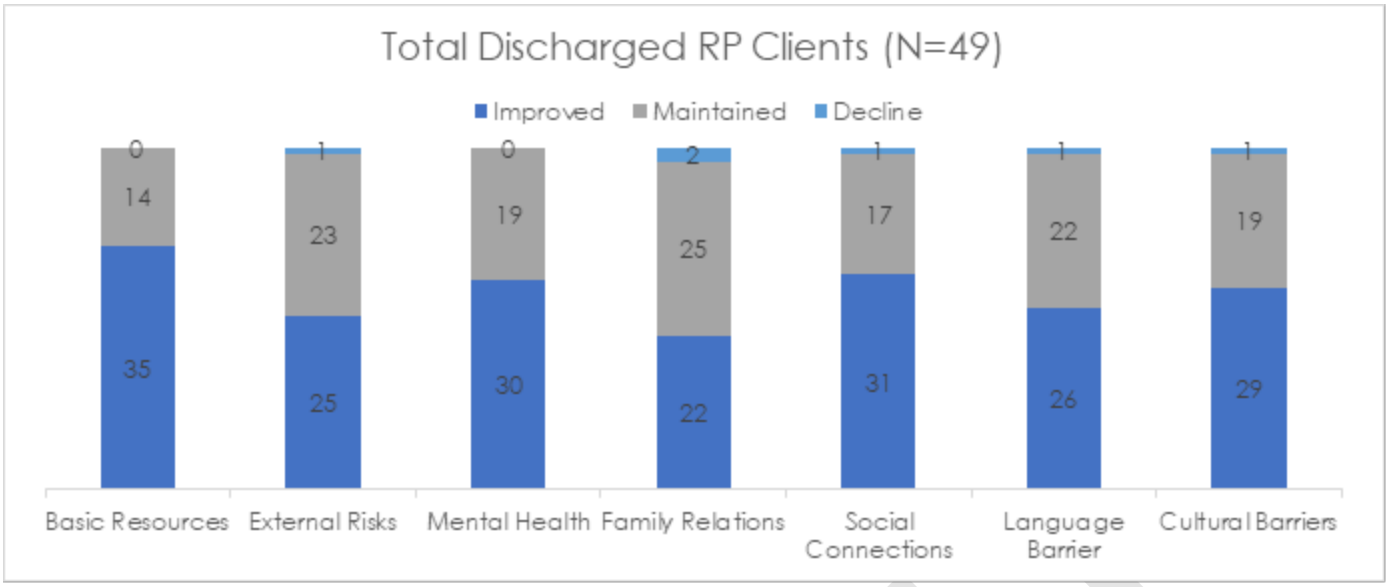
Consistent with our client centered, holistic approach, we have selected measures of adaptive functioning to measure successful client outcomes. For successful rehabilitation to occur, it is critical for the client to become

more functional across multiple life domains while managing his/her mental health symptoms. The first tool we use to track clients' progress is the CAFI-XC (Current Adaptive Functioning Index - Cross-Cultural Version); a professional rating tool developed by The Center for Multicultural Human Services, whose programs also provide services for torture survivors. The CAFI-XC fills a major gap in terms of measuring adaptive functioning for this population, as mainstream assessment instruments do not work well with survivors, who often present with a multiplicity of needs. The CAFI-XC is useful for assessing the functional needs and progress of cultural and language minority clients in eight key areas—Basic Resources, External Risks, Mental Health, Family Relations, Social Connections, Educational Achievement, Language Barriers and Cultural Navigation Barriers. Each area or domain is rated on a scale of 1 to 5, with 1 being "in-crisis" and 5 being "thriving." Through CST's services we can impact the client's functioning directly in the areas of Basic Resources, Mental Health, Family Relations and Social Connections, while linking clients with cultural and educational resources and English as a Second Language classes.

Tables below represent the data for the period 7/1/2022 to 6/30/2023.

CAFI-XC Domains	CAFI Intake	CAFI Discharge	% Improved	% Maintained
Basic Resources	2.6	3.7	71%	29%
External Risks	3.0	3.7	51%	47%
Mental Health	2.6	3.5	61%	39%
Family Relations	2.8	3.4	45%	51%
Social Connections	2.3	3.2	63%	35%
Language Barrier	1.9	2.5	53%	45%
Navigation of Cultural Barriers	2.1	2.8	59%	39%





6. Demographic Data

Demographics reported by provider

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	9	4%
16 -25 years	37	17%
26- 59 years	149	70%
60+ years	18	9%
Prefer not to answer		
Unknown		
Unduplicated Total	213	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native		
Asian		
Black or African American		

Native Hawaiian or Other Pacific Islander		
White/ Caucasian		
Other		
More than one race		
Prefer not to answer		
Unknown	213	100%
Unduplicated Total	213	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino		
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		

Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer		
Unknown	213	100%
Unduplicated Total	213	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	82	38%
Female	131	62%
Prefer not to answer		
Unknown		
Unduplicated Total	213	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male		
Female		
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	213	100%
Unduplicated Total	213	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	213	100%
Unduplicated Total	213	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	4	2%

Spanish	45	21%
Vietnamese		
Chinese		
Tagalog		
Farsi	9	4.2%
Other	154	72.3%
Prefer not to answer		
Unknown	1	0.5%
Unduplicated Total	213	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military		
Prefer not to answer		
Unknown	213	100%
Unduplicated Total	213	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability		
No Disability		
Prefer not to answer		

Unknown	213	100%
Unduplicated Total	213	100%

*Participants may choose more than one option for Disability.

7. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
3 (each group - 8 weeks)	23	7.67

8. Detailed Outcomes

We continued to facilitate our ongoing 8-week Parenting groups, we have gathered feedback from participants of our previous groups that CST incorporated for future sessions.
As gathered during our fall and winter group pre-screening survey, most parents attended telehealth sessions via Zoom due to ease in accessibility, as most of our refugee families face transportation barriers. However, during our winter group post-test surveys during the previous two closed group sessions, parents voiced their interest in sessions facilitated in person. Most also expressed that they would like to have their children play and socialize with others in a setting where they can also learn.
Since many parents expressed the desire to meet and connect with others who share the same cultural background, we could advocate for in-person sessions. As we continue facilitating group sessions, we have gathered lessons learned to meet refugee families' needs.
We transitioned to in-person group sessions for our spring Refugee Parent Support Group in collaboration with our AACI Wellness Department to conduct the group at Capitol Park Community Center.
As summer approaches, most families will have their children at home as the summer break begins. Families are more likely to participate in activities if their children can participate, which also provides our program an opportunity to enhance positive parent-child relationships through our curriculum.
As part of our service delivery, we successfully facilitated the groups with age and developmentally-appropriate toys, which were utilized to model positive social peer interaction among children and as well as model to parents. We included activities to incorporate arts enrichment to our families. In addition, we also provided families with children's books to support early literacy in which both parents and children can learn together.
A barrier that many of our refugee families face is a lack of transportation. We provided Lyft/Uber transportation to parents to bridge the gap towards being able to participate in person and access services. It will also decrease potential no-shows if we can provide them with transportation.
During the group, we also provided healthy snacks and as well as provide culturally sensitive food options at the end of the group as we celebrate parents who have successfully participated in the groups.
In order to create a curriculum that meets the needs of our families, we have incorporated guest speakers such as AACI Patient Health Navigator and AACI Registered Health Dietician to provide additional support and information as it relates to accessing medical and dental health care as well as providing our families with information about healthy eating.

Lastly, we were able to meet the most urgent need and the primary stressor of our Refugee families which concerns immigration and legal assistance. We were able to collaborate with Asian Law Alliance (ALA) along with their team of 5 Immigration Attorneys were able to provide legal consultation for 11 of our CST Families.

Post-test survey for Group 3 Refugee Parent Support Group

How confident are you with navigating the following resources for your child?

1 – not confident

2 – somewhat confident
3 – very confident

	Par 1 SG	Par 2 MA	Par 3 HJ	Par 4 LA	Par 5 BG	Par 6 FH	Comments
Health Care	2	2	3	2	2	3	"The struggle is the language barrier, which button to press and how to make an appointment."
Child Care	3	2	2	2	3	2	"Didn't attend the session, I want to learn what they teach and how they treat our kids when we are not around"
School Readiness/ Child Development	2	1	3	2	3	2	"I need more education about this and how to navigate the school system."
Legal/Immigration	2	3	2	3	2	3	"The lady was nice and she explained the information nicely"
Access to Basic needs such as Food, Clothing	2	2	3	2	2	3	"Words can't convey. My EID is now of two. When I came here we didn't have money, I didn't have proper clothing. I wore winter clothing during summer, others Afghans made fun of me and I'm beyond grateful for the traditional clothing that you provided."
Nutrition	2	2	3	2	2	3	"I need more information about how to apply for my green card, I want to ask more questions but it was very helpful."

What did you learn? What other topics would you have liked to learn more about? Quotes from participants

"Meeting other moms, I was looking forward to it every day and now that its done I'm sad. I enjoyed learning, meeting with providers and understanding different services every week."

"It was a great program; we learned a lot. We learned nutrition and how to feed them in a healthy way. How to deal with my kids behaviors and how to help them calm down"

"I feel safer to call you, and to go to the group. "

"I have a good relationship now with one of the moms, so I can call her now and talk to her. I'm really glad about that. "

“I saw an improvement in my son. he learned how to play with other kids and he was excited to go to class. He learned how to share. He doesn’t have any other kids to play with since his sister is a baby. I saw a difference in him. “

What is the most challenging about accessing services for your family?

“Because of the language barrier, everything is hard for me, I can’t really express my needs in a way that I’m comfortable with. “

“The transportation is challenging; my husband works the whole day and I have wait for him and im relying on him.

9. Evaluation Summary

❖ Program Barriers/Implementation challenges:

The past year has been marked by our commitment to assisting refugee families coming from Afghanistan, Ukraine, El Salvador, Columbia, Nicaragua, Venezuela, and other parts of the world in their resettlement journey. While progress has been made, it is essential to acknowledge the challenges faced during the early stages of resettlement.

In this section of the annual report, we will outline the program barriers and implementation challenges encountered while addressing the psychosocial needs of newly arrived refugee families.

After resettlement to a new country, many families face barriers during the early stage of resettlement, notably less than a year after their arrival. Barriers such as culture shock, loss of cultural identity, isolation from their community, lack of social support, language barriers, lack of knowledge about systems, transportation barriers, and housing are among the challenges that impede positive resettlement. These post-migration stressors cause psychological distress and impact refugee’s ability to sustain their growth and live optimal life.

Addressing the psychosocial needs of refugee families requires trust, empathy, cultural sensitivity, and trauma-informed service delivery. Care coordination to support the critical needs of refugee families and their children requires a multidisciplinary team approach that can be provided with the foundations of trust and strong rapport building.

Since this is a one-year program, access to services in many cases is limited availability of mental health providers who specialize in working with refugee population. Finding another provider with the same level of expertise and cultural competency is a huge challenge and for those who need transferring the mental health services to another provider can be challenging for several reasons:

i. Trust and Rapport building: trust and rapport between mental health provider and a client is essential for effective treatment. Newly arrived refugee may have already established a trusting relationship with their current provider and transferring to a new provider can disrupt this connection. It takes time and effort to develop a new therapeutic alliance and for the client to feel comfortable sharing their experience and seeking help
ii. Cultural and Linguistic competence: a mental health provider who are culturally sensitive and have experience working with the refugee populations are often better equipped to understand and address the unique challenges and needs of these individuals transferring to a new provider may means starting from scratch in terms of cultural understanding and may require the new provider to familiarize themselves with their client specific cultural background and experience.
iii. Trauma and sensitivity: many refugees have experienced significant trauma in their home countries or during the migration process. Mental health providers who are already familiar with a client's trauma history can provide more targeted and effective treatment. Transferring to a new may require retelling traumatic experiences which can be emotionally challenging, distressing and retraumatizing for a client.

❖ Lessons learned:

Building trust with newly arrived Afghan refugees or families requires sensitivity, patience, and understanding. It is vital to incorporate steps to foster a supportive environment, such as:

i. Demonstrate empathy and respect- to build trust and rapport, it is essential to respect their values, beliefs, and customs, treat them with dignity and kindness, and recognize their challenges.
ii. Cultural Sensitivity and trauma-informed care – service providers must learn about Afghan culture and the cultural background of clients served, such as traditions, to be sensitive to cultural differences and avoid making assumptions or judgments. We must ask questions respectfully and be open to learning from them.
iii. Foster a sense of safety by creating a safe and welcoming environment where they feel physically and emotionally secure. We must also ensure confidentiality and privacy is met to build on the trust that they have with providers.
iv. Facilitate opportunities for Refugee families to meet and interact with others who share their culture or have a similar experience. This can provide a sense of belonging and support.
v. Involve cultural providers/ family partners who can help bridge gaps, provide additional support, help translate, explain cultural nuances, and act as intermediaries when necessary.

In addition, trauma-informed care for refugees with children aged 0 to 5 requires a compassionate and empathetic approach that recognizes this population's unique challenges and needs. Providing a safe, supportive, and empowering environment can promote healing, resilience, and recovery for both children and caregivers. When working with refugees with children aged 0 to 5, it is essential to recognize the unique challenges that they face. These children are at a critical stage of development and are particularly vulnerable to the effects of trauma. Here are some fundamental principles of trauma-informed care that we practice while working with this population:

i. we create a safe and supportive environment trauma can cause individuals to feel unsafe and threatened. Creating a safe and supportive environment is critical and can be achieved by ensuring that the physical space is welcoming and comfortable and providing a warm and nurturing atmosphere.
ii. Recognize the impact of trauma on children's development, like cognitive, emotional, and social development. We take time to help them understand how trauma may be affecting each child and to tailor interventions accordingly.
iii. Promote resilience and healing to support recovery from adversity and to thrive in the face of challenges. This can be achieved by providing opportunities for children to express themselves engage in positive activities and build supportive relationships with caregivers.
iv. Strong partnership with the caregivers. This can involve providing support and resources to caregivers, helping them to build their resilience, and empowering them to support their children's recovery.
v. Use culturally sensitive and responsive approaches which involve incorporating cultural practices and beliefs into the intervention and ensuring that interventions out of spectral and appropriate for each family

❖ Successes:

Partnership with First 5 and local IRC, we facilitated a Refugee Parent Support Group. This group aims to provide support to newly arrived families with children under 5 years old by helping them navigate systems such as access to medical and dental care, learning how to raise children in a new country, healthy eating, safety laws, and understanding child-care options which are often very difficult for families who have experienced trauma in their past. The support groups are run in two languages, Dari and Pashto. We facilitated this along with our agency-integrated care. Our AACI Health Center Patient Navigator supported our families with linkage to health

care services, especially dental care. Through these psychosocial activities we provided platform for our clients to connect with others who have similar experiences, providing a sense of community and support.

The Refugee Parent Support Group is conducted for a refuge family with kids aged 0-5. This was a closed group, in which identified participants remain the same throughout the entire duration of the group. This approach facilitates and establish an open trusting relationship between participants as they remain to interact with each other for the mentioned time frame.
The sessions are facilitated by CST staff which includes CST Program Lead, LCSW. Intern from San Jose State University Masters in Social Work, Case Managers/ Peer Support Specialists (former refugee from Afghanistan). The sessions are interpreted in two languages, Dari and Pashto which are the 2 primary dialects spoken by Afghans. Sessions are conducted via Zoom, one day per week for approximately 1.5 hours for each session.
During the session about Health Care, participants learned about how to find a doctor (health and dental) for children, making an appointment, what to expect during appointments, emergency medical help and knowing their rights to transportation and interpretation services.
Building upon the publication “Raising Children in a New Country: Supporting Early Learning and Healthy Development” by Bridging Refugee Youth and Children Services (BRYC), ensures that newly arrived refugee families have the basic information that they need to know about US laws and parenting practices.
Childcare is an area of great need for families with children in order to support self-sufficiency and success of employment. This session will support participants in understanding their childcare options. Resources such as Santa Clara County R&R Program was utilized to help navigate resources for families.
Early Literacy and positive parenting activities are crucial for a healthy development of a child. Refugee families gain exposure to literacy-learning techniques modeled in the Parent-child class, which they then reinforce at home. In this way, parent and child learn together.
Healthy Living focused on providing a brief health education for refugees and to gather perspectives on learning habits toward healthy eating and regular physical activity in consideration of the participants' culture, values, and tradition.

Inter-agency collaboration was also implemented as part of our group curriculum. During the Health Care session, an AACI Health Center Patient Navigator was able to present information such as how to connect with the Health Clinic, signing up and registering for Dental Services and referrals in supporting families in navigating insurance in order to remove barriers to accessing care. In addition, during our Health Living session, AACI’s Registered Dietician, presented about Healthy Eating Habits in Afghan Cuisine which honored cultural food groups in respect of our participants' traditions.

- **Client Experiences and relevant examples of impact:**

She is a widowed mother of 5 young children from Afghanistan arrived in the United States after the fall of Kabul to the Taliban in 2021. The impact of trauma and forced migration was evident as the family navigated the resettlement stressors. As the mother shared, she cannot read and write in her language due to not having access to education when she was younger in her own country—navigating the system in a language and culture that she is unfamiliar with causes distress, helplessness, and frustration. Despite the challenges, she remained motivated and hopeful that her children would have opportunities and access to fundamental human rights such as education in hopes of a better life after the war.
The mother also shared that her challenges were the lack of social support, economic hardships, and unfamiliarity with the new country's health care and education system. As she tries to establish her own needs, it is even more challenging to access support for her children, especially her son, with special medical needs. With the lack of daycare, she must bring and attend to her youngest daughter during medical appointments,

which adds to the stressors of understanding the health system, accessing transportation, coordinating school schedules, and caring for her family as a single mother and refugee in a new country.
Parental and child well-being are strongly related to each other. Through our CST team approach, we were able to support this Afghan mother with a team that is culturally sensitive and trauma-informed. Her service provider and a case manager who speaks her primary language of Pashto created and built trust over time. Through several home visits and assistance with community services, our First5 Refugee Support Group created a space for her to learn with other parents from her home country of Afghanistan. She was able to understand access to care, connect with dental services, learn how to raise her children in a new country, gain knowledge about healthy nutrition, and most especially, gain positive social support sensitive to her culture.

❖ Refugee Parenting Groups

Our group service delivery approach is focused on providing comprehensive support to refugee families, particularly those with children aged 0 to 5 during their early resettlement stage. As a part of our efforts, we have successfully implemented various enriching activities, including age and developmentally appropriate toys, art enrichment and early literacy support through a children's books. These activities aim to foster positive social interaction among children and parents while promoting their overall development and well-being.
Facilitating positive social peer interaction: one of the key components of our groups is facilitating positive social peer interaction among children and parents. To achieve this we carefully curated a collection of age and developmentally appropriate toys that encourage cooperation sharing and communication. These toys where design to stimulate the children's imagination and creativity while also fostering a sense of play and collaboration among them.
During our group session the children were encouraged to engage in playtime together where they could interact and learn from one another. Our train facilitators guided the children in various group activities that promoted teamwork problem solving and emotional expression. By participating in these activities, the children learn important social skills and build friendship helping them adjust to their new environment and form a sense of belonging.
Modeling positive social behavior for parents: As a part of our program, we also recognized the importance of modeling positive social behaviors for parents. During group session parents had the opportunity to observe their children's interaction and learn from them. Additionally, our facilitators engaged in discussion with parents about the significance of social play and how they can actively support their children's social development.
By providing parents with insight into positive social interaction and emphasizing the benefits of the play in a child development we aim to empower them to continue promoting positive social behaviors at home. This approach helps strengthening the parent child bond while fostering A nurturing and supportive family environment. The arts enrichment sessions provided the space for families to bond over share creative experiences. D is not only promoted the deeper connection with the family unit but also offered a means of stress relief and self-expression during the resettlement process. The artistic expressions of children and parents alike serve as a testament to their resilience and adaptability.
Supporting early literacy: recognizing the importance of early literacy in child's development we provided families with a collection of children's books. These books were carefully selected to reflect diverse cultures and experiences enabling parents and children to explore stories from different backgrounds together.
Our program encourages parents to engage in interactive reading sessions with their children creating a nurturing environment for language development and bonding. As a parents and children read together, they not only build language skills but also strengthen their emotional connection laying the foundation for a lifelong love of learning.
During one of our group sessions on discussing raising children in a new country, two of our Afghan mothers with infants (children under 1year old) were able to connect with each other. Both of them shared experiences with how different it is to raise children in a new country compared to their home country. For example, one

mother stated “In Afghanistan, we have in laws and family living with us so we raise children together. Here it's different because I'm learning on my own. It is very difficult but I'm doing my best.” Both shared experiences such as sleeping habits and eating habits of their babies and connected in a level that is welcoming of their own culture.

Two Afghan fathers are engaged and involved with our group, both of them take active roles in connecting with resources for their children. They participate consistently and shows great interest in learning the topics discussed.

While learning about child safety, one father shared:

“Thank you for sharing this information with us, I learned about this while also studying for my driver’s license exam and I'm glad you also share it with me here.”

“I appreciate all you are teaching us, especially with learning about giving our children healthy food, it is hard to get kids to learn how to eat healthy food, thank you for including our own Afghan food here.”

Conclusion: The successful implementation of our groups service delivery and program enrichment initiatives has contributed significantly to the positive resettlement experience of refugee families with the children aged 0 to 5. By providing age-appropriate toys facilitating positive social interaction incorporating arts enrichment and supporting early literacy we have fostered an environment where families can grow and thrive together. Our commitment to promoting social development creativity and early literacy among refugee families remains steadfast. These enriching activities not only empower children to embrace their new surroundings but also equip parents with valuable tools to support their children's growth and development. As we continue to refine and expand our services we remain dedicated to making a lasting and positive impact on the lives of the families we serve.

To help refugees foster and build social connections CST hosted several activities in this past year such as:

i. Thanksgiving Event in which clients share stories and learn about US traditions in a safe space. Families were eager to share their own stories of similarities and differences related to their culture.
ii. In addition to our yearly events, AACI/CST continued to support survivors of torture, refugees and their families, children, and adults with our annual Holiday Gift Giving drive. Also, through our Wish Book Project, awarded by Mercury Newspaper- we served survivors and their family members each with $ 100 Target gift cards so they can have access to basic needs that is essential to support positive resettlement.
iii. Through our partnership with First 5 and local IRC, we facilitated a Refugee Parent Support Group. This group aims to provide support to newly arrived families with children under 5 years old by helping them navigate systems such as access to medical and dental care, learning how to raise children in a new country, healthy eating, safety laws, and understanding child-care options which are often very difficult for families who have experienced trauma in their past. The support groups are run in two languages, Dari and Pashto. We facilitated this along with our agency-integrated care. Our AACI Health Center Patient Navigator supported our families with linkage to health care services, especially dental care. Through these psychosocial activities we provided platform for our clients to connect with others who have similar experiences, providing a sense of community and support.

Cultural Communities Wellness Program

PEI Stigma & Discrimination Reduction Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The Cultural Communities Wellness Program harnesses the distinctive experiences and insights of culturally and ethnically diverse community members to fortify behavioral health support. The Cultural Communities Wellness Program (CCWP) envisions nurturing communities where individuals and families from all cultural backgrounds enjoy a high quality of life, liberated from the stigmas linked to mental health status, and are empowered to transition within mental health systems. The program seeks to enhance understanding and awareness of behavioral health, diminish stigma, and bias within cultural contexts, and intensify community outreach and engagement to alleviate the impact of mental health conditions. The County of Santa Clara's Cultural Communities Wellness Program serves seven ethnic/culture groups: African Heritage, African Immigrant, Chinese, Filipino, Latino, Native American, and Vietnamese. The Cultural Communities Wellness Program's activities are categorized into three main components: Community Outreach and Engagement: This facet involves outreach efforts at various sites, organizing community events, delivering presentations, facilitating support groups, and providing one-on-one peer support services. Mental Health Training and Education: The program strives to heighten awareness of behavioral health through a variety of training initiatives including Mental Health First Aid (MHFA), Question Persuade and Refer (QPR), and Wellness Recovery Action Plan (WRAP) trainings. It also encompasses training in symptom management, depression management, parent education, workshops covering mental health, substance use, and trauma, as well as training aimed at reducing stigma. Culture-Specific Programs: Collaborating with community agencies, the program coordinates events targeted towards underserved ethnic communities. Beyond these three core components, our program offers the following services: Linkages and Referrals Outreach and engagement Advocacy Navigation services to support the community Diminution of mental health stigma The staff of the Cultural Communities Wellness Program is multicultural and multilingual, representing a minimum of eight cultural communities and proficiently speaking at least twelve languages. The program's objective is to dismantle cultural barriers that impede access to mental healthcare, diminish stigma and discrimination, and function as cultural ambassadors for community members in need of services.

The primary focus of the Cultural Communities Wellness Program centers on preventive measures and early intervention for communities that are underserved and unserved. The program is dedicated to addressing and reducing suicide, incarcerations, unemployment, prolonged suffering, and homelessness by providing peer support, community outreach and engagement and educational services to underserved and unserved communities. The Cultural Communities Wellness Program is resolute in its mission to erode stigma and bias while enhancing the accessibility of mental health services within these communities. Cultural Communities Wellness Program prioritizes cultural responsiveness, increase accessibility, and explores innovative outreach efforts. CCWP prioritizes cultural and diversity needs and supports coordination and collaboration with the community to improve access to care.

2. Program Indicators

i. Suicide: CCWP team members provide 1:1 peer support services, trainings such as Question, Persuade, and Refer (QPR), Mental Health First Aid, and Wellness Recovery Action Plan (WRAP) to educate the public and prevent suicide. WRAP helps educated beneficiaries on how to utilize their wellness tools and recognize triggers to help reduce the risk of crisis and suicide. CCWP peer support workers regularly attend trainings such as intentional peer support, trauma informed training and motivational interviewing training to enhance the delivery of 1:1 peer support services of individual and family support.
ii. Mental health peer support workers provide resources and linkages to help reduce suicide risk for the community, peers refer consumers to Call Center for behavioral health services and refer to Emergency Psychiatric Services, Mobile Crisis Unit, Trusted Response Urgent Support Team, and Behavioral Health Urgent Care for crisis management. CCWP also offers the cultural knowledge to help engage family and community support for individuals who are at risk of suicide.
iii. Incarcerations: CCWP provides 1:1 peer support with modalities such as trauma informed, and tools from WRAP to help beneficiaries reduce the risk of incarceration by creating a wellness and crisis prevention plan. CCWP also provides support for individual who are transition back into the community post incarceration through our outreach effort at and collaboration with Re-Entry Center.
iv. Unemployment: CCWP provides trainings, Mental Health First Aid, Wellness Recovery Action Plan to address stressful emotions that unemployment may create. CCWP also provides 1:1 peer support service to assist beneficiaries who needs assistance. CCWP refers and links service recipients to Office of Consumer Affairs for Employment Support Groups and Center for Employment and Training.
v. Prolonged Suffering: CCWP is dedicated to reducing the prolonged suffering by providing culturally sensitive 1:1 peer support service, health literacy trainings, community outreach and engagement and collaborations with community agencies to destigmatize mental health and provide a supportive environment to support beneficiaries in their wellness and recovery journey.
vi. Homelessness: CCWP provides resources to individuals who may be at risk of homelessness. Each cultural team also utilizes support from their communities to assist beneficiaries who would prefer to live in their cultural communities. CCWP provides resources for the unhoused population to assist with housing. Navigator training enriches CCWP's knowledge of resources for unhoused individuals and improve our ability to serve the unhoused population.

3. Program Goals, Objectives & Outcomes

The goal of Cultural Communities Wellness Program is to reduce the stigma associated with behavioral health conditions, increase understanding of behavioral health issues, increase willingness to seek help, and increase access to behavioral health services.
The outcomes for the Cultural Communities Wellness Program are:

i. Outcome 1: Collaborate with un-, under-, and inappropriately served ethnic groups
ii. Outcome 2: Reduce stigma associated with mental health status
iii. Outcome 3: Increase service connectedness to mental health resources

The Division of Consumer Affairs, Family Affairs and Cultural Communities Wellness Program's top priorities for FY23 are:

❖ Increase outreach and engagement.

i. Promote wellness and recovery.
ii. Promoting peer services into the Behavioral Health System. (I.E. Inpatient, Outpatient, Crisis Services.)
iii. Increase culturally sensitive services and highlight lived experience to improve customer service.
iv. Increase self-help, consumers and family involvement.
v. Increase natural networks of supportive relationships.

vi. Improve data tools, outcomes Increase behavioral health awareness

4. Clients Served & Annual Cost per Client Data

Due to the nature of outreach and engagement activities of CCWP where many of the services are provided in brief interactions and in the community, it is very difficult to obtain data to determine if an individual is a duplicate consumer of services.

Oftentimes, participants in these outreach activities are hesitant to provide their information and may choose to leave when our staff requests demographic details. In the fiscal year 2023, the program maintains its commitment to virtual group sessions, which require registration. However, online participants occasionally bypass the registration process, making it more challenging for facilitators to follow up compared to in-person interactions. The virtual setting doesn't always allow for effective follow-up with individuals who opt out of providing demographic data.

The Cultural Communities Wellness Program also offers training, education, and support groups where peers gather demographic information from participants. Many participants opt not to respond to these surveys due to a lack of trust in the public system and concerns about the intrusive nature of the questions. While our staff provides clear instructions to participants, allowing them to decline specific questions, some participants choose to decline the entire survey and intake process.

The primary aim of the Cultural Communities Wellness Program is to foster engagement, eliminate stigma surrounding behavioral health, and assist consumers in accessing community services. We remain committed to allocating our resources and efforts towards collecting demographic data to enhance our understanding of the program's impact.

Due to the structure of our program, there is potential for data duplication, hence we report on duplicated clients. Participants often engage with peer support workers at various community outreach and cultural events to access resources. These interactions can sometimes be brief. It has been observed that repeated requests for demographic information during these short engagements can be challenging for participants, especially those who are still considering the available support options.

FY 2023		
Duplicated N = 6,288		
Number Served	Program Expenditure	Cost per Person
6,288	**$1,350,389.92**	**$214.76**

5. Evaluation Activities

The Cultural Communities Wellness Program employs inclusive, stigma free and respectful strategies to engage the community. Peers with lived experience provide peers services, mental health literacy, community outreach and engagement to destigmatize mental illness and promote a nondiscriminatory culture. Peers provided services and engaged the community to provide non stigmatizing and non-discriminatory services. The Cultural Communities Wellness Program practices cultural humility while delivering services and supporting the community. Services are provided by peers with lived experience and from similar cultural background to ensure that program staff are connecting with individuals to meet their needs in a non-stigmatizing and nondiscriminatory matter. CCWP is anchored in cultural humility, ensuring services are not only relevant but also empathetic. This

is further enhanced by employing staff from similar cultural backgrounds, enhancing rapport and understanding between the program and the individuals it serves.

Access and Linkage - CCWP Mental Health Peer Support Workers provides peer support for referrals and linkages to behavioral health treatment and resources. Peer support differs from clinical services as it provides trained peer staff with lived experience to help individuals navigate the system and find their own path to wellness and recovery. MHPSWs provide individuals with linkages with behavioral health professionals inside and outside of the clinical setting which include Community based Organization representatives, rehabilitation counselors, community workers and, also connect client to natural supports in the community. The MHPSWs provide access and linkages to other healthcare services, benefits, housing, employment, vocational and educational opportunities, and other client needs.

Cultural Communities Wellness Program conducts outreach in the following settings to promote de-stigmatization and nondiscriminatory practice.

In FY23, CCWP increased staff training from occasionally and as needed basis to regular trainings. all CCWP staff were trained to support the Navigator Program prior to its launch. Staff participated received intensive training to gain knowledge on programs across the Behavioral Health System. With a better understanding of the resources and programs available, staff can address the specific needs of the community more effectively. This translates to faster response times, accurate referrals, and overall enhanced service quality. By equipping mental health peer support workers with the right knowledge and tools, they can identify and address potential issues before they escalate. Early intervention can lead to better outcomes and can often prevent more severe issues down the line. Overall, training all CCWP staff to support the Navigator Program can have multiple long-term benefits, both for the individuals they serve and the broader community. This approach can lead to a more responsive, efficient, and compassionate behavioral health system.

6. Demographic Data

	FY 2023	
Age Group	# Served	% of Served
0 – 15 years	16	0.25%
16 -25 years	71	1.13%
26- 59 years	416	6.62%
60+ years	105	1.67%
Prefer not to answer	12	0.19%
Unknown	5668	90.14%
Duplicated Total	6,288	100.00%

	FY 2023	
Race	# Served	% of Served

American Indian or Alaska Native	16	0.25%
Asian	2625	41.75%
Black or African American	138	2.19%
Native Hawaiian or Other Pacific Islander	1	0.02%
White/ Caucasian	137	2.18%
Other	2	0.03%
More than one race	0	0.00%
Prefer not to answer	23	0.37%
Unknown	3346	53.21%
Duplicated Total	6288	100.00%

	FY 2023	
Ethnicity	# Served	% of Served
Hispanic or Latino:		
Caribbean	9	0.14%
Central American	13	0.21%
Mexican/ Mexican-American/ Chicano	243	3.86%
Puerto Rican	2	0.03%
South American	1	0.02%
Hispanic/ Latino (undefined)	2	0.03%
Other Hispanic/ Latino	33	0.52%
Hispanic or Latino Subtotal	303	4.82%
Non-Hispanic or Non-Latino as follows:		
African	138	2.19%
Asian Indian/ South Asian	58	0.92%
Cambodian	0	0.00%
Chinese	247	3.93%
Eastern European	8	0.13%
European	89	1.42%
Filipino	31	0.49%
Japanese	10	0.16%
Korean	11	0.17%
Middle Eastern	16	0.25%
Vietnamese	2241	35.64%
Non-Hispanic/ Non-Latino (undefined)	30	0.48%
Other Non-Hispanic/ Non-Latino	12	0.19%
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity	0	0.00%
Prefer not to answer	23	0.37%
Unknown	2768	44.02%
Duplicated Total	6288	100.00%

	FY 2023	
Gender (Assigned at Birth)	# Served	% of Served
Male	1073	17.06%
Female	1937	30.80%
Prefer not to answer	19	0.30%
Unknown	3259	51.83%
Duplicated Total	6288	100.00%

	FY 2023	
Gender (Current)	# Served	% of Served
Male	1073	17.06%
Female	1937	30.80%
Transgender (Male to Female)	3	0.05%
Transgender (Female to Male)	20	0.32%
Transgender (Undefined)	1	0.02%
Genderqueer	3	0.05%
Questioning or Unsure	2	0.03%
Another gender identity	11	0.17%
Prefer not to answer	19	0.30%
Unknown	3219	51.19%
Duplicated Total	6288	100.00%

	FY 2023	
Sexual Orientation	# Served	% of Served
Gay or Lesbian	6	0.10%
Heterosexual/ Straight	351	5.58%
Bisexual	8	0.13%
Questioning/ Unsure	0	0.00%

Queer	0	0.00%
Another sexual orientation	4	0.06%
Prefer not to answer	809	12.87%
Unknown	5110	81.27
Duplicated Total	6288	100%

	FY 2023	
Primary Language	# Served	% of Served
English	497	7.90%
Spanish	54	0.86%
Vietnamese	1576	25.06%
Chinese	97	1.54%
Tagalog	9	0.14%
Farsi	0	0.00%
Other	118	1.88%
Prefer not to answer	118	1.88%
Unknown	3819	60.73%
Duplicated Total	6288	100.00%

	FY 2023	
Military Status	# Served	% of Served
Active Military	1	0.02%
Veteran	1	0.02%
Served in Military	1	0.02%
Family of Military	0	0.00%
No Military	223	3.55%
Prefer not to answer	531	8.44%
Unknown	5531	87.96%
Duplicated Total	6288	100.00%

	FY 2023	
Disability*	# Served	% of Served
Difficulty seeing	1	0.02%
Difficulty hearing or speaking	0	0.00%
Other communication disability	0	0.00%
Cognitive	0	0.00%
Physical/ Mobility	2	0.03%
Chronic Health Condition	4	0.06%
Other non-communication disability	12	0.19%
No Disability	521	8.29%
Prefer not to answer	191	3.04%
Unknown	5557	88.37%
Duplicated Total	6288	100.00%

*Participants may choose more than one option for Disability.

In FY23, the program diversified its methods for collecting demographic data, incorporating tools like QR codes, SurveyMonkey, and data collection at trainings and events. While this increased the response rate, it didn't lead to a significant surge in participation, given the varied technological proficiency among our participants.
Throughout FY23, the staff accentuated the confidentiality of QR codes, assuring participants of their privacy. They had the option to enter their names, but it wasn't mandatory. Additionally, to foster trust, more engagement initiatives were undertaken to encourage the community to share demographic information.
However, despite emphasizing the anonymity and confidentiality of our SurveyMonkey questionnaire, where participants could share demographic data without revealing their names, the response rate remained underwhelming.
A notable uptick in data collection was observed when the program staff made consistent requests during the tenure of a support group series. CCWP's presence at community agencies, such as the Vietnamese American Services Center, during wellness group sessions, and while offering on-site peer support and navigation services, proved beneficial. Engaging directly with participants at these venues facilitated building trust over time, resulting in more willing participation.

7. Group Services Delivered

In FY23, Cultural Communities Wellness Program conducted (total no. 110) groups to serve the community.
Cultural Communities Wellness Program provides:

i. Mental Health First Aid in both Adult and Youth versions which targets community members, support systems who may want to support those who are experiencing mental health symptoms and crisis.
ii. Mental Health First Aid is a course that teaches the community how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives the participant the skills one needs to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.
iii. This year our program has provided 68 Adult and Youth Mental Health First Aid trainings to the community.

iv. Question Persuade and Respond is a suicide prevention training for the community. Our program has provided 18 training this year to the community. The course aims to assist the community:
v. To understand the nature, range and importance of suicidal communications and their importance in preventing suicide.
vi. To review and understand the groups at greatest risk of suicide and why QPR can work for them.
vii. To train participants to teach QPR Gatekeeper Training for Suicide Prevention.
viii. To gain a historical perspective about suicide prevention and how QPR fits into national efforts.
ix. To acquire specific knowledge about how audiences may respond to the QPR message and how to react in a helpful manner.
x. To learn how to effectively promote suicide prevention in their own communities.
xi. To gain the competence and confidence to teach others how to save lives and help prevent suicidal behaviors.
xii. Wellness Recovery Action Plan (WRAP) Support Groups targets consumers, family members, and support systems, educators, community members and leaders. The WRAP process supports participants to identify the tools that keeps individuals well and create action plans to put the plan into practice int everyday life. WRAP helps individuals incorporate key recovery concepts and wellness tools into their plan and life. This year we have 11 WRAP groups for the community. The total number of WRAP group is low this year due to the time our program had waited for the arrangement of re-certification for our WRAP facilitators from the Copeland Center before our teams can provide this service to the community.
xiii. Mental Health Workshops for Adult and Youth and workshops in topics such as trauma informed-care, safety, depression, substance use as well as cultural presentation, i.e. Asian American & Pacific Islander and Taste of WRAP have been conducted to the community including parents and educators connected with Santa Clara County Office of Education, youth educators, County contracted and non-contracted agencies, senior apartments, crisis response leaders and volunteers, and general public. All together our program has provided 13 workshops this year.

Our program has facilitated 300 wellness and educational sessions this year at the Vietnamese American Service Center (VASC) specifically for Vietnamese monolingual adults and older adults, as well as Spanish-speaking adults and older adults. These groups have been instrumental in supporting these vulnerable populations, assisting participants in prioritizing their well-being and equipping them with essential skills for a seamless transition and life-building in the United States.

FY 2023		
Duplicated N =		
Number of Groups	Attendance	Average Attendance per Group
410	2803	6.84

8. Detailed Outcomes

❖ Outcome Measure

There were several implementation challenges with the Outcome Measure Survey in FY22. Staff expressed that the content of the survey is not consumer friendly. Some participants refused to complete the survey as they did not believe it is directly related to them. Other participants completed the survey might leave some questions unanswered as those questions are not applicable to their conditions.

CCWP provided surveys to outreach events and participants did not complete the outcome surveys. The feedback received in trainings noted that the survey does not focus on wellness and recovery. Community members and providers who attended trainings did not complete the survey and noted that they did not experience mental health symptoms. Most consumers who attended training declined to complete the survey. CCWP will review the implementation challenges and will review new strategies to engage the participants to complete the survey or explore a different validated survey that is more sensitive and consumer friendly.

There were 26 participants who refused to complete the post surveys.

CCWP collect 136 Pre surveys and 110 Post surveys.

Strongly Agree	4%	2%	3%	2%	21%	19%	38%	35%	2%	5%
Declined to Answer	1%	8%	3%	9%	7%	12%	4%	10%	13%	15%

	People's reaction to my mental health problems make me keep myself to myself		I avoid telling people about my mental health problems		Having had mental health problems has made me a stronger person		Some people with mental health problems are dangerous	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Strongly Disagree	37%	38%	40%	36%	15%	18%	19%	25%
Disagree	30%	31%	26%	27%	15%	7%	21%	21%
Agree	22%	16%	26%	23%	39%	38%	46%	43%
Strongly Agree	5%	5%	3%	5%	26%	25%	10%	6%
Declined to Answer	6%	10%	5%	9%	5%	12%	4%	5%

Our program has become one of the navigation efforts to support the community. Community members are referred to receiving mental health treatment and medication through the mental health call center. Staff also provide many different linkages of community resources to participants such as benefits, housing, adult day health care service, mental health support groups, legal service agencies, counselors/therapists, community-based organizations, and so on. Most importantly, the individual service/peer support service our staff provided to the community members has helped individuals going through their hardship in mental health, suicidal ideation, and life difficulties. Peer support service becomes one of the participants' encouragement and motivation in their journey of recovery and wellness

9. Evaluation Summary

❖ Challenges:

Staffing continues to be a challenge in FY23 as several of our coded positions have been frozen due to budget adjustment of Behavioral Health Services. Recruitment is still difficult for language codes due to the lack of qualified candidates. Although our program had been attempting to fill vacant positions as the restrictions are lifted, our program unable to find candidates with specific language codes, e.g. Tagalog speaking, Native background and peers with the appropriate lived experience to serve the targeted population. During the fiscal

year 2023, personnel from the Latino team transitioned to new roles, resulting in a service gap for the Latino Community. Fortunately, we successfully recruited a replacement from the Latino community. However, the issue of staff turnover has posed a challenge, affecting service provision due to prolonged recruitment timelines and the considerable duration required for the comprehensive onboarding of new staff members. Additional staffing challenges include staff members from the Native Team being on leave and one member departing from the county. This impacted services provided to the Native Community.

In FY23, the division implemented a streamline recruitment and onboarding process, cross training to improve efficiencies in FY24. All new employees are to be cross train to provide coverage across the peer programs. In our program's ongoing efforts to foster community dialogue on mental health, the persistence of stigma remains a significant hurdle. This is evident in instances where community members declined engaging in conversations with our staff regarding mental health during outreach events. Responses ranged from asserting the absence of mental health issues to simply dismissing the matter entirely. A few individuals even exhibited lighthearted reactions as they briefly perused our mental health outreach materials.

Furthermore, the task of gathering demographic data at our program's outreach events presents an ongoing challenge. Despite our team's clear explanations regarding the purpose of collecting this information and assurances of its confidential handling, community members consistently exhibit reluctance to divulge their demographic details. This issue hampers our ability to obtain accurate and comprehensive demographic insights.

- **Program Success:**

Cultural Communities Wellness Program provided 6288 services to the unserved and underserved communities CCWP provided trainings in person and was able to outreach and provide trainings to community partners such as the shelters, hospital staff, underserved community centers, County contracted and non-contracted agencies, educators of school districts and SCC Office of Education, senior centers, colleges, and general public. The program focused heavily on outreach and engagement to help the unserved and underserved communities by attending outreach and engagement events, developing sites for mental health literacy and, developing new agency collaboration to enhance our peer services delivery to serve the unserved and underserved population. Furthermore, the number of trainings increased as COVID restrictions lifted. CCWP also partnered with Division Programs to provide cultural content and cultural relevant presentations and services at the Self Help Centers. CCWP has been engaged with the African Immigration community for a decade to bring mental health awareness and decrease stigma within the community.

In FY23, with much continued efforts, this community recently opened up to engage in mental health education such as Mental Health First Aid to learn and be equipped to help others who are experiencing mental health and/or substance use challenges. African Immigration community has provided very good feedback to the training and is planning to have more mental health education provided to this population. In FY23, CCWP Latino team has been expanding its outreach strategy to different locations within Santa Clara County such as Mexican Consulate, Sacred Heard Community Services, Vietnamese American Service Center and Gavilan College in Gilroy to reach monolingual and/or bilingual Spanish speaking community members. By conducting our outreach strategy in the South County, it helps to bring mental health awareness and extend our program services to the community members of this location.

In FY23, CCWP Chinese team has successfully collaborated with many agencies within Santa Clara County, Santa Clara County Office of Education, school districts, and colleges to provide mental health education including Mental Health First Aid, QPR, WRAP, mental health workshop, trauma informed care, substance use workshop, safety workshop and so on to their staff, volunteers, and clients to be equipped in mental health knowledge and best practice. Additionally, this successful partnership has significantly increased the referral of clients to our individual/peer support service. Chinese and Vietnamese teams also collaborated frequently to serve the community in providing workshops, organizing community events and outreach activities. Besides,

with the time and commitment the Vietnamese team has devoted to the clients in Vietnamese American Services Center (VASC), the number of participations of the wellness exercise group has greatly increased as well as the educational citizenship class and music wellness group. The Vietnamese team is planning to provide more wellness and self-care related workshops to meet the needs of the members of VASC in the next fiscal year. The peers in the Division received extensive training for the systems of care in behavioral health services Department to improve their understanding and ability to provide resources to the community. Staff also received extensive training to become alternatives for Navigator Program which launched in FY23. Staff also has access to electronic database, findhelp.org which allows peers access to online database of resources and information.

- **Success Stories:**

i. Chinese team helped a Korean English speaking community member who has mental illness and living in a shared household with other people who too have mental illness. This Korean community member has issue/problem with her housemates. Our team met up with her on a regular basis to provide peer support services in helping her of how to relate to her housemates with healthy boundaries. Besides, Chinese team also supported her emotionally when her mother was diagnosed with cancer. This community member was very grateful to receive consistent support and hearing a different perspective from our team member as an outsider of her household.

ii. A Chinese community member who has mental illness reached out to the Chinese team to find a support group. Our team referred different support groups to her, and she attended one church cell group gathering. This community member was very happy to join this group and had fun in this gathering. She plans to keep going to this group to build support for herself.

iii. After two different successful YMHFA trainings provided to different unified school districts within Santa Clara County by the Chinese team, Brittan Middle School of Morgan Hill Unified School District would like our team to provide mental health training to their middle school students as the school wants to build up a peer support team within the school. This is in planning process and will be happening in this school year.

iv. This year our Chinese team has collaborated and provided several AMHFA and QPR trainings in Mission College & West Valley College. The participants and colleges gave us very good feedback to these trainings. West Valley College would like to have more of our QPR training offered to the students in the coming college year.

v. Vietnamese peer navigator staff worked with elderly for months at the Vietnamese American Services Center to help engage the elderly into behavioral health services. Initially, elderly woman would decline and only want to receive the meals from the Senior Nutrition Program, however, our peer staff would invite the client to engage and describe the services offered at VASC and introduced her to our behavioral health services team. Our peer made the client feel comfortable and addressed her fears of language barriers and completed the warm hand off. The client is able to receive services from Vietnamese speaking clinicians and address lifelong trauma that she has been fighting with by herself.

vi. The Division help planned the Department's May is Mental Health Month where the Division invited 27 community agencies to participate in our resource fairs. The resource fair and celebration was a big success, it involved peers and consumers as part of the agenda. Consumers were able to showcase and sell their art, perform on stage, participate in the singing wellness activities and enjoyed cultural food and refreshments. This is the first celebration since 2016 hosted by the department and usually it takes months of planning but this celebration was planned entirely by the Division of Consumer Affairs, Family Affairs and Cultural Communities Wellness Program, several CCWP members were key planners in this event and worked very hard to organize the event for the community. The event received amazing

feedback from consumers, agency staff and community members. It was also highlighted in meetings in the community that it was a successful event.

vii. The African Immigrant team and Vietnamese team provided Mental Health First Aid training to the Mid Pen Housing agency Staff, who provide housing service resources and linkages case management and referrals to the unhouses and other clients throughout Santa Clara, Sant Mateo and Alameda Counties as well. The training was well received that the participants were also interested in attending in our QPR training as well, for which we provide the following weeks. Since then we've requested to provide additional training to their other staff in Livermore, which is in Alameda County, so our understanding that our program focus mainly to clients who live or work in Santa Clara County. But in any case, we consider this is one of our CCWP's success stories, in terms of the Trainings we provide which were well received and those participants invited us back to provide to their other fellow staff at their agency.

viii. In June 2023, BHS Native Family Outreach & Engagement partnered with the Red Earth Women's Society, an indigenous women's group advocating against Native community injustices. Both attended a pivotal hearing in Blue Lake, California, organized by the Department of Interior and Department of Justice. At this hearing, BHS Peer who is a tribal member discussed her childhood experience of systemic violence and her recovery, underlining the need for equitable, trauma-informed health care. She highlighted the importance of traditional healing and whole-person care. BHS CCWP Peers aim to keep ties with resources aiding those affected by the crises of Missing and Murdered Indigenous Women, Human Trafficking, and Historical Trauma.

ix. Mohamed who is our African Immigrant Team lead supported an Ethiopian Family who lost their father in March 2023. Mohammed supported the family as a peer support worker and a community elder, his supported the family and community by providing behavioral health resources and emotional support. Mohamed was asked to attend the funeral where he share the same culture, language, and tradition, and religious practice. Muslim have specific mourning practice and rituals, these include prayer, recitation of Quran. The family was very grateful for Mohamed's support and leadership and express gratitude to our program and resources provided.

ACCESS & LINKAGE TO TREATMENT PROGRAMS

Services For Children

The Services for Children program in Santa Clara County covers 2 different programs.

1. Kid Connections Network (KCN)
2. Downtown Youth Wellness Center (DWYC)

The total cost per person, across all programs in this category can be found below. The following pages are detailed reports for each individual program in this category.

FY 2023		
Number Served	Program Expenditure	Cost per Person
1,810	**$ 1,601,751.04**	**$ 884.95**

Services For Children 0-5: KIDCONNECTIONS NETWORK (KCN)

PEI Access & Linkage to Treatment Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

KidConnections Network (KCN) is a coordinated system that identifies children birth through age five with suspected developmental delays and/or social-emotional and behavioral concerns. KCN utilizes an innovative model that bridges children and their families to quality screening, assessment, early intervention and intervention services that promote and support their optimal growth and development. Children receive assessment and treatment services aimed to intervene and address early signs of mental health and developmental delays, while care coordination is provided to assists the family in accessing and linking to appropriate resources that may be necessary to promote the child and family's wellbeing.
General services for children ages 0-5 include:

i. Screenings & Assessments
ii. Behavioral Health Therapeutic Services
iii. Behavioral Health Family Specialist Home Visitation Services
iv. Parenting Workshops
v. Care Coordination/Case Management

2. Program Indicators

Services for children birth through age 5 and families receive an array of supports to meet consumers at whatever point they are at in their stage of development and level of need. The goals of KCN are to reduce prolonged suffering, increase readiness for school, reduce involvement of the child welfare system through promoting the parent-child relationship and ensuring early access to quality care that is age appropriate.

3. Program Goals, Objectives & Outcomes

i. Support the healthy development of children ages 0-5 and enrich the lives of their families and communities.
ii. Increase children and families' access to screening, treatment, and service linkages.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
1,359	**Refer to Cover page**	**Refer to Cover page**

5. Evaluation Activities

KidConnections utilized standardized evidenced based screening/assessment tools, such as CANS-Early Childhood, Keys to Interactive Parenting Scale (KIPS), Ages and Stages Questionnaire- 3rd edition (ASQ-3), and the Problem Symptom Checklist-35 (PSC-35), pre and post measures are completed to identify outcomes for families and children served in this program.
In addition, referral coordination and feedback loop has been aligned to ensure families approve services and linked to provider within 3 business days and secure initial appointment within 10 business days. Enhancements to quarterly reports and system check in's increase monitoring of activities and the effectiveness.
Providers continue to report staff challenges and multiple system level transition impacting data entry flow and retention.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	1359	100
16 -25 years		
26- 59 years		
60+ years		
Prefer not to answer		
Unknown		
Unduplicated Total	1359	100

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	1	.07
Asian	68	5
Black or African American	46	3.38
Native Hawaiian or Other Pacific Islander	6	.44

White/ Caucasian	95	7
Other	936	68.87
More than one race		
Prefer not to answer	10	.74
Unknown	197	14.5
Unduplicated Total	1359	100

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)	941	69.25
Other Hispanic/ Latino		
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		

Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino	212	15.60
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer		
Unknown	206	15.15
Unduplicated Total	1359	100

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	828	61
Female	500	36.80
Prefer not to answer		
Unknown	31	2.20
Unduplicated Total	1359	100

	FY 2023

Gender (Current)	# Served	% of Served
Male	828	61
Female	500	36.80
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	31	2.20
Unduplicated Total	1359	100

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	1359	100
Unduplicated Total	1359	100

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	572	42.09
Spanish	443	32.60

Vietnamese	21	1.54
Chinese	2	.15
Tagalog		
Farsi	2	.15
Other	11	.81
Prefer not to answer		
Unknown	308	22.66
Unduplicated Total	1359	100

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military	220	16.19
Prefer not to answer		
Unknown	1139	83.81
Unduplicated Total	1359	100

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking	10	.74
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability	240	17.66
No Disability		
Prefer not to answer		
Unknown	1109	81.60

Unduplicated Total	1359	100

*Participants may choose more than one option for Disability.

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
1499	KidConnections Services – Therapeutic and Family Specialist Home Visitation Services	1156		6.75 days

8. Detailed Outcomes

Out of 1499 referrals 1156 were connected to provider for 77% conversion rate. Of those referrals 79% of children engaged in their initial appointment within 10 business days and 63% of children served successfully discharged from KCN services. Quarterly data enhancements have allowed us to monitor reasons referrals did not pan out and the highest rate is a result of inability to reach the caregiver, child already in services, or the caregiver declined referral made on their behalf.
Completion rate and delays in submission of tools has created a barrier in providing detailed outcomes for the program. This is an area of improvement and there have been efforts to address submissions with program providers to ensure outcome is available for the next reporting period.

9. Evaluation Summary

KCN System of Care has seen an increased need and acuity and continued to be impacted by pandemic related challenges. Providers have resumed to mostly in-person services, however, due to continued surge of positive COVID cases among children, families and providers, a hybrid approach continued to be utilized. Data reporting and evaluation review has allowed quarterly opportunities to measure areas of improvement and areas that are going well.

Opportunity arose during this fiscal year to re-evaluate the analysis of data that is being captured to demonstrate outcomes for the program. Completion rate and delays in submission have posed a barrier to being able to capture outcomes from the tools that are administered to families that participate in the program. Conversations will continue with service providers and analysis team to address this challenge.

Downtown Youth Wellness Center

PEI Access & Linkage to Treatment Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The Downtown Youth Wellness Center (DYWC) is a new program in San Jose, that is focused on serving youth and young adults, ages 12-25, with a safe, supportive, and youth-focused environment. The development of the youth center was created to address the immediate needs of young people in San Jose. Located at 725 E Santa Clara Street, DYWC services include brief behavioral health support, peer support, workshops, well-being groups, activities, linkage to services (including medical and behavioral health services), life skills development, education and career planning, independent living support, and other related support. The DYWC will foster an inclusive and welcoming environment with a flexible and open approach to decrease barriers to access and reduce stigma. It was designed around current research reflecting that drop-in youth centers can be instrumental in supporting youth in navigating and accessing services across systems while also providing a space for activities, learning, socializing, and having a place to just "be". The behavioral health component will provide same-day access to behavioral health services and support which supports our system of care and immediate access to mental health and substance use. Peer support is using a variety of curriculums for groups and engaging activities. *El Joven Noble* Curriculum is particularly used to support a group called, *Circulo.* Peer support incorporates opportunities in music, art, and self-expression in a judgement-free environment. The rehabilitation counselor will provide psychoeducation groups, case management, care coordination and linkage to services within the Behavioral Health System of Care. Located next door to the Valley Health Center Downtown Outpatient Clinic, the DYWC can utilize our health care system by bridging access to health providers for our youth and young adults. The DYWC is centrally located to mental health and substance use specialty providers, within the Behavioral Health Children, Youth, and Family System of Care. The DYWC is located within close access to our public transportation bus lines. The DYWC is also located near several middle schools and high schools. Outreach efforts about the DYWC is conducted within schools and community events and holds a partnership with the DYWC Community Advisory Board, which supports the center by incorporating the community voice. The value in understanding the community's cultural and linguistic needs is an essential component towards the development and sustainability of a program dedicated to serve our young people within the San Jose community. The DYWC was designed to provide a safe and comfortable environment for youth to visit and feel "at home". The layout and design of the entire center was composed per youth voice and vision. The center has vibrant furniture and wall colors, with artwork created by ethnic and culturally diverse perspectives in effort to introduce youth to a wider range of art. The center is also composed of artwork from current youth, along with guitars and a keyboard to encourage leaning and embracing music. The layout includes a hangout/living room space, the "lounge" which includes an open kitchen for youth, an art table loaded with arts and crafts, a computer nook, and bookshelves. In addition, the site is designed to include counseling rooms for providers to utilize when meeting youth in community settings, a laundry room with clothing closet, and hygiene supplies for youth and young parents. The DYWC is a partnership between BHSD Children, Youth, and Family System of Care, and Alum Rock Counseling Center.

2. Program Indicators

The DYWC provides an inclusive and welcoming environment with a flexible and open approach to decrease barriers and reduce stigma. Instrumental in supporting youth in navigating and accessing services through case management, care coordination, and linkage to services within the Behavioral Health System of Care. Examples of the various needs youth at the DYWC have experienced are:

i. Youth identified as neurodivergent and rely on the peaceful, safe, and supportive environment.
ii. Youth in foster care seeking peer support.
iii. Youth seeking permanent housing and relying on case management services.
iv. Youth with food insecurities and utilizing the kitchen for meals.
v. Youth needing a respite, non-judgmental environment.
vi. Safe space from sex trafficking
vii. Youth with complex trauma utilizing peer specialists and clinicians.
viii. Youth needing resources, linkage, and coaching towards accessing resources within the community.
ix. Youth feeling sick and needing linkage to the VMC Downtown Urgent Care next door to DYWC.

3. Program Goals, Objectives & Outcomes

❖ Program Goals:

i. Foster an inclusive and welcoming environment with a flexible and open approach to decrease barriers to access and reduce stigma
ii. Increase access for youth and young adults within the San Jose community, to an array of services such as:
   a. brief behavioral health support,
   b. peer support,
   c. workshops,
   d. well-being groups,
   e. activities,
   f. linkage to services (including medical and behavioral health services),
   g. life skills development,
   h. education and career planning, and independent living support.

❖ Program Objectives:

i. Understanding community-based drop-in centers and the goal of increasing youth engagement with behavioral health services.
ii. Increase the number of youths in Santa Clara County who are receiving early intervention and preventative Behavioral Health services.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 220		
Number Served	Program Expenditure	Cost per Person
451	**Refer to Cover page**	**Refer to Cover page**

*Cost per person is calculated using duplicated number served data.

5. Evaluation Activities

The Downtown Youth Wellness Center utilized access to linkage through case management, community networking, and care coordination efforts. The model of the center by design, feels very inviting and supportive of youth that visit the center. The program utilizes youth centered strategies through support of the peer lenses, to be mindful of non-stigmatizing and non-discriminatory practices. The program was designed around current research reflecting that drop-in youth centers can be instrumental in supporting youth in navigating and accessing services across systems while also providing a space for activities, learning, socializing, and having a place to just "be".

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	27	12%
16 -25 years	84	38%
26- 59 years	0	0%
60+ years	0	0%
Prefer not to answer	0	0%
Unknown	109	50%
Unduplicated Total	220	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	1	.5%
Asian	12	5.%
Black or African American	2	1%
Native Hawaiian or Other Pacific Islander	2	1%
White/ Caucasian	1	.5%

Other	5	2.%
More than one race	0	0%
Prefer not to answer	2	1%
Unknown	195	89%
Unduplicated Total	220	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
1Caribbean	0	0%
Central American	0	0%
Mexican/ Mexican-American/ Chicano	46	21%
Puerto Rican	2	1%
South American	0	0%
Hispanic/ Latino (undefined)	0	0%
Other Hispanic/ Latino	10	5%
Hispanic or Latino Subtotal	**58**	**27%**
Non-Hispanic or Non-Latino as follows:		
African	0	0%
Asian Indian/ South Asian	0	0%
Cambodian	0	0%
Chinese	1	1%
Eastern European	0	0%

European	1	1%
Filipino	1	1%
Japanese	1	1%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	1	1%
Non-Hispanic/ Non-Latino (undefined)	16	7%
Other Non-Hispanic/ Non-Latino	3	2%
Non-Hispanic or Non-Latino Subtotal	**25**	**12%**
More than one ethnicity	0	0%
Prefer not to answer	11	5%
Unknown	109	50%
Unduplicated Total	220	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	39	18%
Female	72	32%
Prefer not to answer	0	0%
Unknown	109	50%
Unduplicated Total	220	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	0	0%

Female	0	0%
Transgender (Male to Female)	0	0%
Transgender (Female to Male)	2	1%
Transgender (Undefined)	0	0%
Genderqueer	0	0%
Questioning or Unsure	0	0%
Another gender identity	0	0%
Prefer not to answer	0	0%
Unknown	218	99%
Unduplicated Total	220	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	0	0%
Heterosexual/ Straight	0	0%
Bisexual	0	0%
Questioning/ Unsure	0	0%
Queer	0	0%
Another sexual orientation	0	0%
Prefer not to answer	0	0%
Unknown	220	100%
Unduplicated Total	220	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	0	0%
Spanish	0	0%
Vietnamese	0	0%
Chinese	0	0%
Tagalog	0	0%

Farsi	0	0%
Other	0	0%
Prefer not to answer	0	0%
Unknown	220	100%
Unduplicated Total	220	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	0	0%
Veteran	0	0%
Served in Military	0	0%
Family of Military	0	0%
No Military	0	0%
Prefer not to answer	0	0%
Unknown	220	0%
Unduplicated Total	220	100%

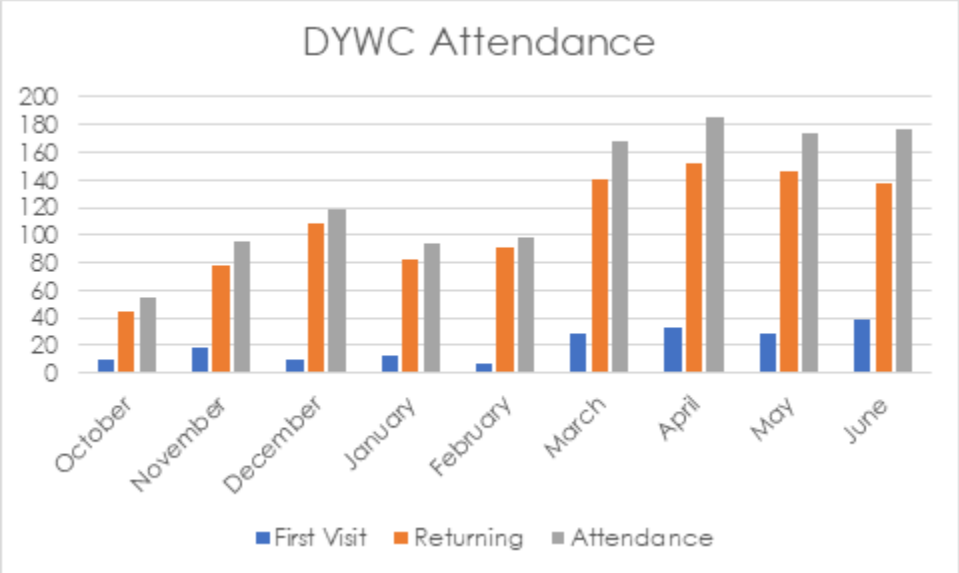
	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	0	0%
Difficulty hearing or speaking	0	0%
Other communication disability	0	0%
Cognitive	0	0%
Physical/ Mobility	0	0%
Chronic Health Condition	0	0%
Other non-communication disability	0	0%
No Disability	0	0%
Prefer not to answer	0	0%
Unknown	220	0%
Unduplicated Total	220	100%

*Participants may choose more than one option for Disability.

7. Referrals

FY 2023				
Unduplicated N =220				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
Not Available	Integrated Behavioral health Services that include individual, family and group therapy, case management, medication support and crisis intervention.	Not Available	Not Available	Not Available

8. Detailed Outcomes



Service	December Totals	January	February	March	April	May	June
Outreach Events	3	5	6	18	14	16	12
Community Tours	14	29	21	35	31	45	42

Service	October	November	December	January	February	March	April	May	June
Behavioral Health	3	6	7	7	3	26	10	18	23
Rehab Counselor	n/a	n/a	n/a	n/a	n/a	26	45	21	8
Peer Support	52	90	111	87	26	142	120	68	82
Center Use (Using facilities in addition to services)	Not tracked	Not tracked	Not tracked	80	93	126	161	141	177

*Rehabilitation Counselor position was filled March 2023
*Center opened to public Sept 2022 and data tracking was in development in the beginning of implementation.

Various workshops & group activities are held weekly for youth. They range from the following topic and increase or change per the season and holidays. Attendance

i. Move Night
ii. Café Lounge
iii. Mic Night
iv. Art
v. Self-Care Saturdays
vi. Outdoor Activities
vii. Joven Noble
viii. Anxiety
ix. Life Skills

9. Evaluation Summary

❖ Program highlights and successes:

i. The center is being utilized by parenting youth more often and infant supplies are on hand to assist them.
ii. Outside providers report that youth speak highly of the program and their experiences. One Social Worker from Valley Med Inpatient pediatrics recently said a youth told her “The DYWC is the only place I can truly be myself”.
iii. Our returning youth numbers are very high.
iv. Two separate youth and their families, who were homeless and living in their cars were able to be placed in housing with the assistance of DYWC staff.
v. Additional groups are adding to the Clinical and psychoeducational resources available, including Joven Noble, Life Skills and an Anxiety Group.
vi. More youth are reaching out to DYWC for connection to substance use treatment services.
vii. The entire team is now Narcan trained, and the center has supplies on hand.
viii. The “Backyard” space is ready to start hosting activities and events, allowing staff to add outdoor games, art, and groups to the weekly summer plans.
ix. The summer events will include activities, groups, and daily lunch to help youth with food insecurity.
x. Youth report that they have come to the DYWC as a strategy to avoid self-harm and relapse.

xi. Outside providers report that the center is a “calm and welcoming space” and a great program, and they are using the space for their individual sessions with youth and bringing youth for tours.

Partnerships have been developed with outside programs, including Bill Wilson Center, who is coming to the DYWC to complete VSPDT intakes with youth and their families.

Office Of Consumer Affairs

PEI Access & Linkage to Treatment Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Office of Consumer Affairs (OCA) provides peer support in two drop-in centers, Zephyr and Esperanza. The self-help centers provide a safe, confidential, and supportive environment for those who are living with behavioral health challenges and family members who are striving to achieve wellness and recovery. The self-help centers are also designated as walk-in Navigation sites where individuals can come into the centers and receive resources, linkages and referrals to community resources. Operated by mental health consumers and family members, the self- help centers provide support for individuals who want to take control of their lives by focusing on the dimensions of wellness as defined by SAMHSA; emotional, financial, social, spiritual, occupational, physical, intellectual, and environmental. Mental Health Peer Support Workers (MHPSW) are dedicated to reducing stigma and help bring about the highest level of wellness by modeling, sharing, and creating safe spaces. Mutuality and compassion are intentional peer support practices as well as respect and dignity used to support the consumers and family members served. Individuals who share a disability or have supported someone with a disability have something to offer each other which cannot always be provided clinical services. Peer support differs from clinical services as it provides trained peer staff with lived experience to help individuals navigate the system and find their own path to wellness and recovery. Peer support services augments clinical service by providing consumers and families support for their basic needs, for their emotional support, for self-improvement, navigation of services, as well as linkages.

Zephyr and Esperanza Self-Help Centers: Zephyr (San Jose) and Esperanza (Gilroy) provide peer support to assist consumers in achieving wellness and recovery; participating in meaningful activities; and obtaining education, employment, and housing. Self-help centers have capacity to serve English- and Spanish-speaking consumers with the following resources:

i. One-on-one peer support with a trained Mental Health Peer Support Worker
ii. Psycho-educational as well as a variety of wellness peer-facilitated support groups
iii. Provides opportunities to engage in recreational and meaningful activities.
iv. Wellness Recovery Action Plan (WRAP®) groups
v. Peer-supported events and social activities
vi. TAY support group – Zephyr Self-Help Center
vii. Educational and Community Resource Guest Speaker presentations
viii. Computer workshops and classes to support beneficiary empowerment at the Consumer.
ix. Learning Center

The Mental Health Peer Support Workers at the self-help centers maintain communication with professionals inside and outside of the clinical setting which include Community Based Organizations (CBO) representatives, rehabilitation counselors, community workers, and communicate about other beneficiary needs.

2. Program Indicators

Office of Consumer Affairs (OCA) is focused on prevention and early intervention for the underserved, unserved and hard to reach communities. The program is dedicated to addressing and reducing prolonged suffering, suicide, incarcerations, unemployment, and homelessness by providing peer support, psycho-educational and social peer groups, navigation of services, resources, and engagement to underserved, unserved and hard to reach communities.

i. **Suicide:** OCA Mental Health Peer Support Workers actively support recovery and wellness, including suicide prevention. Mental Health Peer Support Workers are trained in Mental Health First Aid (MHFA) and suicide prevention: Question, Persuade and Refer (QPR). Mental Health Peer Support Workers provide consumers navigation of the behavioral health system, linkages to crisis care providers, Urgent Care, Crisis Stabilization, Mobile Crisis Unit, and Emergency Psychiatric Services (EPS). Mental Health Peer Support Workers are trauma informed, trained in Intentional Peer Support, Emotional CPR, Motivational Interviewing, and Wellness Recovery Action Planning (WRAP®). Mental Health Peer Support Workers provide one-on-one peer support with consumers and/or family members, facilitate peer support groups, including WRAP®, to educate and support consumers and family members prepare their own crisis prevention plan. Mental Health Peer Support Worker may participate in the coordination of care with care providers.

ii. **Incarcerations:** Mental Health Peer Support Workers provide emotional support for those released from incarceration as well as provide resources and linkages to the Re-Entry Center, employment, vocational and housing resources. Other supports include documentation of group participation for court requirements which have been helpful to some to evidence self-help efforts for self-improvement.

iii. **Unemployment:** OCA Consumer Learning Centers provides a computer lab. Computer classes that are free and open to the public. The lab allows individuals to take classes to learn how to use a computer, improve computer skills, create resumes, applying for jobs online, set up and access personal emails, perform employment searches and receive job notifications and communication from possible employers. Zephyr provides an Employment Support group for individuals contemplating employment, currently seeking employment, or support while working. The group provides space where participants engage in supporting each other in the job search process, career exploration, encouragement, and support by preparing for interviews, resources, and information to help individuals gain employment and remain employed. Mental Health Peer Support Workers also provide linkages to employment services. OCA host educational presentations to consumers and providers on a variety of employment related topics to address working while disabled, working while receiving cash/medical benefits (SSI/SSDI), Department of Rehabilitation, Ticket to Work, Social Security work incentive programs, and connecting to adult education and vocational opportunities in the community.

iv. **Prolonged Suffering:** OCA provides a safe, confidential, and supportive environment, staffed by trained Mental Health Peer Support Workers with lived experience for individuals seeking hope, relief, support, education, and access to resources, linkages, and meaningful activities. Consumers who engage in peer support services can benefit by connecting with others in mutuality, finding meaning in their lived experiences with behavioral health challenges. The peer support groups, guest speakers, events, and social atmosphere provide opportunity for consumers to connect and learn about themselves, inspires hope in recovery, health, and wellness; as well as introducing natural supports in the community expanding their sense of belonging, social connection, and purpose.

v. **Homelessness:** OCA supports the efforts for those seeking housing. Mental Health Peer Support Workers support individuals advocate for financial assistance to prevent homelessness, better housing conditions in their board and cares preventing homelessness, resources and support completing

applications to permanent housing and linkages to community agencies supporting the homeless population. Staff are trained to administer the Vulnerability Index-Service Prioritization Decision Assistance Prescreening Tool (VI-SPDAT) to help identify eligibility for service intervention.

3. Program Goals, Objectives & Outcomes

The Division of Consumer Affairs, Family Affairs and Cultural Communities Wellness Program's top priorities for FY23

i. Increase outreach and engagement.
ii. Promote wellness and recovery.
iii. Promoting peer services within the Behavioral Health System. (i.e., Inpatient, Outpatient, Crisis Services) and throughout the county.
iv. Increase culturally sensitive and linguistic services and highlight lived experience to improve beneficiary experience.
v. Increase self-help, consumers, and family involvement.
vi. Increase natural networks of supportive relationships.
vii. Improve data tools, outcomes, and beneficiary experiences.

4. Clients Served & Annual Cost per Client Data

Office of Consumer Affairs served: 582 Individuals (unduplicated) and 5,357 services (duplicated). These are services from both Esperanza and Zephyr Self-Help Centers.
One-on-Ones: 2028 services
Group duplicate attendance: 3329

FY 2023		
Unduplicated N = 582		
Number Served	Program Expenditure	Cost per Person
5,357	**$988,066.89**	**$ 184.44**

*Cost per person is calculated using duplicated data number of 5357

5. Evaluation Activities

Access and Linkage - OCA Mental Health Peer Support Workers provide peer support in two walk-in Navigations sites, Zephyr and Esperanza self-help centers. The self-help centers provide a safe, confidential, and supportive environment for individuals to find information, resources, navigation of the behavioral health system, access and linkages to County Behavioral Health Services, community resources to support their basic needs, emotional support, and self-improvement. Peer support differs from clinical services as it provides trained peer support workers with lived experience to help individuals navigate the system and find their own path to wellness and recovery. Mental Health Peer Support Workers provide individuals access and linkages with behavioral health professionals inside and outside of the clinical setting which include community-based organization representatives, rehabilitation counselors, community workers and, also connect consumers to natural supports in the community.

In Spring FY22, the Division began the process of developing a new referral form to capture and track referrals to the Division programs for peer services and outcomes. The new referral form will be completed by behavioral health professionals, paraprofessional staff, and community members.

The referral form will streamline the process for referrals to any of our three programs: Office of Family Affairs for family support, Office of Consumers Affairs/Self-Help Centers for individual support services, and/or Culture Community Wellness Program services for cultural and/or linguistic support. The referral shall be assigned to a trained Mental Health Peer Support Worker(s) to provide requested services such as one-on-one peer support, peer support group(s), trainings, and navigation services and linkages to other healthcare services, benefits, housing, employment, vocational and educational opportunities, and other beneficiary needs. Depending upon the client's need, the support provided is to augment the client's treatment plan, it is our hope that additional outcomes data will be available with the improved process. Outreach and presentations were provided to community partners, county, and contracted providers in FY23.

Outcome Measure:

Pre and post Peer Services Surveys were provided to consumers when they came to the self-help centers, before and after peer groups and distributed thirty days later to determine if their attitudes and knowledge had changed by receiving peer support services at the self-help center.

The Peer Services Survey is an evidenced based practice with a validated tool with 9 questions from "The Stigma Scale: Development of a Standardized Measure of the Stigma of Mental Illness" which will be use measure pre and post attitudes and knowledge of mental illness. The survey will be distributed to consumers prior and after they receive services.

Reference: King M; Dinos S; Shaw, J; Watson, R; Stevens, S; Passetti F; Weich S; Serfaty M; "The Stigma Scale: Development of a Standardized Measure of the Stigma of Mental Illness." The British Journal of Psychiatry: the Journal of Mental Science, U.S. National Library of Medicine, pubmed.ncbi.nlm.nih.gov/17329746/.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	0	0%
16 -25 years	95	16%
26- 59 years	309	53%
60+ years	100	17%
Prefer not to answer	37	6%
Unknown	41	7%
Unduplicated Total	582	100%

	FY 2023

Race	# Served	% of Served
American Indian or Alaska Native	10	2%
Asian	88	21%
Black or African American	18	4%
Native Hawaiian or Other Pacific Islander	2	1%
White/ Caucasian	161	38%
Other	38	9%
More than one race	17	4%
Prefer not to answer	56	13%
Unknown	43	8%
Unduplicated Total	428	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	1	<1%
Central American	5	4%
Mexican/ Mexican-American/ Chicano	106	71%
Puerto Rican	6	4%
South American	7	5%
Hispanic/ Latino (undefined)	24	16%
Other Hispanic/ Latino		
Hispanic or Latino Subtotal	149	100%

Non-Hispanic or Non-Latino as follows:		
African	18	8%
Asian Indian/ South Asian	2	<1%
Cambodian	2	<1%
Chinese	17	7%
Eastern European	13	7%
European	83	37%
Filipino	13	6%
Japanese	5	2%
Korean	1	<1%
Middle Eastern	15	6%
Vietnamese	51	23%
Non-Hispanic/ Non-Latino (undefined)	7	3%
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal	227	100%
More than one ethnicity	17	3%
Prefer not to answer	56	11%
Unknown	133	25%
Unduplicated Total	528	

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	267	46%
Female	236	41%

Prefer not to answer	28	5%
Unknown	51	8%
Unduplicated Total	582	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	263	45%
Female	230	40%
Transgender (Male to Female)	3	<1%
Transgender (Female to Male)	2	<1%
Transgender (Undefined)	0	0%
Genderqueer	2	<1%
Questioning or Unsure	0	0%
Another gender identity	7	1%
Prefer not to answer	29	5%
Unknown	46	8%
Unduplicated Total	582	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	9	2%
Heterosexual/ Straight	357	62%
Bisexual	21	3%
Questioning/ Unsure	3	<1%
Queer	2	<1%
Another sexual orientation	5	<1%
Prefer not to answer	116	20%
Unknown	69	12%

Unduplicated Total	582	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	462	80%
Spanish	20	3%
Vietnamese	2	<1%
Chinese	1	<1%
Tagalog	0	0%
Farsi	3	<1%
Other	10	2%
Prefer not to answer	56	10%
Unknown	133	5%
Unduplicated Total	582	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	0	0%
Veteran	24	4%
Served in Military	12	2%
Family of Military	0	0%
No Military	449	77%
Prefer not to answer	60	10%
Unknown	37	6%
Unduplicated Total	582	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	24	4%
Difficulty hearing or speaking	13	2%
Other communication disability	3	<1%

Cognitive	23	4%
Physical/ Mobility	18	3%
Chronic Health Condition	31	5%
Other non-communication disability	100	17%
No Disability	215	37%
Prefer not to answer	91	16%
Unknown	64	11%
Unduplicated Total	582	100%

*Participants may choose more than one option for Disability.

7. Referrals

OCA Mental Health Peer Support Workers provide navigation services and refers and links consumers to Behavioral Health treatment services, Call Center/Substance Use Treatment Services, Behavioral Health Urgent Care, Crisis Stabilization, Mobile Crisis Unit, Emergency Psychiatric Services (EPS) while peers are providing supportive services to clients.

In FY23, Office of Consumer Affairs provided services to 582 individuals, 331 were “self-referred”.

In Spring FY23, the Division began the process of developing a new referral form to capture and track referrals to the Division programs for peer services and outcomes. The new referral form will be completed by behavioral health professionals, paraprofessional staff, and community members.

The referral form will streamline the process for referrals any of our three programs: Office of Family Affairs for family support, Office of Consumers Affairs/Self-Help Centers for individual support services, and/or Culture Community Wellness Program services for cultural and/or linguistic support. The referral shall be assigned to a trained Mental Health Peer Support Worker(s) to provide requested services such as one-on-one peer support, peer support group(s), trainings, and navigation services and linkages to other healthcare services, benefits, housing, employment, vocational and educational opportunities, and other beneficiary needs. Depending upon the client’s need, the support provided is to augment the client’s treatment plan, it is our hope that additional outcomes data will be available with the improved process. Outreach and presentations will be provided to community partners, county and contracted providers in FY23

FY 2023				
Unduplicated N = 582				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once**

overseen by county mental health versus treatment that is not)		overseen by county mental health)		**in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)

8. Detailed Outcomes

❖ Outcome Measure:

Pre and post Peer Services Surveys were provided to consumers when they came to the self-help centers, before and after peer groups and distributed thirty days later to determine if their attitudes and knowledge had changed by receiving peer support services at the self-help center.

The Peer Services Survey is an evidenced based practice with a validated tool with 9 questions from "The Stigma Scale: Development of a Standardized Measure of the Stigma of Mental Illness" which will be use measure pre and post attitudes and knowledge of mental illness. The survey will be distributed to consumers prior and after they receive services.

Reference: King M; Dinos S; Shaw, J; Watson, R; Stevens, S; Passetti F; Weich S; Serfaty M; "The Stigma Scale: Development of a Standardized Measure of the Stigma of Mental Illness." The British Journal of Psychiatry: the Journal of Mental Science, U.S. National Library of Medicine, pubmed.ncbi.nlm.nih.gov/17329746/.

After receiving peer support services by attending peer support groups for over thirty days, outcomes results:

Consumers responded,

i. Less ashamed of having mental problems.
ii. Less worried about telling people they received mental health services.
iii. Believed people have been understanding of their mental health problems
iv. Strongly agreed that they were as good as other people even with mental health challenges.
v. Strongly agreed and disagreed over telling people they take medication.
vi. Maintained their views on peoples reaction to their mental problems make them keep to themselves.
vii. More likely to avoid telling others of their mental challenges, others were more open to telling people about their mental problems.
viii. Not being stronger as a result of their mental health problems, others strongly agreed.
ix. Consumers opinion that people with mental health problems are dangerous did not change with more believing people with mental health problems are dangerous.

	I feel ashamed of myself that I have had mental problems	**I worry about telling people I received**	**People have been understanding**	**I am as good as other**

			psychological treatment		of my mental problems		people, even though I have had mental health problems	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Strongly Disagree	28%	40%	22%	24%	14%	8%	17%	13%
Disagree	25%	29%	11%	36%	22%	10%	8%	4%
Agree	19%	27%	39%	27%	50%	48%	53%	51%
Strongly Agree	22%	4%	28%	11%	11%	23%	14%	28%
Decline to Answer	6%	0	0	2%	3%	10%	8%	3%

	I worry about telling people that I take medicine/tablets for mental health problems		People's reaction to my mental health problems make me keep myself to myself		I avoid telling people about my mental health problems		Having had mental health problems has made me a stronger person		Some people with mental health problems are dangerous	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Strongly Disagree	31%	2%	22%	18%	19%	23%	28%	21%	14%	16%
Disagree	11%	25%	22%	25%	25%	14%	0%	19%	22%	20%
Agree	44%	31%	28%	31%	31%	40%	53%	30%	36%	39%
Strongly Agree	8%	18%	22%	17%	25%	17%	16%	30%	28%	20%
Decline to Answer	6%	4%	6%	8%	0%	6%	3%	0%	0%	4%

9. Evaluation Summary

❖ IMPLEMETATION CHALLENGES

Centers re-opened July 2021 with safety concerns and precautions established for staff and beneficiaries. The centers re-opened and began in-person peer support groups, in-person one-on-one peer support services, in-person presentations and activities; and, continued with telehealth phone support. While the COVID restrictions had lessened in the community, self-screening and strict mask requirements were established for everyone entering and working in the self-help centers and eating and drinking inside the centers was prohibited. As a

safety precaution, food and beverages were no longer provided for consumers in the centers. The slow opening resulted in lower attendance and our consumers felt isolated inside the center.
Compared to pre-pandemic FY20, FY23 centers' notable difference in the lower daily attendance reflects a significant decrease in the number of the unhoused population, board and care residents, and others who regularly came to the centers before the COVID closures. One factor was the mask requirement and the restriction of eating and drinking inside the facility. Visitors complained about the mask requirement and did not want to want to wear masks inside the facility. Prior to Covid, we served coffee and guests would enjoy socializing over a cup of coffee with fellow guests providing a social environment. Others who would bring their lunch and stay for the day and eat with their peers. The new restrictions affected the regular guests who did not want to eat or drink outside, especially during inclement weather. The center was missing the social component that we underestimated.
Other noticeable factors were the board and care operators were not providing transportation to the centers and in a few cases, board and care operators prohibited their residents from coming to the centers to protect their other residents from possible exposure. This discovery became the impetus for a new MHSA preliminary recommendation to engage community participants residing in board and cares, senior living facilities, community centers and other care facilities for an outward service model for FY24

- **Vacant Codes.**

In FY22, OCA had 6 vacant codes which caused barriers in providing services and to retain staff. OCA reconstituted codes, merged codes, created language-specific codes to maximize services for open recruitment and staff retention. Recruitment to fill all vacant codes occurred in FY23 resulting in four new staff starting in FY23. The addition of four new staff allowed OCA to re-open Esperanza to five days a week, with additional bi-lingual services for Spanish. OCA had 2 vacant Vietnamese codes but struggled to find qualified candidates and after 2 recruitment cycles, the two codes were deleted.

However, since our re-opening with our improved data collection methods data indicates our attendance is on a gradual uptick and peer services exceed previous years' data collected before and during the pandemic.
FY23 – Office of Consumer Affairs served: 582 Individuals (unduplicated) and 5,357 services (duplicated). These are services from both Esperanza and Zephyr Self-Help Centers.
One-on-Ones: 2028 services Group duplicate attendance: 3329

- **SUCCESSES**

The Centers are continually improving and enhancing the cultural aspect of the programming, planning for additional activities, presentations, and celebrations. The program works collaboratively with all the programs within Division of Consumer Affairs, Family Affairs, and Cultural Community Wellness Program (CCWP) to improve cultural relevance and support inside the self-help centers and peer of services provided in Zephyr for the underserved and unserved communities. Zephyr also invites community partners and providers to showcase their services. The consumers appreciated and enjoyed learning more about their peers and their cultures, participating in new and interesting activities, and with guest speakers and artists representing diversity in our community.
FY23, OCA number one priority in the Strategic Plan was to improve group curricula and ambiance of Self-Help Centers to reflect a more multi-cultural and welcoming perspective. OCA translates all marking materials into Spanish and Vietnamese and are increasing our outreach efforts to targets within the Latino and Vietnamese community. OCA created a Cultural Improvement Committee dedicated to improve the cultural influence in both centers with guest speakers, cultural events, group curricula, aesthetics, art activities, music, movies,

decorations and the training of facilitators and the creation of monolingual groups. Esperanza started a Spanish WRAP in May and Zephyr will start a Spanish WRAP in FY24. Plans to add an additional monolingual Spanish group at each site and an additional Vietnamese hosted group at Zephyr in August FY24.
OCA has improved staff onboarding and training process for new staff. Staff receive extensive training on Behavioral Health programs and services, as well as cross trained with other programs. Staff are also required to shadow seasoned staff for their first month with peer support, group facilitation and navigation services. Staff continue to receive mentoring support, coaching and take trainings to continue to improve their skills and abilities to provide peer services in the county.

FY23, five of OCA staff passed the California Medi-Cal Peer Support Specialist Exam

- **May is Mental Health Month Healthy Mind Healthy Life Expo:**

The Division of Office of Consumer Affairs, Office of Family Affairs, and Cultural Communities Wellness Program hosted a Division May is Mental Health Month event, Healthy Mind Healthy Life Expo with each team hosting a booth sharing their cultural promoting wellness and recovery. The day was filled with activities as attendees visited booths to learn about the cultural teams' services, participate in activities such as African Zumba, Karaoke, musicians, enjoyed food and refreshments on the patio and were provided with resources, take-aways, and gift bags.

- **Consumer Success Stories:**

#1

A regular beneficiary of Esperanza Self- Help Center located in Gilroy, California. The beneficiary began attending our peer support groups based on a recommendation. She had been struggling from several mental health related issues. Among other things, she had difficulties with setting healthy boundaries, building self-esteem, and finding opportunities to socialize with other people outside of her household.

At the same time, being so creative, she was naturally drawn to our arts and crafts group, creative writing group, and book club. Staff still remembers the time when she was able to identify with one of the characters in a book we were reading: on how difficult it was to navigate the mental health system not only for herself but family members as well. And it was great to see how, in the process of sharing her writing, she slowly cracked that shell. A shell built for so many different reasons, as a form of protection, but which had then stopped a flower from blossoming. Furthermore, it was amazing to see how her creative abilities manifest themselves into incredible works of art that have been the source of admiration and inspiration for other peers at the center. Not only from peers, but also from many people who have purchased her art through our seasonal arts and crafts shows.

To conclude, our beneficiary is a person who not only has attended our WRAP and other educational groups but has also put what she learned into practice. She had set goals of returning to school and getting back to work. She has accomplished both. Ironically, her busy schedule allows her to come into the center occasionally now. But it is always great to have her here even if it's just a couple times a week. She is such a remarkable example for fellow peers: of how a person can learn to manage mental health symptoms and live a fulfilling life. Her story is a success story that is still growing and evolving. And, it has been a pleasure being part of it.

#2

It is a delight to be able to write about one of our consumers success stories, who registered in 2021 seeking mental health services. Staff first met him in one of the groups they facilitated last year in 2022 and had the pleasure of seeing his growth. Staff also had the pleasure of writing an acknowledgement letter for him, that he

shared with his Sponsor, and Manager at Recovery Cafe. He has attended over 50 facilitated peer support groups such as healthy boundaries, symptom management, arts & crafts, and positive thinking all while maintaining a job and attending college. He always engaged in the groups and maintained a positive outlook. He has now been able to obtain a role in providing peer support. Although he does not attend the Zephyr Self-Help Center as often as he has in the past, he has still been able to refer peers he works with to our center and comes when time permits in his busy schedule. It is amazing to see the growth and inspiration that he displays every single time we are in his presence.

Office Of Family Affairs

PEI Access & Linkage to Treatment Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The mission of the Office of Family Affairs (OFA) is to empower family members and loved ones of mental health consumers with accessible education, support, and resource opportunities. The Mental Health Peer Support Workers at OFA assist families in navigating the behavioral health system through offering direct support, information, and education, with the goal of providing recovery and hope.
OFA operates at facilities that provide a more intensive level of care, and focuses on meeting the needs of family members of people with mental health issues through the following services:

i. Individual Peer Support
ii. Family Support Groups
iii. Trainings and Education
iv. Outreach and Engagement
v. Linkages and Referrals
vi. Navigation services to support the community
vii. Public Assistance Support
viii. Client Advocacy in Mental Health and Substance Use Courts
ix. Educational and Community Resource Guest Speaker presentations

OFA also provides Mental Health First Aid (MHFA) trainings through an 8-hour course that prepares members of the public to provide MHFA to those in need. The Mental Health Peer Support Workers at OFA maintain communication with professionals inside and outside of the clinical and court settings which include Contracted Community Partners (CCP), rehabilitation counselors, community workers, and communicate about other beneficiary needs.

2. Program Indicators

The Office of Family Affairs provides services to the Community with the focus of Prevention & Early Intervention through education, WRAP (Wellness & Recovery Action Plan), one-on-one support, and family support. Our focus is to increase awareness and decrease stigma about mental health and mental health challenges for our client, their families, and the community at large. The hope in providing our services is that individuals will have an increased knowledge of the services and resources available in Santa Clara County and how to navigate them. In addition, we also advocate for our clients who are incarcerated or are in the criminal justice system, awaiting court. The hope is to decrease incarcerations by advocating for treatment (Diversion Program or Mental Health & Substance Use Courts) and not incarceration. Advocating for our clients to receive treatment will undoubtedly decrease hospitalizations and homelessness. It is our goal to provide and link to resources to help our clients develop skills to help maintain their mental health stability.

i. **Suicide:** OFA team member provides one-on-one peer support and family support services to inform and educate families for resources. Mental health peer support workers provide resources and linkages to help reduce suicide risk for the community; peers refer consumers to the Call Center for behavioral health services referrals and refer to Emergency Psychiatric Services, Mobile Crisis Unit, and Behavioral Health Urgent Care for crisis management, support consumers to call 988 for Suicide and Crisis Hotline, request for referrals and treatment; peers also refer to NAMI and respite care to help support individuals who are at risk. Mental health peer support workers provide resources and linkages to help reduce suicide risk for the community and support families who are struggling with loved ones who are at risk of suicide.

ii. **Incarcerations:** OFA provides one-on-one peer and family support to help beneficiaries reduce the risk of incarceration by creating a wellness and crisis prevention plan, and as well as client advocacy in court. OFA supports justice involved beneficiaries with resources and support for reintegration after incarceration, such as connecting individuals to the Reentry Center.

iii. **Unemployment:** OFA provides navigation services for individuals looking for employment; peers connect individuals looking for employment with job fair resources, support with resume writing, and refer them to Zephyr Self-Help Center for computer classes and employment postings and search engine. In addition, peers also connect individuals to the Reentry center or CalWORKs programs.

iv. **Prolonged suffering:** OFA peers provide one-on-one peer support and family support services to inform and educate families for resources. Referrals are made to NAMI, CCWP, Zephyr, resources in the community, and/or other county programs for additional support.

v. **Homelessness:** OFA provides resources to individuals who may be at risk of homelessness. Staff are trained to administer the Vulnerability Index-Service Prioritization Decision Assistance Prescreening Tool (VI-SPDAT) to help identify eligibility for service intervention. For the time being, peers refer consumers to the Bill Wilson Center's Here4You program for housing support and for connecting with housing specialist. OFA peers also provide consumers looking for housing with the monthly housing open list as a resource. Peers also refer consumers to Sacred Heart for housing financial assistance as needed.

3. Program Goals, Objectives & Outcomes

The goal of OFA is to increase understanding of behavioral health issues for family members and support system, increase willingness for individuals to seek help, increase access to behavioral health services and reduce the stigma associated with behavioral health conditions by increasing awareness and resources.

Outcome 1: Provides consumers, families and loved ones with education and peer support to navigate the behavioral health system to increase services connected to mental health resources.
Outcome 2: Reduce stigma associated with mental health status to support family member's recovery.

The Division of Consumer Affairs, Family Affairs and Cultural Communities Wellness Program's top priorities for FY23 are:

i. Increase outreach and engagement.
ii. Promote wellness and recovery.
iii. Promoting peer services into the Behavioral Health System. (I.E. Inpatient, Outpatient, Crisis Services.)
iv. Increase culturally sensitive services and highlight lived experience to improve customer service.
v. Increase self-help, consumers, and family involvement.
vi. Increase natural networks of supportive relationships.
vii. Improve data tools, outcomes, and client experiences.
viii. Create support in the community
ix. Improve client experience

x. Increase access to public system

4. Clients Served & Annual Cost per Client Data

Below are the data for Individual and Group Services for Fiscal Year 2023:

# of Clients Served (Unduplicated): 4037
# of Total Services (Unduplicated): 5322
Family WRAP/Support and psychosocial Groups: 59
of Total Unidentified Events and Services: 217

FY 2023		
Unduplicated N = 4037		
Number Served	Program Expenditure	Cost per Person
5,322	**$735,521.13**	**$138.20**

*Cost per person is calculated using the number of total services.

5. Evaluation Activities

❖ Access and Linkage

Office of Family Affairs provide linkages to resources based on individual's needs. OFA assists families in navigating the behavioral health system through offering direct support like calling 988 with the families or individuals, providing information about different available community programs or support groups, and supporting individuals with enrolling in educational programs or classes such as the NAMI Family to Family or Peer to Peer classes and CCWP Question Persuade Respond, Mental Health First Aid, and Wellness Recovery Action Plan (WRAP) classes. For the fiscal year 2023, Office of Family Affairs was able to provide 59 Support/WRAP groups and Mental health First Aid classes with the average of 24 attendees. In addition, Office of Family Affairs also increased outreach effort from once during the annual Mental Health Month event to an average of three outreach events per week.

OFA staff are also trained to support with the Navigator Program and our staff are accounted for 1007 calls at the Navigator Program for fiscal year 2023. OFA staff are also the first original Navigators to help launch the program successfully.

❖ Improving Timely Access to Services for Underserved Populations:

OFA provides support with language translation in Spanish and Vietnamese for individuals whose seek for services in their own primary or preferred language. OFA also has a working unofficial referral process via emails and calls, where the lead will assign a staff to call and check in with a client referred within 48 hours. In addition, OFA partner with different agencies, like NAMI, Starlight, ACCI, Reentry Center, the Probation Department, and the court system to provide underserved clients with appropriate and timely access to services.

OFA supports family members who need support connecting their family members to the Call Center and help advocate for timely access. OFA can provide peer support to client by showing them how to get to their outpatient providers to improve timeliness to access.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	**0**	**0%**
16 -25 years	**62**	**1.536%**
26- 59 years	**681**	**16.869%**
60+ years	**115**	**2.849%**
Prefer not to answer	**85**	**2.106%**
Unknown	**3094**	**76.641%**
Unduplicated Total	**4037**	**100%**

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	**4**	**0.099%**
Asian	**85**	**2.106%**
Black or African American	**16**	**0.396%**
Native Hawaiian or Other Pacific Islander	**4**	**0.099%**
White/ Caucasian	**64**	**1.585%**
Other	**602**	**14.912%**
More than one race	**0**	**0%**
Prefer not to answer	**176**	**4.360%**
Unknown	**3086**	**76.443%**
Unduplicated Total	**4037**	**100%**

	FY 2023

Ethnicity	# Served	% of Served
Hispanic or Latino:		
Caribbean	**0**	**0%**
Central American	**4**	**0.099%**
Mexican/ Mexican-American/ Chicano	**579**	**14.342%**
Puerto Rican	**0**	**0%**
South American	**5**	**0.124%**
Hispanic/ Latino (undefined)	**0**	**0%**
Other Hispanic/ Latino	**14**	**0.348%**
Hispanic or Latino Subtotal	**602**	**14.912%**
Non-Hispanic or Non-Latino as follows:		
African	**16**	**0.396%**
Asian Indian/ South Asian	**8**	**0.198%**
Cambodian	**0**	**0%**
Chinese	**37**	**0.917%**
Eastern European	**0**	**0%**
European	**10**	**0.248%**
Filipino	**4**	**0.099%**
Japanese	**0**	**0%**
Korean	**1**	**0.025%**
Middle Eastern	**2**	**0.050%**
Vietnamese	**31**	**0.768%**
Non-Hispanic/ Non-Latino (undefined)	**10**	**0.248%**

Other Non-Hispanic/ Non-Latino	**54**	**1.338%**
Non-Hispanic or Non-Latino Subtotal	**173**	**4.285%**
More than one ethnicity	**0**	**0%**
Prefer not to answer	**176**	**4.360%**
Unknown	**3086**	**76.443%**
Unduplicated Total	**4037**	**100%**

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	**305**	**8%**
Female	**453**	**11%**
Prefer not to answer	**193**	**5%**
Unknown	**3086**	**76%**
Unduplicated Total	**4037**	**100%**

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	**300**	**7.431%**
Female	**443**	**10.973%**
Transgender (Male to Female)	**0**	**0%**
Transgender (Female to Male)	**0**	**0%**
Transgender (Undefined)	**0**	**0%**
Genderqueer	**0**	**0%**
Questioning or Unsure	**0**	**0%**
Another gender identity	**0**	**0%**
Prefer not to answer	**208**	**5.152%**
Unknown	**3086**	**76.443%**
Unduplicated Total	**4037**	**100%**

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	**6**	**0.149%**
Heterosexual/ Straight	**589**	**14.590%**
Bisexual	**8**	**0.198%**
Questioning/ Unsure	**0**	**0%**
Queer	**0**	**0%**
Another sexual orientation	**2**	**0.050%**
Prefer not to answer	**346**	**8.571%**
Unknown	**3086**	**76.443%**
Unduplicated Total	**4037**	**100%**

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	**607**	**15.036%**
Spanish	**669**	**16.572%**
Vietnamese	**49**	**1.214%**
Chinese	**34**	**0.842%**
Tagalog	**1**	**0.025%**
Farsi	**1**	**0.025%**
Other	**3**	**0.074%**
Prefer not to answer	**29**	**0.718%**
Unknown	**2644**	**65.494%**
Unduplicated Total	**4037**	**100%**

	FY 2023	
Military Status	**# Served**	**% of Served**

Active Military	**0**	**0%**
Veteran	**0**	**0%**
Served in Military	**1**	**0.025%**
Family of Military	**0**	**0%**
No Military	**559**	**13.847%**
Prefer not to answer	**390**	**9.661%**
Unknown	**3087**	**76.468%**
Unduplicated Total	**4037**	**100%**

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	**1**	**0.025%**
Difficulty hearing or speaking	**0**	**0%**
Other communication disability	**0**	**0%**
Cognitive	**1**	**0.025%**
Physical/ Mobility	**9**	**0.223%**
Chronic Health Condition	**10**	**0.248%**
Other non-communication disability	**13**	**0.322%**
No Disability	**137**	**3.394%**
Prefer not to answer	**780**	**19.321%**
Unknown	**3086**	**76.443%**
Unduplicated Total	**4037**	**100%**

*Participants may choose more than one option for Disability.

7. Referrals

Office of Family Affairs provides information on how to access behavioral health services and distributes community resources to their clients based on individual and family needs. Staff check in and follow up with their clients and family members regarding resources and information that has been provided. Once clients are linked to services, program staff focus on providing peer support services as they are needed.
Office of Family Affairs provide linkage and referral to the Call Center for connection to treatment.
Office of Family Affairs receives referrals from community partners, law enforcement agencies and liaisons.

FY 2023
Unduplicated N =

Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
N/A	N/A	N/A	N/A	N/A

8. Detailed Outcomes

Office of Family Affairs collected 33 Pre and 25 Post Surveys. Post Surveys do not equate to pre surveys as participants drop out.

	I feel ashamed of myself that I have had mental problems		**I worry about telling people I received psychological treatment**		**People have been understanding of my mental problems**		**I am as good as other people, even though I have had mental health problems**	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Strongly Disagree	36%	64%	18%	52%	9%	32%	9%	28%
Disagree	9%	24%	24%	32%	9%	8%	0%	8%
Agree	18%	12%	15%	16%	21%	44%	30%	36%
Strongly Agree	3%	20%	6%	0%	24%	16%	24%	28%
Declined to Answer	33%	0%	36%	0%	36%	8%	36%	0%

	I worry about telling people that I take medicine/tablets for mental health problems		**People's reaction to my mental health problems make me keep myself to myself**		**I avoid telling people about my mental health problems**		**Having had mental health problems has made me a stronger person**		**Some people with mental health problems are dangerous**	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Strongly Disagree	18%	44%	6%	48%	3%	44%	6%	32%	9%	36%
Disagree	21%	24%	9%	28%	12%	28%	12%	12%	21%	20%

Agree	15%	24%	36%	20%	30%	24%	30%	36%	24%	32%
Strongly Agree	3%	0%	9%	4%	18%	4%	6%	16%	18%	8%
Declined to Answer	42%	8%	39%	0%	36%	0%	33%	4%	24%	4%

The Office of Family Affairs provides services to community members with the focus on Prevention & Early Intervention to help increase awareness on mental health by providing one on one support and through education, WRAP (Wellness Recovery Action Plan) and family support. We also advocate for our clients who are currently incarcerated or are in the criminal justice system, awaiting court. The hope is to decrease incarcerations by advocating for treatment (Diversion Program) and not incarceration. Advocating for our clients to receive treatment will undoubtedly decrease hospitalizations and homelessness. It is our goal to provide support and linkage to resources to help our clients develop skills to help them maintain their mental health stability.

❖ Challenges:

OFA is making improvements in collecting PEI demographic data requested by MHSA; however, there are still challenges OFA face in collect data and surveys when clients denied disclosing information due to personal privacy and fear of stigma.
Family members reported that they struggle with answering the survey as the survey is more related to mental health consumers.

9. Evaluation Summary

In FY23, Office of Family Affairs significantly expanded its services by providing outreach by tabling, participating in events, tabling at the Mexican Consulate, Urgent Care, and significant outreach sites throughout the county. This is an increase from having no coordinated outreach events to having 10 sites in FY23. Family Affairs is expanding its outreach efforts to reach more of the community and collaborating with community partners. The program continues to provide family peer services to cultivates a sense of connection and belonging during challenging times. Families often experience isolation when dealing with complex issues, but peer support fosters a sense of camaraderie among families sharing similar concerns. Through WRAP group sessions, and one-on-one and family peer support, families form bonds that provide emotional validation and reduce feelings of isolation.

Peers play a pivotal role in reducing the stigma associated with certain family challenges, such as mental health issues or substance abuse. By openly discussing their experiences and demonstrating that recovery and growth are attainable, peers help families overcome societal biases and self-imposed stigma. This process not only builds resilience within families but also encourages them to seek help without fear of judgment. Families have provided feedback to our program and expressed their gratitude in our services during complex times.

Office of Family Affairs continue to be successful in responding and managing the incoming referrals that they received from Urgent Care, NAMI, Mobile Crisis and Staff has started to provide one-to-one in-person support to clients and families.

Family Affairs staff continues to have effective working relationships with the Court system – the team works collaboratively with the Public Defender's office to assist clients to be diverted from jail and explore mental health resources and treatment. Clients consistently express feelings of support and relief stemming from the avoidance

of incarceration and crisis. This sentiment is further amplified by the reduction of perceived stigma, as the support offered by the program promotes a sense of understanding and empathy among individuals seeking assistance.

The collaboration between Court staff and Family Affairs program staff is characterized by a seamless exchange of knowledge and support. Family Affairs program staff actively participate in court proceedings, accompanying clients during their hearings for peer emotional support. This presence enables them to provide real-time information on how clients navigate the Behavioral Health System. The firsthand accounts shared by program staff shed light on the challenges and triumphs that clients experience, offering Court staff a deeper understanding of the intricacies involved.

Office of Family Affairs started to outreach at Behavioral Health Urgent Care in Fy23. OFA received very positive feedback from the Behavioral Health Urgent Care clinic and families for the resources and support provided to participants.

Challenges which impacted the success of Office Family Affairs is staffing level and masking guidelines. Office of Family Affairs faced challenges due to workforce shortage of peers with family experiences.

❖ OFA Success Stories

Narrative 1: “I was introduced to this client a few months into 2023. When I first met this client, they were lost, torn and didn’t know what to do for themselves in many areas of their life. As I introduced myself and went over briefly about who I was and why I was where I was, my client began to open little by little about their self and the things they were dealing with and noticing. Their biggest concern was about the family and or others outside of themselves. As we went through their story, I assured them they were the focus and that they needed to be able to know and understand they were their #1. With out themselves, they wouldn’t be able to support anyone else. We bullet pointed a few focus points and created a plan to work through and from that plan my client has been working towards every goal and keeping in touch with me about every milestone they accomplish. I cannot be any prouder of my client and their progress since the first time we met. One of the biggest accomplishments was their cosmetology licensing exam they finally passed. I am Proud! With the access of a few services myself/Peer Support of OFA has been able to lead my client to and assist them with getting in contact with, they are now a more confident individual and now have a better understanding of themselves and how to treat their life challenges, they can know now they can do anything with the strength of reaching out and asking for help as they did in the beginning.”

Narrative 2: “The family called to OFA to ask for information because they did not know what to do the day after a family member, who suffers from dual diagnosis, tried to commit suicide by hanging. We talked for a long time, and I managed to calm them down. The consumer agreed to talk with me, and I went to his house to visit them and talk to everyone in the family. The first thing I saw when I arrived was the rope that hung from the tree and the state of deterioration of the consumer and as well as the devastated family. I asked the consumer why he had ideas of hurting himself, and he told me that because there was no longer any help for him. He had an arrest warrant for violating his probation, couldn't stop self-medicating, and he felt that he was only getting his family into trouble. Those were the reasons why he wanted to end it all.

I connected with the client with my own mental health experience and the story of acquaintances who, with the help of the family and different programs, had managed to get ahead, and he too could do it if he wanted to. I won his trust and acceptance, and I promised him that OFA would help him whenever he needed it, but that he would have to do his part. I explained that the mental illness would not go away but that following his treatment

it would be controllable, and that his addictions could be eradicated if he agreed to enter and follow a treatment program, which he accepted.
I talked to the family and referred them to NAMI for mental health education so they could help him. I referred the consumer to NAMI and GATEWAY. We went to his court and presented his progress and cooperation to the Judge and PO, and they took away his arrest warrant.
Today he is taking the classes ordered by the Judge, seeing his psychiatrist, attending classes at NAMI, working and is waiting to enter a detoxification program.
OFA team continues to support him in his recovery."

Narrative 3: "The OFA received a referral from Pacific Clinics, Mrs. Jane Doe, to whom PCS reported to the police for alleged child abuse and because of that she had to appear in court and her daughter would be removed from her side. Mrs. Jane Doe was very ill, she went into crisis and that is why they referred her to us. We talked to her and after telling us her story we asked her to let us help her and she agreed. She received services at Gardner and had a diagnosis (schizophrenia). We referred her to Nami for classes to understand her illness and learn to manage it. We provided her with WRAP in Spanish, which is the only language she knows, and we provided her with court advocacy, we teamed up with her public defender and it was proven that she was not a bad mother. Everything had been a confusion due to her diagnosis. Jane Doe finished the classes that the judge requested, she attended and continued to attend the support group. We had one-on-one sessions when she needed it, she never missed any court dates and took her medications religiously. She learned to use what she learned at WRAP in Spanish and ultimately the judge dismissed the charges."

Narrative 4: "I got a monolingual Vietnamese client from ACCI, who needed help with a DV and mental health situation. The client lived in Alameda County and had just gotten a shelter thru ACCI in Santa Clara County since she had relocated herself and her two young children from a DV situation perpetrated by her husband occurred in Alameda County. Since the client did not speak English, I supported her by explaining a lot of how processes work for different programs and across counties. For example, she needed to transfer her Medi-cal to Santa Clara County, she needed help with getting her green card and her children's social security cards from Alameda, she needed help with getting her driver license or get connected with a driving school/teacher, she also needed to understand how restraining order works and how to get full custody of her kids. I partnered with ACCI case manager and supported the client with what she needed. I helped the client to retrieve all documents she needed for herself and her children, I helped with finding out how Alameda County case filing works and how she can file for a restraining order and child custody in Alameda County when she's in Santa Clara County. I supported her in getting application for childcare centers so she can work on getting her driver license and get herself started with securing employment. I provided her with emotional and motivational support with my own experience with DV and restraining order and let her know that if she needs anything, OFA is there for her in just one phone call away. In the process of helping her, I also got connected with her husband's parents, who needed support in navigating the mental health, substance use, and court systems. Since the husband lives in Alameda County and was not willing to go through a SUTS treatment or showing up for court, I could only support his parents to understand how mental health and substance court work and that they can make family request to the court using the AB1424 form.

Re-Entry Resource Centers

PEI Access and Linkage to Treatment Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The BHSD CJS PEI Reentry Resource Center (RRC) located at 151 West Mission Street, San Jose, California 95110 and works in conjunction with justice partners, such as Probation, Adult Custody Health Services, Social Services Agency, Pretrial Services and State Parole. The program offers walk-in services (no appointment necessary) to Santa Clara County adult and older adult residents who are justice-involved. Available services include screenings and referrals to Behavioral Health treatment services, which include mental health and substance use programs specializing in the treatment of justice involved adult and older adult clients. Clients are screened for the appropriate treatment modality and referred to County and Contracted Behavioral Health programs. When clients present as being a danger to themselves or others, or if gravely disabled, BH-RRC staff place clients on a Welfare & Institution Code (WIC) 5150 hold. The BH-RRC program is also state certified as a Substance Use Outpatient treatment program. The BH-RRC program was originally developed to serve AB 109 (prison realignment) clients being released from state prison into community under the supervision of the County's Probation Department. However, over time, has expanded the target population to include all Santa Clara County, justice involved adults and older adult residents with Medi-Cal benefits, or those who are uninsured. It is a "one stop shop" where clients can be linked and referred by BH-RRC staff to not only behavioral health services, but also a variety of other County services, such as employment, education, housing, medical care, transportation, counseling, and benefits, i.e., Medi-Cal insurance and EBT cards (food stamps). Individuals needing a higher level of care and/or services not available at this location are appropriately referred via a "warm hand off" approach. In closing, the BH-RRC program operates based on a service delivery model that facilitates interagency coordination to assess and provide relevant and effective community re-integration for incarcerated adults exiting from prison and jail settings.

In the FY24 and FY25 annual plan update, a Division name change will be reflected. The Criminal Justice Services (CJS) Division changed its name to the Forensic, Diversion and Reintegration (FDR) Division. This change was officially announced in the FY23 SLC meetings.

2. Program Indicators

The BH-RRC program provides the below noted services that address the various Prevention & Early Intervention Domains:

❖ Suicide

BH-RRC staff are trained and certified in suicide prevention and 5150 holds. All clients are screened and assessed for suicidality and are placed on a 5150 hold when presenting as a danger to themselves, others, or gravely disabled. Additionally, clients who have been placed on a 5150 hold at Emergency Psychiatric Services (EPS), Barbara Arons Pavilion (BAP), custodial and other inpatient settings may be screened and referred by

the BH-RRC team to a behavioral health program prior to being discharged/released into community. This pre-discharge/release coordination is intended to facilitate outreach/engagement necessary with building rapport and determining/coordinating community linkages. Furthermore, the BH-RRC provides SUTS Outpatient treatment and monitors clients' treatment adherence and progress which in turn increases the likelihood of a successful treatment completion, decreasing the risk of suicide.

- **Incarcerations**

The BH-RRC is a "one stop shop" where clients can be linked and referred to a variety of county services. The RRC works in conjunction with a service delivery model that facilitates interagency coordination with various justice and community partners. These partnerships allow justice involved individuals with the tools and resources needed to effectively re-integrated into community. This is particularly vital for incarcerated adults and older adults exiting prison and jail settings in decreasing reincarceration rates. The BH-RRC staff works with the Public Defender, Probation, Pretrial, Parole and Adult Custody Health Services (ACHS) staff, who refer individuals who are incarcerated at the Santa Clara County jails and requiring BH services in community. The justice partner staff submit an electronic referral form via a secure electronic mailbox for individuals in custody who would benefit from behavioral health services. These referrals are processed by the BH-RRC team, resulting in a referral to BHSD treatment provider.

- **School failure or dropout**

The BH-RRC team also links justice involved individuals to the Santa Clara County Office of Education in providing access to high school diploma credits online. The BH-RRC team is also able to link clients to a free, Peer Mentor Certification course in Drug and Alcohol Counseling through San José City College.

- **Unemployment**

The BH-RRC team also can refer justice involved individuals to employment agencies in the community. Referrals are made to Goodwill of Silicon Valley which provides paid, on-the-job training and linkage to employment. Additionally, the BH-RRC refers justice involved individuals enrolled in the BH-RRC substance use outpatient program to increase clients' successful transition into the community.

- **Prolonged suffering**

The BH-RRC program assists individuals struggling with mental health and substance use conditions with linkage to substance use and mental health treatment, as well as community placements and resources. These linkages are instrumental in decreasing the prolonged effects brought on by these conditions. Additionally, the BH-RRC staff also provides SUTS Outpatient treatment to individuals with substance use conditions which assist individuals in gaining the skills to maintain sobriety, thus decreasing prolonged suffering brought on by addiction. Lastly, the BH-RRC program assists in linking individuals with behavioral health services who are high-end users of Emergency Psychiatric Services, inpatient settings, and/or correctional setting who have struggled to remain in the community due to their mental health and substance use conditions. Linking individuals to treatment and community placement assists in decreasing the need for accessing emergency psychiatric services, custodial and or inpatient settings, and/or risking homeless. Increased success in these areas can result as they remain in treatment and learn therapeutic strategies that will help improve their symptomology and behavioral health conditions.

- **Homelessness**

The BH-RRC works with the Office of Supportive Housing (OSH)and the Faith Based Resource Center providers in assisting clients not in need of behavioral health services with accessing shelter stays, housing/rental assistance, and accessing permanent housing for qualified individuals. Likewise, the RRC screens and refers individuals into behavioral health treatment programs. Once the individual is connected to a mental health and/or substance use treatment provider, the provider assists the individual with linkage to community placement. Moreover, the Forensic, Diversion, and Reintegration Division for which the BH-RRC is under, contracts with transitional housing providers who receive funding to house justice involved clients enrolled in behavioral health outpatient programs, For individuals in need of housing and who are referred/enrolled in a SUTS OP program, access to Recovery Residential facilities is available, allowing an individual to focus on their substance use treatment rather than on attaining basic needs. Lastly, to ensure that individuals are linked to community placement, the mental health provider also completes a VI-SPDAT (Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool) which assists in determining risk of becoming homeless and facilitates the identification of the most appropriate housing and supportive interventions for those individuals who are identified as homeless or at risk of homelessness.

- **Removal of children from their home**

The BH-RRC program provides mental health referrals and substance use treatment to clients referred by Social Services Child Protective Services. Clients who are adherent to recommended/needed treatment and their case plans are at less likely to have their children removed from their home. Furthermore, the BH-RRC team also provides SUTS OP treatment to parents who are part of the Dependency Wellness Court and who are required to complete substance use treatment to avoid removal of their children from their home. Treatment adherence will equip parents with the tools needed to maintain sobriety and stabilize their mental health symptoms, resulting in long-term stability and a decreased risk of having their children removed from their care.

3. Program Goals, Objectives & Outcomes

The BH-RRC program seeks to link justice involved adults/older adults with timely access to appropriate behavioral health services and is dedicated to the following goals:

i. Collaborate with the justice involved adults and their families to support reentry.
ii. Reduce stigma associated with mental health status among those in the Forensic, Diversion and Reintegration (FDR) network of care.
iii. Increase service connectedness to mental health resources among justice involved adults and older adults.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
287	**$359,718.63**	**$ 1,253.38**

5. Evaluation Activities

The BH-RRC program utilizes the following strategies:

❖ Access and Linkage

The BH-RRC program offers "walk in" services (no appointment necessary) to individuals in need of mental health and SUTS treatment services. The BH-RRC team receives weekly referrals from the Call Center for substance use outpatient treatment enrollment. Peer mentors and community workers provide case management services and assist clients with a variety of needs. A "warm hand off" to needed community services is conducted by the BH-RRC team when transitioning clients from SUTS outpatient to other levels of care. Furthermore, the BH-RRC program provides screenings and referrals for justice involved individuals in need of mental health and/or substance use treatment. A licensed, pre-licensed, or CADC clinician screens the individual to determine the individual's level of care need and thereafter links the individual by sending a referral to the appropriate treatment program. To facilitate client access, the BH-RRC program has expanded the referral process to include a secure referral mailbox in which justice partners, such as Adult Custody Health Services, Probation, Parole, Pretrial Services, etc., refer individuals who would benefit from behavioral health services. Upon receiving a referral, the BH-RRC clinicians contact the client via the telephone or if necessary, arrange to meet with the individual to complete a face to face screening resulting in a referral to the appropriate level of care. This process allows individuals, particularly those incarcerated, with access to behavioral health treatment and community placement upon release from a custodial setting.

❖ Improving Timely Access to Services for Underserved Populations

By having a screening and referral process in which individuals can be screened and referred via in-person or telephone, the BH-RRC team is able to link individuals to the appropriate behavioral health treatment programs. Additionally, all county beneficiaries receive services/appointments within ten (10) business days.

The BH-RRC program provides culturally and linguistically proficient services to justice involved individuals seeking behavioral health services, which includes providing services in the individuals' preferred native language. Services are made available in the County of Santa Clara's six (6) threshold languages (Spanish, Vietnamese, Mandarin, Tagalog, Cantonese, and Farsi) and have the capability to access the interpretation services if additional languages are needed. Furthermore, BH-RRC staff receive cultural competency trainings on an annual basis to ensure that services provided are non-stigmatizing and non-discriminatory. Lastly, the BH-RRC staff includes peer mentors with lived experience who serve as role models to justice involved individuals seeking behavioral health treatment.

Additionally, the BH-RRC program works to ensure that staff gain knowledge of specialized ethnic and cultural populations and regions expected to be served, including through extensive experience in working with specific populations and through the lived experiences of staff providing services to specific communities. Staff must have/gain understanding of psychopathology and physical health problems within the context of clients' age and culture; effectively address clients' cultural and language needs; have awareness of language and cultural influences of the client; and knowledge of the local community resources available to the client population, including self-help centers and ethnic community resources.

i. Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory.

The BH-RRC program is designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory. All justice involved individuals are welcomed to the RRC and treated with respect and dignity. This includes the BH-RRC staff meeting the client where they are at. The BH-RRC program assists individuals with linkages to community resources, even if they do not meet medical necessity criteria for

behavioral health services. The BH-RRC clinicians use a "Whole-Person" approach to treat and link justice involved individuals to needed services.

The following detailed information on the outcomes and methods of measuring these outcomes are described below:

i. Evidence-based practice standard or promising practice standard
   a. The BH-RRC program utilizes motivational interviewing, trauma informed care, strength based interviewing, and Compassionate Communication when completing screenings for behavioral health services, in providing in-house substance use outpatient treatment, case management, and during crisis intervention. Through Motivational Interviewing, the BH-RRC staff seek to enhance the individual's motivation in maintaining adherence to behavioral health treatment. Additionally, by including a peer mentor as part of the BH-RRC team, the program can empower the individual in modeling self-efficacy, autonomy, and a sense of hope.
   b. Similarly, the BTH-RRC program utilizes strength-based interviewing which allows justice involved individuals the opportunity to share their strengths and explore how these have helped them improve their quality of life.

ii. Furthermore, BH-RRC staff utilizes and models compassionate communication with individuals seeking services. This includes role modeling how to remain empathetic with others even in stressful or difficult situations, to individuals impacted by a mental health and/or substance use condition who might be struggling to reintegrate into the community after having spent time in a correctional setting. Utilizing Dr. Marshall B. Rosenberg's role modeling techniques for communicating compassionately to clients, the BH-RRC staff demonstrates how to speak to others without judgment, how to identify situations or memories that trigger emotions, and how to understand how these emotions are connected to an individual's underlying needs, thus allowing the individual to learn how to make reasonable requests.

iii. Lastly, the BH-RRC programs also utilizes trauma informed care. This is especially important with this population as they often might have experienced generational trauma of incarceration. By utilizing trauma informed care, the BH-RRC acknowledges the possibility that the individual most likely has experienced trauma and recognizes the presence of symptoms related to the effects of trauma, thus allowing staff and clients in acknowledging and understanding how trauma has impacted their lives. Additionally, the BH-RRC utilizes the ASAM Criteria when determining the client's most appropriate substance use level of care need, as well as their level of motivation which allows staff and clients to explore and address the barriers that may be impacting their motivation to remain treatment adherent. This is key in ensuring that the BH-RRC meet clients where they are and help guide them as they progress through the motivational tiers.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	Not Applicable	Not Applicable
16 -25 years	27	9%
26- 59 years	251	87%

60+ years	9	3%
Prefer not to answer	Not Applicable	Not Applicable
Unknown	Not Applicable	Not Applicable
Unduplicated Total	287	

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	1	0.3%
Asian	17	5.9%
Black or African American	17	5.9%
Native Hawaiian or Other Pacific Islander	6	2.1%
White/ Caucasian	57	19.9%
Other	133	46.3%
More than one race	Not Available	Not Available
Prefer not to answer	1	0.3%
Unknown	55	19.2%
Unduplicated Total	287	

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	Not Available	Not Available
Central American	2	0.7%
Mexican/ Mexican-American/ Chicano	83	28.9%

Puerto Rican	1	0.3%
South American	5	1.7%
Hispanic/ Latino (undefined)	Not Available	Not Available
Other Hispanic/ Latino	35	12.2%
Hispanic or Latino Subtotal	126	
Non-Hispanic or Non-Latino as follows:		
African	Not Available	Not Available
Asian Indian/ South Asian	2	0.7%
Cambodian	Not Available	Not Available
Chinese	Not Available	Not Available
Eastern European	Not Available	Not Available
European	1	0.3%
Filipino	2	0.7%
Japanese	Not Available	Not Available
Korean	Not Available	Not Available
Middle Eastern	1	.3%
Vietnamese	12	4.2%
Non-Hispanic/ Non-Latino (undefined)	27	9.4%
Other Non-Hispanic/ Non-Latino	22	7.7%
Non-Hispanic or Non-Latino Subtotal	67	
More than one ethnicity	Not Available	Not Available
Prefer not to answer	49	17.1
Unknown	45	15.7

Unduplicated Total	287	

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	240	84%
Female	47	16%
Prefer not to answer	Not Available	Not Available
Unknown	Not Available	Not Available
Unduplicated Total	287	

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	240	84%
Female	47	16%
Transgender (Male to Female)	Not Available	Not Available
Transgender (Female to Male)	Not Available	Not Available
Transgender (Undefined)	Not Available	Not Available
Genderqueer	Not Available	Not Available
Questioning or Unsure	Not Available	Not Available
Another gender identity	Not Available	Not Available
Prefer not to answer	Not Available	Not Available
Unknown	Not Available	Not Available
Unduplicated Total		

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	Not Available	Not Available
Heterosexual/ Straight	Not Available	Not Available

Bisexual	Not Available	Not Available
Questioning/ Unsure	Not Available	Not Available
Queer	Not Available	Not Available
Another sexual orientation	Not Available	Not Available
Prefer not to answer	Not Available	Not Available
Unknown	Not Available	Not Available
Unduplicated Total	Not Available-Not a required field	

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	182	63.4%
Spanish	50	17.4%
Vietnamese	5	1.7%
Chinese	Not Available	Not Available
Tagalog	Not Available	Not Available
Farsi	Not Available	Not Available
Other	1	0.3%
Prefer not to answer	Not Available	Not Available
Unknown	49	17.1
Unduplicated Total	287	

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	Not Available	Not Available
Veteran	Not Available	Not Available
Served in Military	1	0.3%
Family of Military	Not Available	Not Available
No Military	36	12.5%
Prefer not to answer	Not Available	Not Available

Unknown	250	87.1%
Unduplicated Total	287	

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	Not Available	Not Available
Difficulty hearing or speaking	Not Available	Not Available
Other communication disability	Not Available	Not Available
Cognitive	Not Available	Not Available
Physical/ Mobility	Not Available	Not Available
Chronic Health Condition	Not Available	Not Available
Other non-communication disability	2	0.7%
No Disability	Not Available	Not Available
Prefer not to answer	Not Available	Not Available
Unknown	285	99.3%
Unduplicated Total	287	

*Participants may choose more than one option for Disability.

7. Referrals

FY 2023				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
373	SUTS ADULT OP	217	Not Available	4 days

8. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
Not Available	Not Available	Not Available

9. Detailed Outcomes

In FY 2017-2018, the BH-RRC program struggled to implement measures to evaluate the eight domains: housing; income and benefits; physical health; substance use; mental health; family; faith and community; and peer and associates. As a result, the program staff was not able to effectively track all services provided and progress made over the tenure of the program, including recidivism rates. The BH-RRC program has been using an Access database developed early on at the beginning of the program.

In FY 2018-2019, two tools were used to track program progress in addressing client needs in multiple functional domains: one tool assessed risk and was utilized by the Probation Department and the Sheriff's Office to determine supervision plans, and the other tool, the Critical Needs Screening, was used by Behavioral Health staff to assess and address service needs. These tools were important in identifying the strategies to be used to determine the needs of the clients returning to the community from a custodial setting. However, due to staff turnover, the risk assessment tool for law enforcement was not continued, but Behavioral Health staff still used the Critical Needs Screening tool and through collaboration and assembled resources, provided the required services to address the needs of this population.

In FY 2019-2020, the emergence of the COVID-19 Pandemic prompted procedural changes within the BH-RRC program. Staff had to modify their protocols to ensure adherence to the Public Health orders as well as ensure the safety of staff and clients. Initially, all in-person services were halted as the county attempted to adjust to the rapidly changing Public Heath mandates. Additionally, there was a huge decline in the number of clients seeking services, possibly due to client supervision being conducted remotely and officers not being able to force individuals to comply with treatment recommendations. Moreover, the BH-RRC had to limit the number of individuals gathered in the building to adhere to the CDC and Public Health Social Distancing mandates. These various factors resulted in a decrease in the number of clients served during FY 2019-2020.

In FY 2020-2021, the BH-RRC program implemented the CJS Referral Form to expand referral source, streamline the referral process, and increase access for justice involved clients to behavioral health services. The CJS Referral Form is utilized by both justice and non-justice partners to refer both in-custody and out-of-custody individuals for a screening and referral to mental health and/or substance use treatment services.

In 2021-2022, the BH-RRC began developing substance use group treatment programming to reintroduced substance use group therapy services, which was paused during the pandemic, as an additional treatment modality to individual therapy. This will enhance the services offered to individuals receiving substance use treatment.

- **Percent improvement (From pre- to post- results)**

During Fiscal Year 2017-2018, the BH-RRC program served 2,489 unique clients over the course of 4,579 visits; conducted 923 critical needs screenings and 732 clinical needs screenings; generated 975 referrals to clinical

services, 734 referrals to substance use treatment agencies, 241 referrals to mental health treatment providers and 390 referrals to Community-Based Organizations.

During Fiscal Year 2018-2019, the BH-RRC program served 3,103 unique clients over the course of 4,965 visits; conducted 911 critical needs screenings and 553 clinical needs screenings; generated 988 referrals to clinical services, 856 referrals to substance use treatment providers, 132 referrals to mental health treatment providers, and 225 referrals to Community-Based Organizations. In FY 2018-2019, the BH-RRC program served a total of 614 more unique clients which is a 24.5% increase in comparison to FY 2017-2018. Additionally, BH-RRC staff referred 122 more clients to substance use treatment (14.5%), while on the other hand, there was a decrease in the number of individuals referred to mental health services (N=109 less clients). This is a 55% decrease in the number of individuals referred to mental health treatment.

During FY 2019-2020, the BH-RRC program served 715 unique clients over the course of 1007 visits. At the time the clients were seen at the Reentry Resource Center, 416 reported they were actively looking for employment. 280 clients reported having access to their own transportation, while 412 relied on public transportation and 322 clients were reported as homeless. In FY2019-2020, the BH-RRC program served a total of 2,388 (77%) less clients than in FY 2018-2019.

During FY 2020-2021, the BH-RRC program served 182 clients. In FY 2020-2021, the BH-RRC program served 533 (74%) less clients than in FY 2019-2020. This reduction was due to the safety measures that were implemented during the COVID Pandemic in accordance with County Public Health orders. As a result, minimal face-to-face services were available. Telework/telehealth was limited to phone calls and screenings, assessments and referrals were completed over the telephone. This had its set of challenges as many clients did not have access to a phone and therefore could not follow through with calls and needed referrals. In addition, only individual outpatient treatment was available which was limited to telehealth and/or telephone contact. In addition, the lack of enforcement by justice partners to comply with required treatment and services limited enrollment at the BH-RRC program.

- **Any summary narrative explaining the outcome data, any information on data collection, and any observations made by the program in the outcome and data collection process.**

It is critical to design and test outcomes “dashboards” to track progress in addressing client needs in multiple functional domains (health, mental health, substance abuse, housing benefits, employment/education, benefit assistance, and social network). In September of 2020, the Behavioral Health Services Department implemented a new electronic health record (EHR), myAvatar, to provide data and optimize the availability and utilization of services. Currently, only County providers are utilizing this software to enter data. As myAvatar continues to evolve, the BH-RRC continues to gather data from Unicare(if necessary), the RRC Behavioral Health Access database, the DRS-RRC Referral Tracking System and myAvatar to accurately account for all services provided (outpatient treatment services, Mental Health and Substance Use Treatment Services referrals, and all walk-in service requests).

As myAvatar is modified, and all information is accurately entered and stored (e.g., referrals, registration, admission/discharge, billing services received, etc.), the BH-RRC program will have access to accurately populated reports and relevant dashboards. At this time, myAvatar can report data from screening tools that are currently in use and exist in myAvatar. This includes the Integrated Justice Screening Assessment (IJS)used for mental health referrals and the Integrated Screening Tool (IST) used for substance use treatment referrals. The integration of County and Contracted service providers into myAvatar will allow the BH-RRC program to collect data, and monitor capacity, referrals, enrollment, and service utilization. As a result, real-time

data on the number of clients served, dosage, and types of services provided by the Behavioral Health Team at the Reentry Resource Center is anticipated to be available in the future.

10. Evaluation Summary

❖ The indicators utilized are as follows:

In FY 2017-2018, the BH-RRC program struggled to implement measures to evaluate the eight domains: housing; income and benefits; physical health; substance use; mental health; family; faith and community; and peer and associates. As a result, the program staff was not able to effectively track all services provided and progress made over the tenure of the program, including recidivism rates. The BH-RRC program has been using an Access database developed early on at the beginning of the program.

In FY 2018-2019, two tools were used to track program progress in addressing client needs in multiple functional domains: one tool assessed risk and was utilized by the Probation Department and the Sheriff's Office to determine supervision plans, and the other tool, the Critical Needs Screening, was used by Behavioral Health staff to assess and address service needs. These tools were important in identifying the strategies to be used to determine the needs of the clients returning to the community from a custodial setting. However, due to staff turnover, the risk assessment tool for law enforcement was not continued, but Behavioral Health staff still used the Critical Needs Screening tool and through collaboration and assembled resources, provided the required services to address the needs of this population.

In FY 2019-2020, the emergence of the COVID-19 Pandemic prompted procedural changes within the BH-RRC program. Staff had to modify their protocols to ensure adherence to the Public Health orders as well as ensure the safety of staff and clients. Initially, all in-person services were halted as the county attempted to adjust to the rapidly changing Public Heath mandates. Additionally, there was a huge decline in the number of clients seeking services, possibly due to client supervision being conducted remotely and officers not being able to force individuals to comply with treatment recommendations. Moreover, the BH-RRC had to limit the number of individuals gathered in the building to adhere to the CDC and Public Health Social Distancing mandates. These various factors resulted in a decrease in the number of clients served during FY 2019-2020.

In FY 2020-2021, the BH-RRC program implemented the CJS Referral Form to expand referral source, streamline the referral process, and increase access for justice involved clients to behavioral health services. The CJS Referral Form is utilized by both justice and non-justice partners to refer both in-custody and out-of-custody individuals for a screening and referral to mental health and/or substance use treatment services.

In 2021-2022, the BH-RRC began developing substance use group treatment programming to reintroduced substance use group therapy services, which was paused during the pandemic, as an additional treatment modality to individual therapy. This will enhance the services offered to individuals receiving substance use treatment.

❖ Percent improvement (From pre- to post- results)

During Fiscal Year 2017-2018, the BH-RRC program served 2,489 unique clients over the course of 4,579 visits; conducted 923 critical needs screenings and 732 clinical needs screenings; generated 975 referrals to clinical services, 734 referrals to substance use treatment agencies, 241 referrals to mental health treatment providers and 390 referrals to Community-Based Organizations.

During Fiscal Year 2018-2019, the BH-RRC program served 3,103 unique clients over the course of 4,965 visits; conducted 911 critical needs screenings and 553 clinical needs screenings; generated 988 referrals to clinical services, 856 referrals to substance use treatment providers, 132 referrals to mental health treatment providers, and 225 referrals to Community-Based Organizations. In FY 2018-2019, the BH-RRC program served a total of 614 more unique clients which is a 24.5% increase in comparison to FY 2017-2018. Additionally, BH-RRC staff referred 122 more clients to substance use treatment (14.5%), while on the other hand, there was a decrease in the number of individuals referred to mental health services (N=109 less clients). This is a 55% decrease in the number of individuals referred to mental health treatment.

During FY 2019-2020, the BH-RRC program served 715 unique clients over the course of 1007 visits. At the time the clients were seen at the Reentry Resource Center, 416 reported they were actively looking for employment. 280 clients reported having access to their own transportation, while 412 relied on public transportation and 322 clients were reported as homeless. In FY2019-2020, the BH-RRC program served a total of 2,388 (77%) less clients than in FY 2018-2019.

During FY 2020-2021, the BH-RRC program served 182 clients. In FY 2020-2021, the BH-RRC program served 533 (74%) less clients than in FY 2019-2020. This reduction was due to the safety measures that were implemented during the COVID Pandemic in accordance with County Public Health orders. As a result, minimal face-to-face services were available. Telework/telehealth was limited to phone calls and screenings, assessments and referrals were completed over the telephone. This had its set of challenges as many clients did not have access to a phone and therefore could not follow through with calls and needed referrals. In addition, only individual outpatient treatment was available which was limited to telehealth and/or telephone contact. In addition, the lack of enforcement by justice partners to comply with required treatment and services limited enrollment at the BH-RRC program.

- **Any summary narrative explaining the outcome data, any information on data collection, and any observations made by the program in the outcome and data collection process.**

It is critical to design and test outcomes “dashboards” to track progress in addressing client needs in multiple functional domains (health, mental health, substance abuse, housing benefits, employment/education, benefit assistance, and social network). In September of 2020, the Behavioral Health Services Department implemented a new electronic health record (EHR), myAvatar, to provide data and optimize the availability and utilization of services. Currently, only County providers are utilizing this software to enter data. As myAvatar continues to evolve, the BH-RRC continues to gather data from Unicare, the RRC Behavioral Health Access database, the DRS-RRC RTS and myAvatar to accurately account for all services provided (outpatient treatment services, Mental Health and Substance Use Treatment Services referrals, and all walk-in service requests).

As myAvatar is modified, and all information is accurately entered and stored (e.g., referrals, registration, admission/discharge, billing services received, etc.), the BH-RRC program will have access to accurately populated reports and relevant dashboards. At this time, myAvatar can report data from screening tools that are currently in use and exist in myAvatar. This includes the Integrated Justice Screening Assessment (IJS)used for mental health referrals and the Integrated Screening Tool (IST) used for substance use treatment referrals. The integration of County and Contracted service providers into myAvatar will allow the BH-RRC program to collect data, and monitor capacity, referrals, enrollment, and service utilization. As a result, real-time data on the number of clients served, dosage, and types of services provided by the Behavioral Health Team at the Reentry Resource Center is anticipated to be available in the future.

LGBTQIA+ Wellness PEI Program: The Q CORNER & CAMINAR'S LGBTQ Wellness Team

PEI Improve Timely Access to Services for Underserved Populations Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The Behavioral Health Services Department (BHSD) is committed to creating and maintaining safe and welcoming healing environments that provide the highest quality of services for all clients, inclusive of their sexual orientation, gender identity, and gender expression. Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and other sexual and gender minority (2SLGBTQIA+) individuals have been identified as an underserved population. The population routinely faces individual and institutional barriers to accessing safe, affirming, and competent services and are more likely to experience disparities in quality of care and access to affirming support.

This community is also over-represented in systems of care and crisis services, and experience mistrust in service systems, due to these services being entrenched in anti-gay and anti-transgender biases, discrimination, deeply engrained heterosexism and cisgender privilege that further disadvantages the community and cause enduring harm to an already culturally traumatized population. Due to institutional and individual bias and discrimination and the impact of minority stress, the research indicates that 2SLGBTQIA+ adults are more than twice as likely to experience a mental health condition, and the statistic is significantly higher for Transgender, Nonbinary, and Gender Expansive (TGNBGE) individuals. Local and national studies demonstrate a 40% lifetime suicide attempt rate for transgender individuals compared to less than 5% in the general U.S. population. BHSD holds that explicit action must be taken to create not just equal, but equitable services for 2SLGBTQIA+ community members, including all transgender, nonbinary, and gender expansive people.

Developing a trusting therapeutic relationship within the BHSD system of care is life saving and requires a deep and nuanced understanding of the lived experience of 2SLGBTQIA+ individuals and of gender affirming care. There must be staff available with sufficient and specialized cultural competence to establish healing relationships with 2SLGBTQIA+ community members, which entails knowledge and experience beyond introductory competency training. Understanding that this population has historically faced discrimination from government and/or mental health systems, County and community-based programs serving the community must focus on building trust between the community and service providers.

The BHSD LGBTQIA+ Wellness PEI Program is aimed at ensuring 2SLGBTQIA+ Community Members in Santa Clara County have access to welcoming, affirming, knowledgeable, and competent behavioral health services and community resources. This PEI Program includes both The Q Corner, a County-run team of peer navigators, community outreach specialists, and health educators, as well as the LGBTQ Wellness Program operated by Caminar, a contracted community provider. This report will include data from all these efforts. The Q Corner and Caminar's LGBTQ Wellness provide one on one and group peer support, resource linkage and navigation, and community wellness and social engagement events and activities, along with capacity building efforts such as trainings, resource development, and consultation.

Caminar's LGBTQ Wellness was created in 2015, initially as a program of the Cultural Communities Wellness Program to identify and address existing gaps in service for the 2SLGBTQIA+ community in Santa Clara County. The programs reduce stigma, improves cultural competencies, and activates allyship at both the individual and institutional levels through educational outreach and trainings about mental health & sexual orientation, gender identity, & expression (SOGIE). In addition, Caminar's LGBTQ Wellness engages in advocacy and policy work to better connect members of the 2SLGBTQIA+ community with vital support services and resources.

The Q Corner launched in March of 2020 in order to address the disparities in access to mental health services for the 2SLGBTQIA+ population of County of Santa Clara and offer low barrier access to mental health supports, community building, and culturally specific practices and recovery-oriented activities. The team of 2SLGBTQIA+ Peer Navigators and Outreach Specialists work in collaboration with the Cultural Community Wellness Programs, Office of LGBTQ Affairs, and community based-service providers, to increase connectedness to behavioral health resources and services, in a timely manner to access appropriate mental health prevention and early intervention services. The Q Corner was designed to be co-located with clinical mental health services for the population, to offer holistic non-clinical cultural activities and programs where individuals are welcome to participate without limit. The clinical program that The Q Corner will be co-located with is the MHSA CSS-funded Gender Affirming Care Clinic. Updates for this clinic are under the CSS Gender Affirming Care Clinic section.

The Q Corner initially opened online and with remote services, and near the end of FY21, once COVID-19 Shelter in Place was lifted and in person services were again possible, The Q Corner officially opened the office to the public to provide Peer Support Services and resource connection opportunities by way of a drop-in space with open office hours three times per week (at varied times to offer upmost flexibility for community members). The Q Corner and Caminar's LGBTQ Wellness teams are able to meet at locations in the community convenient and safe for clients, if meeting in the office is not feasible for someone.

The educational arm of The Q Corner works in collaboration with Caminar's LGBTQ Wellness program to offer trainings and consultation to deliver best practices for providers to better serve, understand, and support 2SLGBTQIA+ folks in our communities. There is now a menu of over a dozen training courses, some provided by the team and others through contracted trainers, that offer a comprehensive array of options to provide education, support, and technical assistance to behavioral health providers, educators, families, etc. in order to establish a baseline competency of welcoming, affirming, and knowledgeable services to support 2SLGBTQIA+ individuals.

Throughout FY23, The Q Corner and Caminar's LGBTQ Wellness programs have expanded their reach to even more services and supports. The innovative and culturally responsive services provided by The Q Corner and Caminar's LGBTQ Wellness have been a huge step forward in creating a more comprehensive system of support for 2SLGBTQIA+ community members in Santa Clara County. Extensive details about the specific program offerings and successes are outlined throughout this report.

- **The BHSD 2SLGBTQIA+ Wellness PEI Program intends to address 2SLGBTQIA+ community needs across 7 arenas of impact:**

i. Diversify and multiply the reach of all 2SLGBTQIA+ Wellness Services across Geographical regions, Language needs, and Intersectional cultural identities (ie. across race/ethnicity)
ii. Increase Direct Clinical (through collaboration and colocation with the Gender Affirming Care Clinic) and Peer Support Services (The Q Corner and Caminar's LGBTQ Wellness) to 2SLGBTQIA+ Community Members, including specialized gender affirming care services for trans, nonbinary, and gender expansive folks
iii. Offer comprehensive menu of Supports and Services to Families/Caretakers and Schools supporting 2SLGBTQIA+ Youth including transgender, nonbinary, and gender expansive children, youth, and young adults

iv. Increase access and linkage to improved services through intensive collaboration with system partners across mental health, substance use, suicide and crisis prevention and response, health services, housing, criminal justice, etc.
v. Establish systemwide Baseline Competency for 2SLGBTQIA+ knowledgeable, welcoming, and affirming environments and supports through foundational Training and Technical Assistance
vi. Expand Network of Specialized Services, including Behavioral Health Services through a community of practice of dedicated and individualized Training and Consultation staff and supports
vii. Improve Efficacy and Quality of System through implementation of culturally responsive SOGI Data Collection and Administrative and Clinical Best Practice Recommendations.

2. Program Indicators

Suicide Prevention: The LGBTQ Wellness Services are committed to reducing prolonged suffering and rates of suicide among the 2SLGBTQIA+ community in Santa Clara County through two primary avenues: by providing direct services to 2SLGBTQIA+ community members and by providing trainings and resource development for existing services to increase cultural humility and accessibility. All the peer support offered are protective factors for suicide risk. Having an affirming and trusted person or group to connect with, along with access to resources are suicide prevention. Peer support groups can decrease feelings of loneliness and isolation and increase feelings of community and connection. The Programs emphasize accessibility and offer a mixture of in-person and virtual groups to meet varying community needs. One-to-one peer support services address the more individualized needs of participants, and resource connection allows staff to bridge gaps in resource awareness and connect participants to wider systems of support.

The educational efforts from the programs are also linked to suicide prevention, including the trainings that offer participants information on affirming care. All the Family Acceptance Project work that is shared through The Q Corner trainings, are evidence based as suicide prevention, and all the gender affirming services and consultation that The Q Corner providers are also all forms of suicide prevention. The Understanding GAE (Gender, Attraction, Expression) and SOGIE 101 trainings provide existing agencies and programs with the fundamentals required to serve the 2SLGBTQIA+ community safely and respectfully. Training topics include pronouns and misgendering, community terminology and definitions, intersectionality, data collection best practices, and cultural/historical trauma. Understanding GAE was developed specifically for behavioral health services providers, while SOGIE 101 is regularly tailored for audiences such as social workers, educators, religious organizations, and general community services. Fostering a deeper sense of cultural humility at the individual and institutional levels creates safer and more accessible services for the 2SLGBTQIA+ community.

Caminar's LGBTQ Wellness delivers Mental Health First Aid trainings to both service providers and community members. Though Mental Health First Aid itself does not specifically address the 2SLGBTQIA+ community, Caminar's LGBTQ Wellness delivers the training with an 2SLGBTQIA+ lens. The 2SLGBTQIA+ community experiences disproportionally higher rates of mental health challenges such as depression, anxiety, post-traumatic stress, eating disorders, and substance use disorders. Mental Health First Aid helps both providers and community members to better recognize warning signs and symptoms of mental health crises in 2SLGBTQIA+ adults.

In addition to live trainings, The Q Corner and Caminar's LGBTQ Wellness develop educational resources for service providers independently and through the Trans Care Coalition (TCC). The Trans Care Coalition specifically addresses the need for safe, accessible mental health care for transgender, nonbinary, and gender expansive individuals. As a member of the TCC, The Q Corner and Caminar's LGBTQ Wellness helped develop educational materials about safe data collection practices, creating welcoming environments, pronouns basics, and general gender affirming care best practices.

Incarcerations and Removal of children from their home: The SOGIE 101 Trainings, which are foundation trainings that the teams deliver and endorse others to deliver covers information and insight on the overrepresentation of 2SLGBTQIA+ youth in systems of care: juvenile justice systems, dependency/child welfare environments, emergency housing continuums, etc. and discusses how to support youth in getting out of systems of care, how to reduce/stop re-traumatization of youth, and how to increase permanency. The Q Corner team also meets monthly with partners from the County of Santa Clara Department of Family and Children Services (DFCS) to discuss and strategize of the care of 2SLGBTQIA+ clients within the Child Welfare System, as well as specific work related to support trans youth in the child welfare system navigating health services, including emergency psychiatric services. We work very closely with the LGBTQ+ Social Worker in DFCS, as well as the Youth Acceptance Project and the HUB, all who provide support services to 2SLGBTQIA+ youth in DFCS. Colleagues from DFCS participate in our various trainings.

Homelessness: The County of Santa Clara recognizes that there are disparities with unhoused 2SLGBTQIA+ folks accessing housing services, especially permanent housing services. The Q Corner has worked with the housing and homeless Continuum of Care to make and review recommendations for reducing these disparities, including by implementing SOGIE 101 trainings throughout the system of care. The Q Corner is trained to administer the VI-SPDAT, the coordinated assessment tool used to refer individuals to housing in Santa Clara County and has offered our space to folks to complete this assessment. We also collaborate with Bill Wilson Center, a local non-profit that has several programs focused on supporting 2SLGBTQIA+ youth who are experiencing homelessness, including supporting several of their PRIDE celebrations with resources.

School failure or dropout: The Q Corner has supported reducing school failure and drop out through several partnerships with the County Office of Education (SCCOE), dozens of local school districts, and the BHSD School Linked Services team. We collaborated with SCCOE in their development of a comprehensive Resource Guide for LGBTQ+ Students, an accompanying website, and an assortment of Out for Safe Schools materials such as badges, posters, and pronoun pins and stickers. We have supported SCCOE and specific districts with subject matter expertise on Policies and Procedures related to 2SLGBTQIA+ students, with support for GSA clubs on campuses, through outreach/resource events at schools, and through many trainings available to school professionals. We deliver introductory 2-hour SOGIE 101 trainings to schools/school staff, continue to offer a virtual, interactive training simulation available to all middle and high school staff to support 2SLGBTQIA+ youth on campus and intervene with bullying, called “Step In, Speak Up!”, and advertise all of our other trainings to school professionals, including the Gender Wheel workshops, which are specifically relevant for people involved in early childhood education. There will be new offerings for school support in FY24 that the program has been planning for.

3. Program Goals, Objectives & Outcomes

The goals and objectives of the LGBTQ+ Wellness PEI Program (formerly LGBTQ Access & Linkage and Technical Assistance, LGBTQ Cultural Specific Wellness Center, and LGBTQ Cultural Community Wellness Program) as outlined in the MHSA Plan are as follows:

i. Address disparities in access and connectedness to safe, competent behavioral health resources and services for 2SLGBTQIA+ adults in Santa Clara County through outreach initiatives in community spaces and connecting 2SLGBTQIA+ individuals and their families in a timely manner to access appropriate mental health prevention and early intervention services.

ii. Decrease the impacts of social isolation and other mental health challenges among 2SLGBTQIA+ adults in Santa Clara County by providing peer support groups, a variety of healing services, community engagement activities, health education, one-to-one peer support, and linkage to safe, appropriate resources.

iii. Expand 2SLGBTQIA+ trainings and technical assistance across the system to build capacity with providers within all service systems to offer affirming care for 2SLGBTQIA+ individuals.

iv. Support youth and their families by integrating across the lifespan, a best practice model for training and technical assistance for families and providers to better serve, understand and support 2SLGBTQIA+ youth in our communities.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N = 20,028		
Number Served	Program Expenditure	Cost per Person
Total – 20,028 The Q Corner Peer Support – 15,105 The Q Corner Trainings – 1,633 Caminar LGBTQ Wellness – 3,290 TOTAL for all LGBTQIA+ PEI	**$1,324,945.06**	**$ 66.15**

5. Evaluation Activities

The LGBTQ Wellness Program utilizes Community and practice-based evidence standard as the method to measure outcomes. The Q Corner and Caminar's LGBTQ Wellness receive evaluation feedback from program participants through email, in-person/virtual community gatherings, and through an anonymous qualitative survey provided to support services participants periodically and at each training.
Further details about participant feedback can be found in sections 8 and 9.

6. Demographic Data

TRAININGS total: 1633
Demographics known: 964
Unknown: 669

	FY 2023	
Age Group	**# Served**	**% of Served (calculated only from demographics collected)**
0 – 15 years	3	0%
16 -25 years	137	14%
26- 59 years	753	77%
60+ years	52	5%
Prefer not to answer	13	1%
Unknown	6 + all other uncollected	1%

Duplicated Total	1633	100%

	FY 2023	
Race	**# Served**	**% of Served (calculated only from demographics collected)**
American Indian or Alaska Native	24	2%
Asian	209	21%
Black or African American	39	4%
Native Hawaiian or Other Pacific Islander	4	0%
White/ Caucasian	433	44%
Other	121	12%
More than one race	58	6%
Prefer not to answer	104	11%
Unknown	59 + all other uncollected	6%
Duplicated Total	More than 1633 because its multiselect	More than 100% because its multiselect

Please note that this is a problematic data point. It is essentially forcing Latinx folks to choose one of these racial identities (this categorization was originally set up by colonizers to have Latinx folks identify as white), which many do not identity as. The majority of Latinx folks choose “other” or “prefer not to answer” for this question.

	FY 2023	
Ethnicity	**# Served**	**% of Served (calculated only from demographics collected)**
Hispanic or Latinx:		
Caribbean	3	0%
Central American	38	4%
Mexican/ Mexican-American/ Chicano	317	32%
Puerto Rican	15	2%
South American	13	1%
Hispanic/ Latinx (undefined)	NA	NA
Other Hispanic/ Latinx	5	1%
Hispanic or Latinx Subtotal	378	38%
THE FOLLOWING IS A BREAKDOWN FOR ALL RESPONDENTS REGARDLESS OF ETHNICITY (this is not only “non-latinx”, otherwise the racial identities		

of Latinx folks who also identify with these identities are invisible):		
African	32	3%
Asian Indian/ South Asian	26	3%
Cambodian	5	1%
Chinese	45	5%
Eastern European	62	6%
European	327	33%
Filipino	37	4%
Japanese	20	2%
Korean	18	2%
Middle Eastern	16	2%
Vietnamese	50	5%
Non-Hispanic/ Non-Latinx (undefined)	NA	NA
Other Non-Hispanic/ Non-Latinx	41	4%
Non-Hispanic or Non-Latinx Subtotal	520	53%
More than one ethnicity	13	1%
Prefer not to answer	64	7%
Unknown	All other uncollected	NA
Duplicated Total	More than 1633 because its multiselect	More than 100% because its multiselect

Other includes: Creole, Indonesian, Guamanian, Northern European, Blackfeet, Pomo, Jewish, Taiwanese, Thai, New Zealand, South African, Mestizo (Mayan), Hmong, Cherokee, Ethiopian, Lakota, Apache, Salvadorean, Chilean

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served (calculated only from demographics collected)**
Male	NA	NA
Female	NA	NA
Prefer not to answer	NA	NA
Unknown	NA	NA
Duplicated Total	NA	NA

The Q Corner and LGBTQ Wellness do not ask this question – "Sex assigned at birth" (SAAB) refers to the categorization of an infant's physical anatomy at birth (typically as "male" or "female"). It should not be part of data collection for demographics purposes. Sex assigned at birth is distinct from gender identity and Gender Identity is the only data point necessary, which is already being asked. Sex assigned at birth data should only be collected by behavioral health services when required for insurance plan information.

Asking for a person's sex assigned at birth is unnecessary and invasive in almost all settings. When we ask clients for both their sex assigned at birth and gender identity, we may be forcing Transgender/Gender non-conforming/Intersex (TGI) clients to out themselves when they do not feel safe to do so. Because this is the population we are aiming to engage, and our priority is to be welcoming, safe, and culturally responsive, we do not ask this question.

	FY 2023	
Gender (Current) (Gender Identity)	**# Served**	**% of Served (calculated only from demographics collected)**
Cisgender Man	114	12%
Cisgender Woman	664	67%
Transgender Woman	3	0%
Transgender Man	13	1%
Transgender (Undefined)	NA	NA
Genderqueer	16	2%
Questioning or Unsure	7	1%
Another gender identity	52 (44 nonbinary, 6 agender, 2 genderfluid)	5%
Prefer not to answer	72	7%
Unknown	19 + all other uncollected	7%
Duplicated Total	1633	100%

Answer option working on this should read: Cisgender Woman, Cisgender Man, Transgender Woman, Transgender Man, etc. Also, nonbinary should be a gender identity specifically listed, and separate from genderqueer.

	FY 2023	
Sexual Orientation	**# Served**	**% of Served (calculated only from demographics collected)**
Gay or Lesbian	60	6%
Heterosexual/ Straight	611	62%
Bisexual	83	8%
Questioning/ Unsure	9	1%
Queer	81	8%

Another sexual orientation	75 (56 Pansexual, 6 Asexual, 4 Two Spirit, 9 other)	8%
Prefer not to answer	36	4%
Unknown	9 + all other uncollected	1%
Duplicated Total	1633	100%

Other also includes: Fluid, Polysexual, Demisexual, “things change”

The Q Corner asks about variations in physical sex characteristics (sometimes referred to as an Intersex Condition). Not including this is erasing this already very invisible community, as this identity is neither a sex assigned at birth, gender identity, or sexual orientation:

	FY 2023	
Difference in Sex Characteristics	**# Served**	**% of Served (calculated only from demographics collected)**
Yes	19	2%
No	822	84%
Not sure	56	6%
Prefer not to answer	31	3%
Unknown	36 + all other uncollected	4%
Total Served (duplicated)	1633	100%

	FY 2023	
Primary Language	**# Served**	**% of Served (calculated only from demographics collected)**
English	848	86%
Spanish	60	6%
Vietnamese	10	1%
Chinese	2	0
Tagalog	3	0
Farsi	3	0

Other	17	2%
Prefer not to answer	6	1%
Unknown	6 + all other uncollected	1%
Duplicated Total	1633	100%

Other includes: Japanese, Korean, Russian, Dutch, Dari, Arabic, Bengali, Portuguese, Khmer

	FY 2023	
Military Status	**# Served**	**% of Served (calculated only from demographics collected)**
Active Military	0	0
Veteran	22	2%
Served in Military	0	0
Family of Military	0	0
No Military	900	91%
Prefer not to answer	10	1%
Unknown	32 + all other uncollected	3%
Duplicated Total	1633	100%

	FY 2023	
Disability*	**# Served**	**% of Served (calculated only from demographics collected)**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability		
No Disability		
Prefer not to answer		
Unknown	1633	100%
Duplicated Total	1633	100%

*Participants may choose more than one option for Disability.
We are unclear as to why the following are not available options: Mental Health Disability, Learning Disability, Neurodivergence, etc.

Peer Support

Demographics known: 90
Unknown: 15,015

	FY 2023	
Age Group	**# Served**	**% of Served (calculated only from demographics collected)**
0 – 15 years	2	2%
16 -25 years	26	29%
26- 59 years	57	63%
60+ years	3	3%
Prefer not to answer	2	2%
Unknown	0 + all other uncollected	0
Duplicated Total	90	100%

	FY 2023	
Race	**# Served**	**% of Served (calculated only from demographics collected)**
American Indian or Alaska Native	9	10%
Asian	19	21%
Black or African American	4	4%
Native Hawaiian or Other Pacific Islander	1	1%
White/ Caucasian	46	51%
Other	16	18%
More than one race	6	7%
Prefer not to answer	5	6%
Unknown	0 + all other uncollected	0
Duplicated Total	More than 90, because this is multi-select	More than 100%, because this is multi-select

Please note that this is a problematic data point. It is essentially forcing Latinx folks to choose one of these racial identities (this categorization was originally set up by colonizers to have Latinx folks identify as white), which many do not identity as.

	FY 2023	
Ethnicity	**# Served**	**% of Served (calculated only from demographics collected)**
Hispanic or Latinx:		
Caribbean	2	2%
Central American	4	4%
Mexican/ Mexican-American/ Chicano	29	32%
Puerto Rican	2	2%
South American	2	2%
Hispanic/ Latinx (undefined)		
Other Hispanic/ Latinx	1	1%
Hispanic or Latinx Subtotal	37	41%
THE FOLLOWING IS A BREAKDOWN FOR ALL RESPONDENTS REGARDLESS OF ETHNICITY (this is not only “non-latinx”, otherwise the racial identities of Latinx folks who also identify with these identities are invisible):		
African	4	4%
Asian Indian/ South Asian	1	1%
Cambodian	0	0%
Chinese	7	8%
Eastern European	9	10%
European	31	34%
Filipino	4	4%
Japanese	3	3%
Korean	0	0%
Middle Eastern	2	2%
Vietnamese	4	4%
Non-Hispanic/ Non-Latinx (undefined)	NA	NA
Other Non-Hispanic/ Non-Latinx	5	5%
Non-Hispanic or Non-Latinx Subtotal	50	56%
More than one ethnicity	2	2%
Prefer not to answer	3	3%
Unknown	0 + all other uncollected	0

Duplicated Total	More than 90, because this is multi-select	More than 100%, because this is multi-select

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served (calculated only from demographics collected)**
Male	NA	NA
Female	NA	NA
Prefer not to answer	NA	NA
Unknown	NA	NA
Duplicated Total	NA	NA

The Q Corner and LGBTQ Wellness do not ask this question – "Sex assigned at birth" (SAAB) refers to the categorization of an infant's physical anatomy at birth (typically as "male" or "female"). It should not be part of data collection for demographics purposes. Sex assigned at birth is distinct from gender identity and Gender Identity is the only data point necessary, which is already being asked. Sex assigned at birth data should only be collected by behavioral health services when required for insurance plan information.

Asking for a person's sex assigned at birth is unnecessary and invasive in almost all settings. When we ask clients for both their sex assigned at birth and gender identity, we may be forcing Transgender/Gender non-conforming/Intersex (TGI) clients to out themselves when they do not feel safe to do so. Because this is the population we are aiming to engage, and our priority is to be welcoming, safe, and culturally responsive, we do ask this question.

	FY 2023	
Gender (Current) (Gender Identity)	**# Served**	**% of Served (calculated only from demographics collected)**
Cisgender Man	4	4%
Cisgender Woman	33	37%
Transgender Woman	10	11%
Transgender Man	10	11%
Transgender (Undefined)	NA	NA
Genderqueer	6	7%
Questioning or Unsure	2	2%
Another gender identity	18 (17 nonbinary, 1 genderfluid)	1%

Prefer not to answer	3	3%
Unknown	1 + all other uncollected	1%
Duplicated Total	90	100%

Answer option working on this should read: Cisgender Woman, Cisgender Man, Transgender Woman, Transgender Man, etc. Also, nonbinary should be a gender identity specifically listed, and separate from genderqueer.

	FY 2023	
Sexual Orientation	**# Served**	**% of Served (calculated only from demographics collected)**
Gay or Lesbian	16	18%
Heterosexual/ Straight	22	24%
Bisexual	10	11%
Questioning/ Unsure	3	3%
Queer	20	22%
Another sexual orientation	0	0
Prefer not to answer	1	1%
Unknown	1 + all other uncollected	1%
Duplicated Total	90	100%

The Q Corner asks about variations in physical sex characteristics (sometimes referred to as an Intersex Condition). Not including this is erasing this already very invisible community, as this identity is neither a sex assigned at birth, gender identity, or sexual orientation:

	FY 2023	
Difference in Sex Characteristics	**# Served**	**% of Served (calculated only from demographics collected)**
Yes	11	12%
No	70	78%
Not sure	5	6%

Prefer not to answer	4	4%
Unknown	0	0
Total Served (duplicated)	90	100%

	FY 2023	
Primary Language	**# Served**	**% of Served (calculated only from demographics collected)**
English	79	88%
Spanish	8	9%
Vietnamese	1	1%
Chinese	0	0
Tagalog	0	0
Farsi	0	0
Other	1	1%
Prefer not to answer	1	1%
Unknown	0 + all other uncollected	0
Duplicated Total	90	100%

Other includes:

	FY 2023	
Military Status	**# Served**	**% of Served (calculated only from demographics collected)**
Active Military	0	
Veteran	0	
Served in Military	0	
Family of Military	0	
No Military	89	99%
Prefer not to answer	1	1%
Unknown	0 + all other uncollected	
Duplicated Total	90	

	FY 2023

Disability*	# Served	% of Served (calculated only from demographics collected)
Difficulty seeing	5	6%
Difficulty hearing or speaking	9	10%
Other communication disability	2	2%
Cognitive	9	10%
Physical/ Mobility	4	4%
Chronic Health Condition	10	11%
Other non-communication disability	38	42%
No Disability	29	30%
Prefer not to answer	5	6%
Unknown	0 + all other uncollected	
Duplicated Total	More than 90 because of multi-select	More than 100% because of multi-select

*Participants may choose more than one option for Disability. We are unclear as to why the following are not available options: Mental Health Disability, Learning Disability, Neurodivergence, etc.

Caminar's LGBTQ Wellness Program

Demographics known: 77

Unknown: 3,213

	FY 2023	
Age Group	**# Served**	**% of Served (calculated only from demographics collected)**
0 – 15 years	0	0
16 -25 years	4	5.4%
26- 59 years	71	92%
60+ years	2	2.6%
Prefer not to answer	0	0
Unknown	0 + all other uncollected	0
Duplicated Total	77	100%

	FY 2023

Race	# Served	% of Served (calculated only from demographics collected)
American Indian or Alaska Native	1	1.3%
Asian	11	14.3%
Black or African American	0	0
Native Hawaiian or Other Pacific Islander	0	0
White/ Caucasian	46	59.7%
Other	8	10.4%
More than one race	9	11.7%
Prefer not to answer	2	2.6%
Unknown	+0 all other uncollected	0
Duplicated Total	77	100%

Please note that this is a problematic data point. It is essentially forcing Latinx folks to choose one of these racial identities (this categorization was originally set up by colonizers to have Latinx folks identify as white), which many do not identity as.

	FY 2023	
Ethnicity	**# Served**	**% of Served (calculated only from demographics collected)**
Hispanic or Latinx:		
Caribbean	0	0
Central American	0	0
Mexican/ Mexican-American/ Chicano	7	9.1%
Puerto Rican	0	0
South American	0	0
Hispanic/ Latinx (undefined)	7	9.1%
Other Hispanic/ Latinx	0	0
Hispanic or Latinx Subtotal	14	18.2%
THE FOLLOWING IS A BREAKDOWN FOR ALL RESPONDENTS REGARDLESS OF ETHNICITY (this is not only “non-latinx”, otherwise the racial identities of Latinx folks who also identify with these identities are invisible):		
African	0	0
Asian Indian/ South Asian	2	2.6%
Cambodian	0	0
Chinese	2	2.6%
Eastern European	6	7.8%

European	28	36.4%
Filipino	4	5.2%
Japanese	1	1.3%
Korean	0	0
Middle Eastern	6	7.8%
Vietnamese	1	1.3%
Non-Hispanic/ Non-Latinx (undefined)	0	0
Other Non-Hispanic/ Non-Latinx	1	1.3%
Non-Hispanic or Non-Latinx Subtotal	51	66.2%
More than one ethnicity	6	7.8%
Prefer not to answer	5	6.5%
Unknown	10 + all other uncollected	13%
Duplicated Total	77	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served (calculated only from demographics collected)**
Male	NA	NA
Female	NA	NA
Prefer not to answer	NA	NA
Unknown	NA	NA
Duplicated Total	NA	NA

LGBTQ Wellness does not collect “Gender (Assigned at Birth)” data. Furthermore, Wellness recommends that all programs cease asking clients for this information. Gender is not assigned at birth, it is an internal understanding of one’s self. The correct phrase is “Sex Assigned at Birth,” and there is no reason for behavioral health services to collect demographic information about clients’ sex assigned at birth.

	FY 2023	
Gender (Current) (Gender Identity)	**# Served**	**% of Served (calculated only from demographics collected)**
Cisgender Man	10	13%
Cisgender Woman	39	50.6%
Transgender Woman	3	3.9%
Transgender Man	4	5.2%
Transgender (Undefined)	0	0

Nonbinary/Genderqueer/Genderfluid	17	22.1%
Questioning or Unsure	3	3.9%
Another gender identity	0	0
Prefer not to answer	1	1.3%
Unknown	0 + all other uncollected	0
Duplicated Total	77	100%

*The language suggested for this question is outdated. LGBTQ Wellness gave participants the following options: cisgender woman, cisgender man, transgender woman, transgender man, nonbinary/genderqueer/genderfluid, transgender (undefined), another gender identity, questioning or unsure, and prefer not to answer.

	FY 2023	
Sexual Orientation	**# Served**	**% of Served (calculated only from demographics collected)**
Gay or Lesbian	13	16.9%
Heterosexual/ Straight	36	46.8%
Bisexual or pansexual	12	15.6%
Questioning/ Unsure	1	1.3%
Queer	11	14.3%
Another sexual orientation	2	2.6%
Prefer not to answer	2	2.6%
Unknown	0 + all other uncollected	0
Duplicated Total	77	100%

*To be more inclusive, LGBTQ Wellness added “or pansexual” to the bisexual option.

	FY 2023	
Primary Language	**# Served**	**% of Served (calculated only from demographics collected)**
English	70	90.9%
Spanish	3	3.9%
Vietnamese	0	0
Chinese	0	0
Tagalog	0	0

Farsi	0	0
Other	3	3.9%
Prefer not to answer	1	1.3%
Unknown	0 + all other uncollected	0
Duplicated Total	77	100%

Other includes:

	FY 2023	
Military Status	**# Served**	**% of Served (calculated only from demographics collected)**
Active Military	0	0
Veteran	1	1.3
Served in Military	0	0
Family of Military	6	7.8
No Military	70	90.9
Prefer not to answer	0	0
Unknown	0 + all other uncollected	0
Duplicated Total	77	100%

	FY 2023	
Disability*	**# Served**	**% of Served (calculated only from demographics collected)**
Difficulty seeing	2	2.6%
Difficulty hearing or speaking	1	1.3%
Other communication disability	3	3.9%
Cognitive	7	9.1%
Physical/ Mobility	1	1.3%
Chronic Health Condition	8	10.4%
Other non-communication disability	4	5.2%
No Disability	54	70.1%
Prefer not to answer	4	5.2%
Unknown	0 + all other uncollected	0
Duplicated Total	77	100%

*Participants may choose more than one option for Disability.

7. Referrals

FY 2023				
Duplicated N = 20,028				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
UNK	SMH OP (tx for PTSD, depression, anxiety, autism, eating disorders, etc.), Peer Support Groups, 1:1 Peer Support, crisis services	UNK	The majority of folks surveyed (2/3) reported having mental health struggles for over ten years.	UNK

This data point is not possible to collect. Our role is outreach and engagement, and we do not know if someone gets connected or how long they remain in treatment.

8. Detailed Outcomes

The majority of activities of The Q Corner and Caminar's LGBTQ Wellness program are not evaluated with quantitative outcome measures, but rather through the qualitative feedback that participants provide to the program during and after the activities. We have opted to utilize a variety of outcome indicators and measures for the Trainings, dependent on the exact training. A sampling of the tailored tools, as well as examples of these positive outcomes, are included in the below evaluation summary.

❖ PAU's LGBTQ+ Clinical Academy:

Palo Alto University conducted an IRB approved research study to evaluate the effectiveness of the LGBTQ+ Clinical Academy, with participants completing both the pre and post course measures. They conducted a within-subjects design and used a mix of the following measures to evaluate outcomes: Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT_DOCSS; Bidell, 2017), Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory – Short Form (LGB-CSI-SF; Dillon et al., 2015), a subjective knowledge questionnaire, an objective knowledge questionnaire, Feeling Thermometers (Haddock, Zanna, & Esses, 1993), Implicit Attitudes Test Towards Gender Nonconformity (IAT-GNC; Matsuno, Conover, & Bettergarcia), a 16 item PAU-designed Subjective Clinical Preparedness measurement, an Affirmative Behaviors

checklist, and the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960). Paired-sample t-tests indicated that participants' clinical preparedness, clinical knowledge, and affirmative counseling self-efficacy for both sexual and gender minorities significantly increased from pre-course to post-course. Results showed that all participants significantly increased their knowledge after the program, and these increases remained stable through the follow-up period. For cisgender heterosexual participants, there was an average increase in knowledge of 36% (range = 14% to 5 68%). Similarly, for 2SLGBTQIA+ participants, there was an average increase in knowledge of 15% (range = 14% to 22%). Like the Knowledge domain, results in the Skills domain showed that all participants significantly increased their clinical skills after the program, and these increases remained stable through the follow-up period. In particular, for cisgender heterosexual participants, there was an average increase of 44% (range = 13% to 81%).
A poignant direct quote from the qualitative feedback was: "My increased knowledge and confidence in how to address clients at different stages of their gender journey has allowed me to better support my clients on their journey's and articulate how social forces impact their personal journeys in both positive and negative ways."

The LA LGBT Center also conducts pre and post surveys with participants of the RISE Training and Coaching Intensive course. They consistently show a 12-62% increase in knowledge of SOGIE content.
For the Mental Health First Aid trainings that Caminar's LGBTQ Wellness program offers, they have built-in pre- and post-training knowledge evaluations. All 23 individuals LGBTQ Wellness trained in MHFA in FY23 passed the MHFA final exam.
The other Q Corner trainings offered through the BHSD Learning Partnership ask participants in the pre and post surveys about their level of knowledge of risk and protective factors for 2SLGBTQIA+ individuals, as well as comfort supporting 2SLGBTQIA+ individuals, on a Likert scale of 1-5. Across the board for all trainings, these numbers increase by one or two data points from pre-test to post-test, which shows promise regarding the positive impact of the training, but does not give specific information about what was most impactful, how the learnings will be implemented, etc. The Q Corner has found the open answer questions related to impact to be the most helpful in evaluating the trainings and making improvements. This impact is further discussed below in the evaluation summary.
Qualitative responses illustrating the position impact of some of the trainings offered are as follows:
Understanding Gender, Attraction, and Expression (GAE) Beyond the Binary: A SOGIE 101: Participants report the training being very engaging, and insightful. Many report enjoying the role plays, breakout groups, and having space to ask questions without judgement and shared the following:

- "I really enjoyed how the hosts shared how impactful language is. They were also very welcoming in answering all questions without judgement."
- "The most impactful and effective elements of training was role playing in how to approach a client with asking them for their pronouns etc."
- "I really appreciated the information about language and the different types of language that are and aren't impactful. I also enjoyed the specific information provided about how to ask for another person's pronouns and how to address misgendering."
- "It's the best paced and instructed sccLearn training"

❖ Family Acceptance Project:

A significant number of participants expressed their appreciation for the breakout rooms and group engagement. Some feedback highlighted the value of the videos, guest speaker, and hearing about experiences directly from family members. Several participants mentioned how the speakers were very knowledgeable about resources and they felt very informed. When asked about usefulness, one participant highlighted their own personal

experience supporting an 2SLGBTQIA+ family member and how this training helped them learn more about the impact of family acceptance vs. family rejection. Overall, a significant number of participants expressed how the information and resources provided in the training were incredibly useful for them to apply with their family, friends, students, and practice. Direct quotes include:

- “It was helpful to think and reflect throughout the entire training about how important it is that families actively listen to their children, accept them, and provide support. Also, it’s very important that we have resources available for families who may go through this kind of situation. The videos and live testimony of the families with LGBTQ children were very effective to understand how families play an important role in reducing risk and promoting the young person's wellbeing.”
- “I'm a social work intern at a school district working with elementary and middle school age children and this information will help me be a better ally and advocate to support this population.”
- “I liked the entire training; the videos were meaningful and helpful. The guest speaker was heartfelt and made me hopeful for the future.”
- “I loved the videos that were shown! They really allowed me to practice having empathy for parents who are beginning a journey of supporting their children.”

Anti-Oppression Training Series:
Participants in this training reported the training was “Amazing and very helpful.” It was noted throughout the feedback the instructor was informative and the content was presented in a way that was easy to understand and relevant to their line of work.

- “I found it useful as this is information that can help support conversations about oppression.”
- “It brought awareness that I haven't thought about”
- “I found the topic of language extremely important for example, "blind spot, I see you, I heard you."
- “I appreciate the call to action/change and to slow down and be intentional”

Comprehensive Care for Trans Youth:
Participants found great value in the presenters' lived experiences and their ability to thoroughly answer questions of possible challenges faced by transgender and gender non-conforming youth in school settings. Many participants stated their appreciation for solutions to bring into their own practices. Several participants stated they liked the authenticity of presenters and relevant visual aids. Several participants stated their increased confidence in applying the information learned with their clients. One client found a high usefulness in covering the caregivers'/parents' perspective as well as the client's perspective. The feedback commented on the range of information from health care to mental health care and the knowledge of the presenters as highly impactful to their understanding of the topics. In summary:
- "All information was impactful, especially the process of family and how they can support their child and validate them."
- "I really liked the honesty that each presenter brought. It made the training feel safe to ask or explore any questions without judgment."
Writing the Support Letter:
- “I can’t wait to share this training with my clinician friends so they can learn how to support their clients with this.”
Consensual Non-Monogamy Training:
- “Very useful and needed material in the behavioral health field and beyond”
Affirmative Practice with Sex Workers Training:
- “So many resources to advocate for, educate, and engage with the community!”

NeuroQueer Complexities:
- “The whole training was effective. I particularly enjoyed the support around the different ways to help support a client who is neurodivergent while in a therapy session as well as with their family or schools.”
- “I loved the space that was created in the group: open, inviting, and accepting. I loved hearing the mini case and the approach to the case, as well as things to remember and keep in mind. The breaks were also effective.”
- “I learned new insights and new language (e.g. high support needs etc.) to communicate more respectfully about neurodivergent people.”
- “It was very impactful to meet with other neurodivergent clinicians and to be able to explore the identity traumas we and our clients share.”
- “Learning about how ableism impacts neurodivergent people and trying to think of how to advocate better for neurodivergent people and create more affirming spaces”
- “Thank you for offering this training. I was able to invite my colleagues to it and looking forward to more trainings re: LGBTQ inclusive practices for all health care providers.”

Gender Wheel:
- “Thank you so much for hosting this workshop! I am a school-based occupational therapist working with elementary school students and I'm so excited to incorporate the concepts from this workshop into my interactions with my kiddos.”
- “This was the best professional training I've ever participated in.”

Feedback from trainings that Caminar’s LGBTQ Wellness offered include:

i. “I thought that it was very powerful, and I had a number of students come and talk to me today about how they want to continue that conversation and spread the message that you shared with other students on campus. I also plan on taking a lot of what you shared in my trainings with staff and faculty. So thank you! We greatly appreciate the time, energy, humor, and wisdom that you shared with us.”
ii. “They were really informative and answered all of our questions without judgement and was genuinely passionate about teaching us.”
iii. “It was the best learning session I’ve heard in a long time.”
iv. “This has been an amazing opportunity. So many wonderful concepts and information. I can't tell you how much I appreciate it.”
v. “Educational and accessible.”

In addition to the qualitative feedback on post training surveys, Caminar’s LGBTQ Wellness program makes intentional efforts to build post-training rapport with service providers to gauge improvements to services’ best practices after receiving a training. For example, one mental health services provider updated their in-house electronic health record immediately after the conclusion of the SOGIE 101 training to better align with the training’s best practices model.

The programs also include space on post surveys for participants to provide feedback about the peer support, resources, and events they experience. Caminar’s LGBTQ Wellness survey utilizes open-ended questions: “What did you find helpful when accessing services with LGBTQ Wellness?” and “What could LGBTQ Wellness improve?” Qualitative feedback has proven most effective for the development of LGBTQ Wellness’ services. Survey participants can select if they’ve interacted with the program through trainings, peer support groups, one-to-one peer support/resource connection, and/or outreach events. 54% of respondents took a training with LGBTQ Wellness and 40% attended at least one peer support group meeting. Support group participants’ feedback was mostly positive, and LGBTQ Wellness was able to implement many suggestions for improvement. Several support group participants, for example,

requested more opportunities for community-building activities outside of the peer support setting, and Wellness thus organized a sound healing event and two bowling outings in FY23 and was intentional in connecting participants to other organizations' 2SLGBTQIA+ community outings and events.
The input from the support groups illuminates the great value they have. Support group participant feedback included:

i. "I need someone like you in all the areas of my life. Not joking, life would be a dream if I had this level of support & advocacy in all the areas of my life. I would feel actually feel safe."
ii. "Community, resources to information I never had access to, laughs, confidence boost, free English class with everyone breaking down words/sentences for me. Attention that the peers hold and really make the space feel welcoming and supported."
iii. "Ease of access, empowered but supportive autonomy."
iv. "I benefited from the convos in the All Bodies All Identities and trans groups. I felt less alone and validated in my experiences."
v. "Helped us to understand that we are not alone. We honestly have felt so alone in our struggles. It is so refreshing."

Through surveys and emails, The Q Corner has received qualitative input such as:

i. "The Q Corner is the best place around and has helped me and the community a ton. Thank you to the workers for all they do."
ii. "I enjoy this place and I feel like I can be myself."
iii. "Thank you for being there for the community. I love coming in and seeing the welcoming faces and colorful decor. I'm happy to show my son that there is a place where he can always come and be accepted for who he is."
iv. "I'm so glad I found out y'all are located in my community. Thank you for your service."
v. "I love what you guys do."
vi. "This was my first Q Corner event! I'm a recent grad who went to college in the area and am looking for connection, thank you!"

Specific qualitative feedback on our holigays gifting program, which matches community members who purchase gifts with community members who could use a gift, included comments such as:

i. "Thanks for dropping it off, I really appreciate it. This means a lot to me as I have something to look forward to for Christmas this year."
ii. "Thank you to whoever hand delivered it to my door. Thank you to everyone involved in this project, I am grateful to have received such a meaningful and well-intentioned gift"
iii. "The gifts I received were my favorites this year. Thank you so much for this program. I felt very seen and heard and affirmed on so many levels"

Feedback specifically from schools included:

i. "Thank you for offering this amazing free resource. I am pushing visibility across my school district, and I am excited to partner with you! I am thrilled for the rainbow stickers to add to their staff IDs! This year we had all staff adding mini pins onto their lanyards that have their pronouns as part of gender inclusion"
ii. "A sincere thank you and shout out for all that you do to support our youth and educate the members of Santa Clara County."
iii. "I wanted to thank you so much for your presentation on Saturday! The students were so appreciative of the knowledge and information you provided. Thank you for being so open and kind to students who are learning more about how to support the LGBTQ+ community as they grow professionally. I think your friendly disposition put many at ease to have discussions after your presentation. We had some really great discussion points afterwards and it was great to hear students being open and vulnerable.

You two were so generous in sharing such great information. I have recommended you to friends and colleagues!"

Ryland Shelton who conducts the TrueVoice workshops conducted a feedback survey with participants and found that folks considered the workshop to be extremely helpful when moving towards their vocal goals. They rated the program very high quality and said they would participate again if given the chance. Direct quotes include:

i. "Ryland was very expressive in his support, affirmations, and excitement. He made a vulnerable experience with a stranger possible and fun!"
ii. "It was very helpful to learn where the effective voice is produced, and the exercises were great. Ryland made me feel super comfortable and at ease. It was a great experience overall."
iii. "I feel more confident in my voice and strategies to help become more comfortable. Before I was often scared to talk because my voice sounded so clockable and I wasn't confident in it Also I'm so excited to live in an area where programs like this are available!"
iv. "I think this experience will be life changing for me. 3 weeks of vocal coaching (with dedicated & continued practice) will be less expensive (given that it was free) and more accessible than hormone therapy but will help me reach my gender goals. I'm taking away PERMISSION to use my vocal range and swim in the possibilities. I'm also taking away lessons from Ryland's facilitation gifts -with the right affirmations and tools, so much is possible"

It is not uncommon for entities to leaders in this field to acknowledge and appreciate the work that the LGBTQ Wellness Programs are doing in Santa Clara County. Through Palo Alto University's consultation work with The Q Corner, they were exploring other models throughout the Country to learn from. They asked the APA Division 44 listserv (LGBTQ+ psychology) and asked if anyone knew of other counties or cities were doing anything similar. They mentioned that they were working with a local county but didn't say which one. The first person to email back was someone in Sacramento and said, "Have you heard of The Q corner in Santa Clara County?" Dr. Ryan, the founder of the Family Acceptance Project wrote a letter to the Board of Supervisors in response to her work with The Q Corner, stating: "I have been deeply impressed with the vision, responsiveness and commitment of Santa Clara County BHSD leadership to develop and implement critically needed services for vulnerable populations. I have trained on quality care for LGBTQ children, youth and families in all of the states and in many other countries. The leadership that Santa Clara County's BHSD has demonstrated in building comprehensive services for LGBTQ populations and, in particular, with transgender and gender expansive individuals, is unsurpassed."

9. Evaluation Summary

In FY23, The Q Corner was able to significantly expand our outreach and engagement events, which included services both to 2SLGBTQIA+ community members as well as across provider systems. While we continue to offer some services online for accessibility, many events have returned to be in person, expanding our reach to provide flyers and other resources both about The Q Corner services as well as other community supports. The Q Corner has had regular presence at pride flag raisings throughout the County, pride-related resource fairs, and a multitude of other outreach events – participating in over 140 different outreach, workshop, or community events in total, reaching thousands of community members and providers. The largest celebration this year, as it is every year, is the annual Silicon Valley Pride parade and festival. At Pride, over 750 people were reached, introduced to The Q Corner, and informed about resources offered by the program. Additionally, promotional items were given, including pronoun buttons, rainbow stress brains, among other promotional items, all featuring either The Q Corner's social media handles or phone number, encouraging further connection. Community members were also encouraged to follow The Q Corner on social media, primarily Instagram, to find out more about programing, local resources, and other community activities provided by The Q Corner and program partners. The Q Corner's social media's presence has continued to grow this year, to almost 5000 followers (with

the largest following on Instagram). The Q Corner's mailing list has grown well beyond 2000 contacts, all of whom now get regular updates on training, resource, and event opportunities from The Q Corner, at least once a month.

❖ Peer Support

Peer support services are at the heart of the work of The Q Corner. Having peers who are part of the 2SLGBTQIA+ community is essential to work with this population who has a history of being critically underserved and unsupported by systems of care. Having peers lead community members through the different resources available to them can make things feel less overwhelming and can be especially beneficial with our peers working frequently with the organizations our resources are from. Warm handoffs are also more easily achieved because of these working relationships. Peers also use lived experience to help with the navigation process, whether that be with legal name and gender marker paperwork, finding a 2SLGBTQIA+ affirming clinician, or navigating other shared experiences our peers often have, being part of the community. We have linked folks with local 2SLGBTQIA+ friendly shelters, gender affirming health services, transition related legal support, dozens of peer support group options, support services for family members, and a menu of mental health services. Several community members have reached out wanting support around exploring their gender identity. They are grateful to a peer who has "been there" and can talk with them about both the personal experience as well as the resources available, including navigating legal name and gender marker change. Participants report that peers have been not only to relate to them but have been able to refer them to affirming services and connected them to programs and providers they trust. Of the 378 individual connections reaching out for support, 202 of those individuals were reaching out for themselves (in addition to 166 being providers and 10 being family members). Email remains the most common method of outreach, with 176 of the contacts having started through email, 138 coming through drop in requests, 50 as phone calls, and 14 through social media. Caminar's LGBTQ Wellness team also provided 50 one-to-one peer support sessions.

This year, The Q Corner we continued to offer gender affirming garments to community, which have been instrumental for program growth over the past fiscal year. Binders – used for chest compression, gaffs – used for tucking, and skin tape – used for both – can be essential to the wellbeing of transgender, nonbinary, and gender expansive individuals, and at the average price, can be unobtainable for some community members. Being able to provide these garments for free lifts that burden from program participants shoulders as well as connects individuals to the larger range of services Q Corner can offer. Most of these individuals were reaching out for what would be their first every binder. Clients can be fitted in office and have a safe space to try the garment on, to assure that they get the correct sizing, which is extremely important for compression garments, especially those that are around the chest. This has been an extremely positive and affirming experience for clients. Participants have reported feeling relief as well as affirmed in their gender after receiving these garments. Having a Peer Support Worker navigate this with someone is particularly appreciated. Clients often express gratitude for not only services offered, but the ability to find guidance from folks just like them. In FY23, we supplied the community with 10 packages of trans tape, 19 Gaffs, and 45 Binders, all in alignment with our goal of decreasing rates of gender dysphoria and increasing gender euphoria.

❖ Peer Support Groups

Caminar's LGBTQ Wellness Program and The Q Corner collaborate in offering 5 different bi-weekly or monthly 18+ support groups. These include:

i. **Trans / Nonbinary / Gender Expansive peer support groups in English**: This group is led by trans, nonbinary, and gender expansive peers, creating a safe space for trans folks to speak about their experiences, ask for advice, and just create a sense of community. Participants continue to return to the

group every other week, enjoying having a space to be themselves, especially for those that are not out as trans yet. Having this kind of safe space in order to connect with peers has been very important for participants. Group participants have also referred friends to join, growing group numbers. The Trans Group (English) is consistently and highly attended, highlighting the need for community connection and safe and supportive resources for the transgender, nonbinary, and gender expansive community. The Spanish group is on temporary pause due to a staffing gap at Gender Health Center but will hopefully be back up and running soon.

ii. **All Identities, All Bodies:** This is a group that was started by LGBTQ Wellness and now supported by The Q Corner as well. It is a peer support group for individuals of all bodies and identities, and specifically a safe space for all 2SLGBTQIA+ community members to connect with others and find support within community. This group is held every third Wednesdays of the month.

iii. **Latinx Diversa:** The Q Corner and Caminar's LGBTQ Wellness partner with Gardner's Ethnic Wellness Center to offer an all-Spanish all identities group called Latinx Diversa that meets in person twice a month and has grown in attendance.

iv. **Queer and Disabled:** New this year, this is a peer group where folks that intersect with queer and disabled identities can meet and support each other. The group meets once a month and has been well attended by those with those intersecting identities. Participants have reported that this group has been helpful for them to "feel seen" in two areas of their lives that often don't have spaces to equally be explored.

v. **Queer and Asian:** This is the newest peer support group, which is also in collaboration with the Vietnamese American Services Center (VASC). It is where individuals who intersect with queer and Asian identities can meet in person at the VASC to connect and find support and to socialize with others alike. The group meets twice a month. Participants have expressed appreciation for having a safe space for topics and discussions and building community for folks who are queer and Asian.

vi. **Queer Book Club and Proud Parents** are groups that LGBTQ Wellness also offered a handful of sessions for.

Across all these peer support groups, there have been 400 participants in FY23.

In addition to these groups, we also offer community building events which are fun and meaningful opportunities for community members to come together to learn or connect with one another in fulfilling ways. Caminar's LGBTQ Wellness team hosted three different community events (sound healing and bowling!). The Q Corner offered two pizza parties (n=200), a weekly DND (Dungeons and Dragons) group (n=52) and some of the following:

i. **Oasis Legal Services:** Through a partnership with Oasis Legal Services, The Q Corner offers in person bi-weekly screening appointments. This collaboration helps clients in Santa Clara County be able to connect with an immigration attorney online at The Q Corner. Oasis is based in Berkley and for folks that may be a roadblock on accessing their services, so we bridge that gap by having their online appointment in our space. We offer decompression time after their appointment in our space because the appointments can be very emotional as they have to talk about the specifics on their case to see if they have a chance of getting status by asylum. We offer peer support and offer support groups to clients after their appointment. We help every other Mondays and have up to 3 clients during those days, helping a total of 49 individuals in FY23.

ii. **TrueVoice:** A program that focuses on helping Transgender, nonbinary and gender expansive individuals find their voice through singing. The program is run by Ryland Shelton a vocal coach based in the LA area. Through Zoom we were able to provide this training at home which gives participants a safe space to find their voice. Participants shared that this workshop, as well as the individual lessons offered afterward, were extremely helpful when find their voices, but were also comfortable and uplifting experiences thanks to Ryland. This year, we have been able to offer the TrueVoice workshop in person

(n=17), with the individual sessions being an in person and online hybrid model. This has been beneficial to community as it gave them more interaction with people like them, and a closer working relationship with trainer Ryland.

iii. **Gay Hiking:** The Q Corner staff collaborated with Santa Clara County Parks Department to organize and lead a series of 2SLGBTQIA+ hikes for the community. Participants were able to increase their awareness and learn specific gender expression within the natural world along with learning the concepts of duality, anthropocentrism, reciprocity, accountability and belonging. Participants have expressed feelings of appreciation and happiness for being able to be in a safe space and in nature with community (n=47).

iv. **Holiday Gatherings:** Holiday gatherings were held to bring community members and allies together in support of learning more about Q Corner services and collaborating programs such as LGBTQ Wellness, Transvision, Next Door Solutions to Domestic Violence, allcove, and The Office of LGBTQ+ Affairs. We held a Halloween and a Valentine's Day party, and around 50 participants came to each, and were able to dress for the festivities, socialize and enjoy light snacks and refreshments.

❖ Collaboration with Schools:

Towards the end of FY23, we began strategic planning to bridge a connection with staff, educators, administrators at schools to provide information regarding our services and trainings offered. The goal is to support youth, educators, and administrators in school settings so that they're able to have the tools to create a safe, affirming, and inclusive space for 2SLGBTQIA+ youth. We are expanding our collaboration with Dr. Ryan through the Family Acceptance Project to include creating a psychoeducation group for parents and caregivers of 2SLGBTQIA+ youth. The goal of this group is to create a safe and welcoming space for parents and caregivers to learn more about topics like SOGIE (sexual orientation, gender identity and expression), how to support your 2SLGBTQIA+ child, navigating family dynamics, the impact of accepting and rejecting behaviors, how to navigate the role of culture and beliefs, and the value of social support.

❖ The Harm ReduQion Project

This is a team of two individuals who are not funded by MHSA but who work as part of The Q Corner team. This Project was launched in April 2023 to bring affirming, trauma-informed support for 2SLGBTQIA+ folks who use substances. This project is committed to providing low barrier access to affirming substance use services and support with navigating the SUTS and MH systems. In addition to providing access to Naloxone and other overdose/poisoning tools for providers and consumers.

The HRQP has been integral in partnering with The Q Corner and Caminar LGBTQ Wellness staff by training all staff members on how to properly administer Naloxone, how to identify signs of overdose/poisonings, and about Harm Reduction strategies to engage with participants. They also join at community events to distribute Naloxone and other prevention tools. The HRQP has helped increase knowledge and awareness of The Q Corner staff on accessing SUTS and working with folks engaging in substance use and the ambivalence with accessing traditional treatment services in SCC.

❖ Q Corner Chats:

We continued our course of Q Corner Chats, which are digital short format presentations/panels from different organizations. While the County of Santa Clara has many community resources for 2SLGBTQIA+ folks, one of the challenges is getting the word out to the community, as many folks aren't aware that specialty programming exists. Q Corner Chats were envisioned to address that gap, and provide a short presentation, followed by question and answer, for community members and providers to get a sense of the work that these organizations do. In FY23 we had 2 Q Corner Chats. One focused on Name and Gender Marker Change with Silicon Valley

Law Foundation, where lawyers explained the processes and paperwork needed and tips for how to navigate a tricky and tedious to manage (n=42). The other was with Oasis Legal Services and reviewed Asylum and Naturalization (n= 27)

- **Presentations and Tours:**

The Q Corner continued to utilize our networks with different agencies and collaborative standing system meetings to provide overviews about our services, with the hope of attracting new training participants and folks interested in peer support or resource navigation. Presentations and tours have reached thousands of people, all to help more people access and link to The Q Corner services and opportunities for support.

- **Resource Dissemination:**

The Q Corner has worked to have organized, streamlined and accurate listings of local, national and international agencies serve the 2SLGBTQIA+ community and completely overhauled the BHSD LGBTQ Resources website. The website overhaul helps visitors efficiently and easily find relevant resources based on their individual needs, as well as events, trainings, best practices, and contact information. The Q Corner has numerous resources available digitally, we also have an online order form where providers can request physical copies of resources that they can pick up or have mailed to them. Providers are so appreciative, sharing that this helps them create affirming and safe spaces for their clients as well as have access to relevant resources. We always accompany the resource pick-ups with a bag of Q Corner promotional items such as rainbow stress balls (in the shape of brains), hand sanitizers, Q Corner masks, etc. All together we had over 58 participants pick up resources through our order form in FY23. Participants had very positive responses about the available resources, noting fondness for the program flyers and posters, as well as the ID Card resources (badge attachments, stickers, pronoun pins).

- **Trans Care Coalition**

The Trans Care Coalition (TCC) continued through FY23. The TCC is a collaboration of gender affirming care champions throughout the behavioral health service delivery system, with representatives from over a dozen different agencies. The TCC's vision includes the four following focus areas: equitable access for all folks at all levels of care, knowledgeable gender-affirming care, champions continuing the work collaboratively, and pooling knowledge and experience. This includes identifying the specific needs and changes needed and implementing best practices across organizations. The TCC includes 5 workgroups: Welcoming environments, Collecting SOGIE Data, Referrals and Placement, Clinical Services, and Care in Institutions. These workgroups are comprised coalition members from the County and County-contracted behavioral health agencies who are dedicated to supporting employees and better services for transgender, nonbinary, gender expansive clients and others. Through TCC, many resources have been created and distributed, such as a Pronouns Booklet, Creating Welcoming Environments brochure, SOGI Data Collection guidelines, a Collecting SOGI Data without Sex Assigned at Birth document, a Children and SOGIE booklet, and Best Practices for Gender Affirming Care in behavioral health settings.

- **Subject Matter Expertise:**

The Q Corner and LGBTQ Wellness staff continue to be utilized for Subject Matter Expertise, Consultation, and Representation in various workgroups as well as be involved in important quality improvement and infrastructure development work in BHSD and the County. We have been the lead on developing and eventually launching BHSD department wide SOGIE data collection, as well as supporting these efforts across the system. We established, through workgroups with other subject matter efforts the SOGIE data question and answer sets for

the new BHSD EMR (myAvatar), have drafted best practices and protocols for the roll out, and will be leading the trainings for implementation. We also helped ensure that SOGIE 101 training and SOGIE Data Collection was added to all BHSD service contracts.
Other important work has included our collaboration in finalizing and rolling out the policies and procedures for serving transgender, nonbinary, and gender expansive clients in behavioral health settings. We hope to duplicate these efforts in other systems of care to embed these standards across many service systems. This aligns as well with our collaborative work with the Department of Family and Children Services workgroups – one focused on supporting 2SLGBTQIA+ youth in the child welfare system and another working on improving services for trans youth in psychiatric hospitals.

The Q Corner team also have staff who participate in the following workgroups and committees: the BHSD Race Equity workgroup, the BHSD Cultural Celebrations Committee, the BHSD Race Equity Workgroup, the Office of Supportive Housing Coordinated Assessment Workgroup, the Office of LGBTQ Affairs annual LGBTQ Summit planning group, and the County Older Adults Study steering committee. The team also participates in conferences when able to, to continue growing knowledge within team.

We continue to see a gap in us reaching people in the age range of 60+ and with more robust staffing in the future, hope to collaborate with senior-serving programs such as Avenidas, to do focused outreach and targeted activities for this demographic in the future. With our new team of bilingual (Spanish/English) staff, we have been able to support Spanish speaking community members much better. However, we continue to see gaps in connecting with folks in languages beyond English and Spanish and hope to bring on team members in the future who speak additional languages.
The biggest challenge for Caminar's LGBTQ Wellness in FY23 was staffing, as the Peer Support Coordinator position was open from August 2022-May 2023. LGBTQ Wellness is a two-person team when fully staffed, so operating at half-capacity significantly impacted Wellness' services. However, Wellness was finally able to find a fantastic new Peer Support Coordinator at the end of May 2023, increasing the program's capacity just in time for the June (Pride Month) busy season.

- **Trainings and Technical Assistance:**

The Q Corner and LGBTQ Wellness continue to offer an extensive range of trainings to increase knowledge and skills on service 2SLGBTQIA+ individuals. The trainings have received overwhelming positive response from local, as well as state and national groups, applauding the expansive and diverse menu of trainings and capacity building efforts that we have built out. Participants enjoy that all our trainings are informative, enlightening and interactive, with genuine and knowledgeable instructors who use appropriate self-disclosure to illustrate the content. We have gotten many comments, across all the trainings, that it was the best training they have had in BHSD or related to the topic (SOGIE, peer support, etc.). We successfully administered over 20 different types of training opportunities, with a total of over 70 trainings, over the course of almost 120 days and 500 hours, to a total of 1633 training participants. The details for each category of training are outlined below:
RISE Training and Coaching Intensive: Creating an extensive network of individuals throughout Santa Clara County who would become trainers to teach foundation SOGIE 101 content throughout the systems and agencies that they work within, was a huge priority for helping to establish baseline competency and awareness of SOGIE related topics and providing adequate service delivery to the 2SLGBTQIA+ community. The RISE Training and Coaching Intensive is a comprehensive 40-hour workshop where participants are trained to facilitate the 6-hour SOGIE 101 curriculum on their own. This training provides participants with in-depth training materials along with opportunities to practice facilitation. Additionally, participants are provided with a physical binder full of resources, materials and best practices for facilitating these trainings which they can reference as they begin

to provide these trainings to their respective agencies. We offered 3 RISE TCI cohorts in FY23, with a total of 33 participants in FY23.

Understanding Gender, Attraction, and Expression Beyond the Binary, a SOGIE 101 Training: The Q Corner team has continued to offer regular SOGIE (Sexual Orientation and Gender Identity and Expression) 101 course at least monthly, as well as customized to various organizations, school districts, etc. The team had been using the RISE is a curriculum from the LA LGBTQ Center for over a year and a half, making important strides toward equity in health care systems for 2SLGBTQIA+ people. In FY22, The Q Corner worked with other 2SLGBTQIA+ service providers to create a new SOGIE 101 training that better integrated intersectionality, breaking down binary thinking, barriers within the behavioral health system, and SOGI data collection. In FY23, the training team expanded and worked on updating the training content based on best practices and participant feedback. This training is called Understanding Gender, Attraction, and Expression (GAE) Beyond the Binary: a SOGIE 101. The Q Corner also offers modifies versions of these trainings in 2-hour sections (instead of the full 6 hours course as designed). In total, the team trained n=450 people in the full 6-hour Understanding Gender, Attraction, and Expression Beyond the Binary: SOGIE 101 course and 163 in the brief course. The Q Corner worked especially close with the local "LGBTQ+ friendly" shelter, in order to help the program become more affirming and welcoming. In addition, Caminar's LGBTQ Wellness Program offered another 11 brief SOGIE 101 trainings to other entities such as social workers, college students, therapists and behavioral health services providers, Public Health Department staff, church staff and parishioners, housing services providers, and recovery services providers. Participants of the trainings regularly remark how beneficial this training has been for their work.

The Family Acceptance Project Trainings are grounded in evidence-based research from Dr. Caitlin Ryan around accepting behaviors that help the health and wellbeing of 2SLGBTQIA+ youth vs. rejecting behaviors that harm 2SLGBTQIA+ youth. They fill a critical existing gap in training offerings related to supporting families and providers who work with 2SLGBTQIA+ youth. These trainings allow providers and all participants to hear from the lived experience of families with 2SLGBTQIA+ youth who went from not being accepting or not understanding their 2SLGBTQIA+ youth to becoming supportive and even protective when extended family was not treating them appropriately. This has included an intentional emphasis on the experience of Transgender youth. in FY23, Dr. Ryan delivered 4 full length Family Acceptance Project trainings (with n=107 participants, as well as 2 advance FAP courses, one on trauma-focused CBT integrated with FAP and a trauma informed care mental health treatment focused course (n=55).

Dr. Ryan has been able to equip participants with research, real life anecdotes and tools in the form of pamphlets and booklets that can be referenced and used when working with families of 2SLGBTQIA+ youth. The Q Corner continues to distribute the Family Acceptance Project posters with accepting and rejecting behaviors, in 3 sizes and in 10+ languages, to anyone interested in Santa Clara County.

Step In, Speak Up!: The Q Corner also continued to offer training licenses for the Kognito "Step In, Speak Up! To professionals in education settings, for supporting 2SLGBTQIA+ youth on campuses, in collaboration with the Office of LGBTQ Affairs. In FY23, 15 people participated in the training.

The LGBTQ Clinical Academy offered by Palo Alto University was created to fill a significant gap in clinical training opportunities for master's level clinician providing clinical support services to 2SLGBTQIA+ clients within the Behavioral Health Services system of care. Clients often report that they cannot find a clinician who is knowledgeable in working with 2SLGBTQIA+ folks, and clinicians often share that they do not feel like they have the skills or knowledge to serve 2SLGBTQIA+ clients. This course consisted of 30 hours of didactic training paired with 10 hours of clinical consultation, over the course of four months. The course covers basic theory and research, identity development, affirmative orientation, ethical considerations, intake, risk management, diagnosis, therapy process, advocacy, and in-depth study on specific populations within the 2SLGBTQIA+ community including trans and non-binary persons, 2SLGBTQIA+ youth and elders, and other special populations. 30 master's level clinicians participated in the third annual academy this fiscal year.

Queer Intentional Peer Support: The 2SLGBTQIA+ focused Intentional Peer Support course ("Intentional Queer Support, or Queer Intentional Peer Support: QIPS) (n=12) was a collaborative design effort between The Q Corner and Intentional Peer Support. Participants reported gaining a significant sense of community and opportunities for connection with the group, as well as developing many peer support skills through the course. There are now monthly co-reflection groups that 18 people participated in, where participants can support one another in the implementation of Intentional Peer Support principals. Two of The Q Corner team members also completed the Advanced IPS course, and one team member completed the IPS Train the Trainer course and will be able to offer QIPS internally.

The Gender Wheel Trainings includes fundamental shift in how we think about gender, which is critical for us to move forward into a new world that supports, celebrates, and values everyone. Trainer Maya Gonzalez uses the Gender Wheel to "tell a story about bodies and gender for everybody." For example, in nature there are animals who live outside of the binary. This training shows that living outside of the binary also extends to people as well. It additionally explains how parents, teachers, providers and more can discuss this information with children in an age appropriate and help children with their own self-discovery. We offered both parts of the workshop (reorientation and implementation) twice, with a total of 91 training participants (duplicated number). Community members and providers alike have said this has been an insightful training for themselves and will be for the younger kiddos they care for/interact with.

Comprehensive Care for Trans Youth: Because of the significant disparities in access to and quality of care for transgender, nonbinary, and gender expansive individuals, we host trainings on comprehensive care for trans and gender non-conforming youth with TransYouth Care. They hosted their 20-hour symposium in FY23 (n=62) as well as four separate specialized half day trainings with a total of 147 participants. TransYouth Care also provided four different unique Gender Google sessions, one of each targeted to the respective audiences of Providers, Educators, and Family Members (n=75 participants). These googles provided a safe space away from loved ones, clients, and students to ask questions about gender that they might not normally be able to ask. These events were popular among participants, who felt comfortable in the space provided to ask questions in a space without judgement.

Writing the Support Letter: Transgender and gender diverse clients seeking medical intervention must often get a Letter of Support from a Behavioral Health provider. This requirement inadvertently places behavioral health providers in the role of gate keepers to gender affirming care. Very little training exists on how to write Letters of Support and our providers often say that they do not feel equipped to write these letters. We prioritized offering two online Letter Writing trainings to provide access to education for our providers, as well as increase access to providers who can write Letters of Support for TGD clients within the County of Santa Clara. (n=21).

Neuroqueer Complexities: This training provides an overview of the neuroqueer experience, specifically for clients at the intersection of gender and sexual minorities and neurominorities, like autism. Providers (n=36) gained fundamental skills in approaching clinical work from an anti-ableist, liberatory framework to support clients in a myriad of environments, including schools, work, family and relationship systems

An Affirmative Approach to Supporting BIPOC LGBTQIA+ Individuals with ADHD: A new pilot training offered this year by Dr. Elizabeth Aranda, provided 27 attendees with a deeper understanding of the barriers to accessing ADHD treatment and support for 2SLGBTQIA+ BIPOC communities along with offering specific strategies to support well-being and resilience through strengths-based practices.

Consensual Non-Monogamous Affirming Mental Health Practice: In the first offering of this new training offered by Theo Burnes (author of "The Handbook of Consensual Non-Monogamy: Affirming Mental Health Practice"), 39 participants gained knowledge on various relationship structures as well as language that can be used in working with consensual non-monogamous clients in clinical settings.

Sex Worker-Affirming Mental Health Practice: Theo Burnes, author of "Essential Clinical Care for Sex Workers: A Sex-Positive Handbook for Mental Health Practitioners," provided a half day training for 31participants who were equipped with the knowledge of legal structures surrounding sex work and language to use when supporting clients of all genders and sexual orientations who engage in sex work.

Gender Affirmative Clinical Consultation: This consultation group is offered to medical and behavioral health providers across Santa Clara County's systems of care that provide services to gender diverse individuals of all ages. This drop-in consultation group is held for 1.5 hours once every month and includes reviewing clinical cases with the application of a gender affirmative lens, discussing how to support families/caregivers of gender diverse individuals, understanding behavioral health staff's role in gender affirmation including writing letters of support for medical affirmation, and learning about resources. This consultation group increases accessibility to affirming care for gender diverse individuals within the county by spreading knowledge, guidance, and support to providers. This also assists in dismantling cisnormativity and anti-trans practices within the systems of care by shining light on gaps in services. So far 15 people have participated, and the numbers continue to grow each month.

Vietnamese LGBTQ Cultural Consultation: As a consultant with many years of experience as a licensed therapist and gender specialist consultant, Lotus Do developed an online Vietnamese LGBTQIA+ Glossary and Resource guide. The glossary portion of this document includes gender identity, sexual orientation, and expression terms and definitions in both English and Vietnamese complete with pronunciation guides for the Vietnamese terms, including pronouns. Beyond the glossary, the shared public document also includes a table of local and global organizations that serve the Vietnamese LGBTQIA+ community. Lotus also provided an online pilot training for The Q Corner and other 2SLGBTQIA+ service providers on how to best support the LGBTQIA+ community, with plans to offer this training in person at VASC later in the summer. Resource documents and social media posts were also able to be provided in Vietnamese as part of Lotus' work.

Creating and Sustaining an Anti-Oppressive Community: Continued this year, to present the basic framework of oppression and critically examined our individual socialization as players in a larger system meant to disconnect and isolate us. Participants learned fundamentals of social justice and began to explore how we have collectively and individually been taught to be agents/oppressors and targets/the oppressed in a larger system of oppression. Attendees also considered actions that we can take on personal, cultural, and institutional levels to create a more equitable organizations, institutions, and communities. Including overall "creating and sustaining an anti-oppressive community" trainings as well as new pilot sessions on more specific topic areas such as Understanding Anti-Blackness and Anti-Indigeneity, Understanding Anti-Asianness and Anti-Latineness, and the relationship between Sizeism, Ageism, Ableism, and Racism. Over a total of 5 sessions there were 102 participants all together.

Mental Health First Aid: Caminar's LGBTQ Wellness team conducted 3 of these trainings to a wide variety of audiences were educated in FY23, including social workers, college students, therapists and behavioral health services providers, Public Health Department staff, church staff and parishioners, housing services providers, and recovery services providers.

The BHSD PEI 2SLGBTQIA+ Wellness Programs are proud of what they accomplished in FY23 and look forward to making an even larger impact on the Santa Clara County community in FY24.

Behavioral Health (BH) Navigator

PEI Access & Linkage to Treatment Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

The peer run BH Navigator program helps connect individuals and families to County and community resources, and guide them through the behavioral health system, ensuring that all community members have access to accurate and relevant information, linkage to services, and partnership navigating various support opportunities. Peer Navigators will offer personalized assistance to get help for behavioral health need, peer guidance about options for wellness services and support, knowledgeable information and resources for mental health, substance use, suicide prevention, support groups, and more, connection to County and community-based resources, and support from Peers with an understanding of local services.
BH Navigators can be accessed through the phone via the centralized access number (1-800-704-0900 [option 4]). This information line where SCC residents, including underserved populations, can talk with a live agent and gain information on how to obtain a referral to MH services, how to contact their providers, and support navigating the system. Peer Navigators handle daily calls for resources and a Clinician provides direct, dedicated support to Peer Staff when clinically complex or urgent cases present. Support is also available by email via the shared address (bhnavigator@hhs.sccgov.org). Peer Navigators are also available during business hours at other BHSD peer support programs, including Zephyr Self-Help Center, Esperanza Self-Help Center, Downtown Youth Wellness Center, and Behavioral Health Urgent Care.

In June of 2023, BH Navigator began offering in-person services at multiple locations. In-person services from the BH Navigator team, also known as “drop-in,” services, are available during scheduled days and times at five community locations (i.e., Los Gatos Public Library, West Valley Community Services- Cupertino, Community Services Agency – Mountain View, Sunnyvale Community Services, and Peninsula Healthcare Connection at the Palo Alto Superior Courthouse).

2. Program Indicators

i. Suicide: Link callers directly to 988 Suicide and Crisis Prevention Lifeline via a warm hand-off to a live agent at time of call.
ii. Incarcerations: We work with folks involved in the justice system by encouraging and assisting them with obtaining behavioral health services in hopes of decreasing incarcerations or recidivism.
iii. School failure or dropout: Provide support to parents with obtaining behavioral health services and assistance with navigation services of available local resources to increase Access to Healthcare.
iv. Unemployment: Assist callers that are seeking such services with available local resources (i.e., Goodwill NOW program and Salvation Army).
v. Homelessness: Providing in-person support services to the unhoused individuals that need behavioral health services and/or healthcare and don’t have access to the technology needed to complete

screenings and complete applications, as well as linkage to housing services and the unsheltered placement call center “Here 4 U”.

3. Program Goals, Objectives & Outcomes

The BH Navigator Program launched in July 2022 to connect individuals and families to County, County-contracted, and community-based services, and when appropriate, even identifies private resources and helps guide the public through the mental health system. The goal is to connect residents with the resources that best fit their needs.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
7,750	**$ 442,394.38**	**$ 57.08**

5. Evaluation Activities

The BH Navigator Program uses community and practice-based evidence standard. On February 1, 2023, the BH Navigator Program launched a six-question customer input survey through a Qualtrics interactive voice response (IVR) creation. Callers were offered to take part in the survey after they finish their interaction with the BH Navigators. The survey consisted of five Likert scale questions and one open-answer question in any of the six County threshold languages. From February 1 through July 31, a total of 462 surveys were completed over the phone, representing 11.2% of callers (high survey return rate, according to the vendor). The following data presented on **Table 1** of the survey illustrates the satisfaction and effectiveness of surveyed participants of the BH Navigator Program.

Question	**Satisfaction Rating (T2B scores)**
How likely are you to call us again?	92%
How successful were you in getting the information you needed?	96%
The degree to which you were clear on the next steps	94%
How was your experience with the agent?	98%
How much confidence did the agent instill in your decision?	98%

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	79	11.6%
16 -25 years	93	13.7%

26- 59 years	409	60.2%
60+ years	71	10.5%
Prefer not to answer		
Unknown	27	4.0%
Unduplicated Total (due to the nature of this being an outreach program, we don't collect specific data that would help with tracking this specific data).	679	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	5	0.7%
Asian	52	7.7%
Black or African American	30	4.4%
Native Hawaiian or Other Pacific Islander	0	0
White/ Caucasian	159	23.4%
Other	273	40.2%
More than one race	0	0
Prefer not to answer	3	0.4%
Unknown	157	23.1%
Unduplicated Total	**679**	

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	2	.7%

Central American	113	40.8%
Mexican/ Mexican-American/ Chicano	0	
Puerto Rican	0	
South American	0	
Hispanic/ Latino (undefined)	11	4.0%
Other Hispanic/ Latino	151	54.5%
Hispanic or Latino Subtotal	**277**	100%
Non-Hispanic or Non-Latino as follows:		
African	30	10.0%
Asian Indian/ South Asian	10	3.0%
Cambodian	1	0%
Chinese	11	4.0%
Eastern European	0	
European	1	0%
Filipino	5	2.0%
Japanese	1	0%
Korean	1	0%
Middle Eastern	2	1.0%
Vietnamese	16	5.0%
Non-Hispanic/ Non-Latino (undefined)	0	
Other Non-Hispanic/ Non-Latino	224	74.0%
Non-Hispanic or Non-Latino Subtotal	**303**	100%
More than one ethnicity	0	

Prefer not to answer	8	
Unknown	327	
Duplicated Total	704	

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	332	48.8%
Female	344	50.9%
Prefer not to answer	0	
Unknown	3	.03%
Unduplicated Total	**679**	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	303	44.6
Female	326	48.0
Transgender (Male to Female)	1	.02
Transgender (Female to Male)	0	
Transgender (Undefined)	0	
Genderqueer	0	
Questioning or Unsure	0	
Another gender identity	0	
Prefer not to answer	0	
Unknown	49	72.1
Unduplicated Total	**679**	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**

Gay or Lesbian	4	0.6$
Heterosexual/ Straight	151	22.2%
Bisexual	4	0.6%
Questioning/ Unsure	0	
Queer	0	
Another sexual orientation	4	0.6%
Prefer not to answer	77	11.3%
Unknown	439	64.7%
Unduplicated Total	**679**	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	486	71.6%
Spanish	87	12.8%
Vietnamese	6	0.9%
Chinese	5	0.7%
Tagalog	0	
Farsi	1	0.01%
Other	7	1.0%
Prefer not to answer	0	
Unknown	87	12.8%
Unduplicated Total	**679**	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	0	
Veteran	1	0.1%
Served in Military	0	
Family of Military	0	

No Military	86	12.7%
Prefer not to answer	0	
Unknown	592	87.2%
Unduplicated Total	**679**	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	0	
Difficulty hearing or speaking	1	0.1%
Other communication disability	6	0.9%
Cognitive	0	
Physical/ Mobility	1	0.1%
Chronic Health Condition	0	
Other non-communication disability	164	24.2%
No Disability	68	10.0%
Prefer not to answer	0	
Unknown	439	64.7%
Unduplicated Total	**679**	100%

*Participants may choose more than one option for Disability.

7. Referrals

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment. (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment.** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation.** (for referrals to treatment that are provided by or overseen by county mental health)

Referred to BHCC (2,470) and private insurance (274) = 2,744	SMH = 3,307 SUTS= 791	N/A	N/A	N/A

8. Detailed Outcomes

The BH Navigator Program used Qualtrics IVR to obtain Customer Satisfaction starting in February 2023 through present. Highlights from the final open-answer question, which asks callers how they feel about the call, include people sharing that they were “able to locate resources,” it was “helpful to understand what options exist,” and that the agents were “clear and concise” and “patient, helpful, and supportive.” Dozens of answers expressed appreciation for the help provided for getting the information and clarification they were looking for, and callers shared feeling “prepared,” “relieved,” “a huge relief,” and “really grateful.”

9. Evaluation Summary

The BH Navigator Program functions as a call center; however, we have been working on implementing in-person peer support services throughout Santa Clara County. Since June 2023, we’ve successfully partnered with other community service providers to include in person community-based support services at the Los Gatos Public Library, West Valley Community Services - Cupertino, Community Services Agency – Mountain View, Sunnyvale Community Services, and Peninsula Healthcare Connection at the Palo Alto Superior Courthouse. In addition to these locations, we have started providing in-person services at the Milpitas Library the first week of September. This service modality offers increased access to services for individuals who are better supported in in-person and in their community, rather than by phone or email, including individuals who are unhoused in the locations served. Peer Navigators are at each of the new partnership sites once a week for half a day. The BH Navigator Program website (www.bhnavigator.org) has up-to-date information about the services provided and locations of where community members can connect with peers for in-person services. Challenges: We’ve been challenged with finding partners in the South County region due to limited confidential spacing; however, we are in the planning phase with the Morgan Hill Unified School District, and it is looking promising. In addition, we are also having difficulty connecting with community-based providers in the East San Jose area.

Outreach efforts are also being carried out through the Kaiser Foundation Hospital Fund for Community Benefit Programs Grant that was received in March 2023 and will allow the program to provide community outreach throughout Santa Clara County through the end of March 2024. BHSD has outreached to 1,024 community members and 47 providers throughout Santa Clara County, specifically in North County, South County, and Central County. Staff are able to distribute program flyers that have been updated to include new in-person services locations, dates, and times. BHSD uses promotional giveaways as a method of encouragement for community members to visit the outreach table and obtain information about the program. We’ve faced some challenges in this area due to scheduling conflicts and finding events taking place at the specific locations outlined in our grant.

Lastly, BHSD is in the process of creating three video advertisements to enhance outreach efforts. The videos will be available in English, Spanish, and Vietnamese and will provide information about services, as well as provide community members with what they can expect when they contact the peer-run BH Navigator Program. We have also learned that our Community Benefit Programs Grant through Kaiser Foundation Hospital Fund will be extended for another year, which will start April 1, 2024, through March 31, 2025. This will allow for continued outreach efforts.

SUICIDE PREVENTION PROGRAM

Suicide Prevention

The Suicide Prevention Program in Santa Clara County covers 2 different programs.

1. Suicide Prevention Plan
2. 988- Crisis and suicide prevention lifeline

The total cost per person, across all programs in this category can be found below. The following pages are detailed reports for each individual program in this category.

FY 2023		
Number Served	Program Expenditure	Cost per Person
1,248,043	**$ 3,245,396.36**	**$ 2.60**

Suicide Prevention Strategic Plan

PEI Suicide Prevention Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Description: The Suicide Prevention Strategic Plan (SPSP) aims to increase suicide prevention for everyone. Through early intervention, education, and awareness, this plan seeks to reduce risk of suicide among all age groups in the County. The plan consists of six distinct but related strategies:

i. Implementation and coordination of suicide intervention programs and services for targeted high-risk populations
ii. Implementation of a community education and information campaign to increase public awareness of suicide and suicide prevention.
iii. Development of local communication "best practices" to improve media coverage and public dialogue related to suicide.
iv. Implementation of policy and governance advocacy to promote systems change in suicide awareness and prevention.
v. Establishment of a robust data collection and monitoring system to increase the scope and availability of suicide-related data and evaluation of suicide prevention efforts.
vi. Integrate culture and diversity throughout all programming, to serve the needs of culturally diverse communities.

This plan aims to provide comprehensive suicide prevention and awareness activities countywide. The SPSP's six strategies have multiple recommendations, all of which will be implemented over time with input from the Suicide Prevention Oversight Committee (SPOC) and its work groups. In FY22 the sixth strategy was added to the SPSP, ensuring all suicide prevention activities within the County are culturally informed and responsive.

Status: Continuing

Stakeholder priorities and target populations addressed:

i. Children ages 5-15 *the program does not serve children 0-5
ii. Transitional-aged youth
iii. Adults and older adults ages 26-59, 60+
iv. Various racial/ethnic populations, primarily Latine, Asian, Pacific Islander, white/Caucasian

Service category: PEI – Suicide Prevention

2. Program Indicators

Established in 2010, the Suicide Prevention Program has the mission of reducing and preventing suicides in Santa Clara County, by bringing community awareness to the issue and engaging in community prevention efforts. The program takes a public health approach to suicide prevention and engages in strategies across the prevention continuum (i.e. primary prevention, intervention, and postvention) and the socio-ecological model (individual/relationship to community/societal levels).

Since 2021, the Behavioral Health Services Department created the Prevention Services Division, bringing together the Suicide Prevention Program with the department's Substance Use Prevention Services (SUPS) Program. This new division allows for joint/braided funding between MHSA and Substance Use Block Grant (SABG) funds, as well as for expansion of primary prevention activities addressing shared risk and protective factors for both suicide and substance use. Some of the shared risk factors addressed include the PEI Intervention Domains, School failure/dropout and Unemployment.

3. Program Goals, Objectives & Outcomes

Program goal: Reduce and prevent suicide deaths in Santa Clara County.

❖ Program objectives, activities, and outcomes:

Objectives	Activities	Short-term outcomes	Medium-term outcomes	Long-term outcomes
1: Strengthen community suicide prevention and crisis response systems	Trainings and consultations: - Schools for Suicide Prevention (S4SP) partnership (school districts) - County Health System (Primary Care/ Behavioral Health, Behavioral Health contractors) Critical Incident Stress Management – community postvention responses and grief support trainings for providers	a) Increase knowledge among helpers and mental health providers about warning signs for suicide and resources. b) Increase knowledge/ understanding of best-practice crisis response protocols among health care providers and school administrators. c) Increase knowledge/ understanding of best-practice suicide assessment, clinical management, and grief support among mental health providers. d) Identify strengths and gaps in suicide screening, assessment, and management at behavioral health clinics.	a) Increase self-efficacy among helpers and mental health providers to help someone who is in suicidal distress or grieving suicide loss. b) Increase self-efficacy of using best-practice crisis response protocols among providers and administrators. c) Increase self-efficacy among mental health providers of using best-practice suicide assessment and clinical management. d) Increase organizational support and training around suicide assessment and management for behavioral health clinics. e) Increase number of people identified and connected to help.	a) Increase use of best-practice crisis response protocols and practices among health providers and school administrators. b) Increase use of best-practice suicide assessment, clinical management, and grief support skills among mental health providers.
2: Increase use of mental	Helper/mental health trainings	a) Increase knowledge about mental health/ illness and suicide.	a) Improve attitudes/ reduce stigma around mental illness, suicide,	a) Increase help-seeking for mental health/suicide.

health services	Public awareness campaigns Community outreach Services (Crisis Text Line)	b) Increase knowledge about available mental health and suicide prevention resources. c) Increase preparedness to identify and help someone who is experiencing psychological/suicidal distress.	and use of mental health services. b) Improve attitudes towards supporting people who are experiencing psychological distress. c) Increase self-efficacy to identify and help someone who is experiencing psychological/suicidal distress. d) Increase number of people identified and connected to help.	
3: Reduce access to lethal means	Public awareness campaigns Distribution of gun locks and firearm safety resources Development of informational materials on ligature means safety for care providers and the public	a) Increase knowledge about the connection between access to lethal means and risk of suicide. b) Increase knowledge about available resources to reduce access to lethal means for suicide. c) Increase knowledge of effective strategies to help reduce access to lethal means for someone who is experiencing psychological/suicidal distress.	a) Improve attitudes towards preventive safety measures, including practicing safe firearm use and storage and limiting ligature means access. b) Increase self-efficacy to identify and implement measures to reduce access to lethal means. c) Increase number of people able to support individuals at risk for suicidality through lethal means access reduction strategies.	a) Increase practice of access reduction strategies. b) Increase engagement in dialogue around suicide and means access among safety net members (e.g., care providers, family, friends) of individuals at risk for suicidality.
4: Improve safe messaging in the media about suicide	Rapid local media response regarding articles addressing suicide	a) Increase knowledge among media and communications officials about safe messaging guidelines.	a) Improve attitudes of media and communications officials toward incorporating safe messaging practices.	a) Improve average adherence to safe messaging guidelines for local media articles, local reporters, and local outlets, when compared to prior years, as

	Development and utilization of tool to evaluate article/media adherence to safe messaging guidelines Safe messaging trainings for media, local officials, youth Media interviews about suicide or suicide prevention	b) Increase confidence among media and communications officials to apply safe messaging practices in reporting work.	b) Increase likelihood of media to apply local safe messaging principles in reporting. c) Increase likelihood of media and communications officials to share and discuss safe messaging guidelines/practices with media colleagues.	measured by safe messaging evaluation tool. b) Increase presence of de-stigmatizing language around suicide and mental health resources in local media stories.

- **Additional Objective, Activities, and Outcomes funded by Substance Abuse Block Grant (SABG) Primary Prevention: Youth activities to increase protective factors, namely social-emotional health, resiliency/coping skills, connectedness, and sense of purpose.**

Objectives	Activities	Short-term outcomes	Medium-term outcomes	Long-term outcomes
5: Improve social-emotional skills and resiliency **6: Increase connectedness and sense of purpose**	Youth Connect Youth Technology Incubator Friday Night Live Caminar Kneaded Culinary Academy Youth leadership groups – Ollin/Xinachtli and El Joven Noble, Heroes, Leaders In Training Life Skills Group Botvins Lifeskills trainings	Youth who participate in alternative activities will demonstrate lower risk factors and higher protective factors	Youth in the county will have increased social emotional health/connectedness/ purpose/resiliency There will be an increase in youth participation in alternative activities	Decreased substance use (i.e. opioids, alcohol, and cannabis use) among youth Decreased suicidality among youth
	Trainings and consultations to	TBD in FY24 (see Evaluation Activities)		

	school districts in social-emotional learning (SEL)	

4. Clients Served & Annual Cost per Client Data

FY 2023		
Duplicated* N = 1,191,200		
Number Served	**Program Expenditure**	**Cost per Person**
1,191,200	**Refer to Cover Page**	**Refer to Cover Page**

*This program cannot differentiate among duplicated individuals as no PHI is collected from trainings, outreach activities, and media campaigns. The same individuals may have participated in multiple group services reported. The reach of different media campaign materials are also duplicated; i.e., the same individual may have seen the campaign different times and on different channels.

Additional FY23 Funding Sources and Expenditures

Funding Source	Program Expenditures	Use of Funds
Substance Abuse Block Grant (SABG) Prevention	$2,944,162	Community Education and Information (mental health, suicide prevention, and substance use prevention)
Supplemental SABG American Rescue Plan Act (ARPA)	$451,121	Consultants (social-emotional learning) and Community Education and Information (mental health, suicide prevention, and substance use prevention)
Supplemental SABG Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA)	$211,946	Community Education and Information (mental health, suicide prevention, and substance use prevention)

5. Evaluation Activities

The Suicide Prevention (SP) Program utilizes strategies that aim to increase Access and Linkage to mental health services. Program activities are also designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory. The below table includes detailed narrative on how program outcomes are measured. (See Section 3 for list of program outcomes by objective.)

Objectives	Activities	Evaluation Activities
1: Strengthen community suicide prevention and crisis response systems	Trainings and consultations: Schools for Suicide Prevention	The SP Program uses **evidence-based and promising practice standards** to evaluate its school-based suicide prevention efforts. School districts participating in the partnership train their teachers and staff in gatekeeping/helper skills using online Kognito simulation modules, which include pre-, post-, and 90-day follow-up surveys assessing knowledge, attitudes, and behaviors around supporting students who are in psychological distress. Kognito measures are based on the validated Gatekeeper Behavior

	(S4SP) partnership	Scale (Albright, Davidson, Goldman, Shockley & Timmons-Mitchell, 2016). Kognito surveys also include the SP Program's eight standardized training outcome measures for knowledge, attitudes, self-efficacy/behavior, and cultural competency around suicide and acting as a gatekeeper/helper. These outcome measures align with the core components and competencies of suicide prevention gatekeeper trainings, as identified in the literature through research conducted by the SP Program and Palo Alto University's Multicultural Suicide and Ethnic Minority Mental Health Research Group (publication pending). In addition to staff gatekeeper training, S4SP school district administration receive technical support from the HEARD Alliance on additional suicide prevention efforts, primarily crisis response protocols and social emotional learning implementation. This technical support is delivered based on the HEARD Alliance's K-12 Toolkit for Mental Health Promotion and Suicide Prevention (www.heardalliance.org/help-toolkit), a compendium of evidence-based and best-practice tools supporting school-based suicide prevention and crisis response. As part of the technical support package, the HEARD Alliance launched a county-wide training series in FY23 to ensure school personnel and mental health professionals are trained to respond to student concerns and crises by strengthening their crisis response protocols and implementing best-practice prevention efforts. At the conclusion of the training series, participants are asked to complete a comprehensive survey reflecting on the training series content and addressing consultation supports and services. These findings will be used to inform the FY24 series efforts and planning. The HEARD Alliance also tracks the number and progress of school districts they work with on implementing best-practice crisis response protocols and social-emotional learning, as an additional outcome of the school-based consultations. References Albright, G. L., Davidson, J., Goldman, R., Shockley, K. M., & Timmons-Mitchell, J. (2016). Development and validation of the Gatekeeper Behavior Scale: A tool to assess gatekeeper training for suicide prevention. Crisis: The Journal of Crisis Intervention and Suicide Prevention, 37(4), 271–280. https://doi.org/10.1027/0227-5910/a000382 Chiu, L., Corpus, G.H., Lien, M., & Chu, J.P. (2023). The Culturally-Infused Curricular Framework (CICF) for Suicide Prevention Community Trainings. Manuscript submitted for publication.
	Trainings and consultations: County Health System (Primary Care/Behavioral Health,	The SP Program contracts with Drs. Joyce Chu and Chris Weaver, from Community Connections Psychological Associates (CCPA), to provide downstream implementation support for primary care and behavioral health clinical sites seeking to enhance their system-wide suicide services. This work is grounded in research that supports the idea that deaths by suicide may be effectively prevented by focusing on clinical settings. The outcome evaluation methods for this work are based on **evidence-based practice standards**.

	Behavioral Health contractors)	Dr. Chu and Dr. Weaver target collaboration sites that represent key entities within the County of Santa Clara's Health System that manage diverse suicidal clients, such as Ambulatory/Primary Care and Behavioral Health Services clinics. Deliverables and outcomes include forming collaborative relationships with sites and providing the sites with a selection of 13 consultation functions. These 13 consultation functions were developed based on organizational practices from the evidence-based Zero Suicide Framework (Layman et al., 2021; Turner et al., 2021; Zero Suicide Institute, 2018; 2020). In addition, the consultation functions themselves include data and evaluation support at the clinical site level, such as collection and analysis of needs assessment data to identify gaps, strengths, and priorities for organizational improvement; collection and analysis of evaluation data to track outcomes on system improvements; and setup of a program evaluation and data collection, monitoring, and analysis system. This work is grounded in a foundation of culture/diversity and community-based participatory approaches. As such, the potential scope of work is flexible and subject to the guidance of the clinical sites, ultimately enhancing adoption of systemic changes. Actual implementation of the consultation functions was site-specific, collaboratively determined, and tailored to fit each organization's identified needs. The evaluation tool utilized for the organizational needs assessments and outcome measurements over time is based on the Zero Suicide Framework's Organizational Self-Study and Workforce Survey of staff knowledge, practices, and confidence in suicide prevention-related competencies (Zero Suicide Institute, 2018; 2020). The competencies measured in this survey are based in evidence-based practices for suicide care, and supported by emerging science (e.g., Layman et al., 2021; Turner et al., 2021). References Layman, D. M., Kammer, J., Leckman-Westin, E., Hogan, M., Goldstein Grumet, J., Labouliere, C. D., ... & Finnerty, M. (2021). The relationship between suicidal behaviors and Zero Suicide organizational best practices in outpatient mental health clinics. Psychiatric Services, 2021 Oct 1;72(10):1118-1125. doi: 10.1176/appi.ps.202000525 Turner, K., Sveticic, J., Almeida-Crasto, A., Gaee-Atefi, T., Green, V., Grice, D., ... & Stapelberg, N. J. (2021). Implementing a systems approach to suicide prevention in a mental health service using the Zero Suicide Framework. Australian & New Zealand Journal of Psychiatry, 55(3), 241-253.
	Critical Incident Stress Management – community postvention	With MHSA funding support, the Bill Wilson Center (BWC) provides Critical Incident Stress Management (CISM) training to increase the capacity of Behavioral Health Services Department staff and contractors to provide grief support services following critical incidents and loss, including suicide. The BWC contract also includes ongoing community grief support/postvention

	responses and grief support trainings for providers	services to community groups and County partners affected by suicide or loss upon request (e.g., when a school district experiences the death or suicide of a student). The pre and post surveys for this training are driven by **evidence-based practice** to compare participant's knowledge, skills, and attitudes regarding grief support before and after the training to determine the training's effectiveness. At pre and post, participants are asked to rate their preparedness on eight outcome measures of the grief support training. These measures align with core components of the training. The pre and post survey data is compiled and analyzed at the end of each fiscal year. The effectiveness of the training is determined by comparing the results of the pre and post surveys, and additional suggestions are gathered to further improve the training.
2: Increase use of mental health services	Helper/mental health trainings	The SP Program uses an **evidence-based standard** to determine the effectiveness of its training program. During the reporting period, the Program offered up to seven trainings in mental health and suicide prevention helper (gatekeeper) skills. Trainings are evaluated using pre- and post-training online surveys, which are completed by participants at the beginning and end of each training. Across the surveys for each training type, the Program incorporated eight standardized outcome measures for knowledge, attitudes, self-efficacy/behavior, and cultural competency around suicide and acting as a gatekeeper/helper. These outcome measures align with the core components and competencies of suicide prevention gatekeeper trainings, as identified in the literature through research conducted by the SP Program and Palo Alto University's Multicultural Suicide and Ethnic Minority Mental Health Research Group (publication pending). SP Program training evaluation data is compiled and analyzed in aggregate and by training type at the end of each fiscal year. This evaluation data has informed the SP Program's decision to phase out certain helper trainings and introduce others. <u>References</u> Chiu, L., Corpus, G.H., Lien, M., & Chu, J.P. (2023). The Culturally-Infused Curricular Framework (CICF) for Suicide Prevention Community Trainings. Manuscript submitted for publication.
	Public awareness campaigns	The SP Program uses an **evidence-based standard** to determine the effectiveness of its public awareness campaigns. The Program develops, implements, and evaluates 1-2 suicide prevention public awareness campaigns per fiscal year. These campaigns strive to utilize a culturally competent approach to raise public awareness through repeated exposure; and improve attitudes, knowledge and behavior by pulling from a combination of the best-available research in the field, contextual evidence gathered through stakeholder feedback and community data sources, and experiential evidence drawing from the expertise of those who are part of the campaign development team.

		An evaluation agency works closely with the Program and media agency partners to implement an evaluation designed to monitor program implementation, assess participant outcomes, and demonstrate program effectiveness. The evaluators begin with a thorough literature review in pursuit of the latest evaluation research from similar campaigns and initiatives. They then develop an evaluation plan to track progress toward the specified outcomes and gather the data that is needed to inform future decision-making. Learning questions are aligned with the Program's logic model; each of the campaign-related outcomes has one or more evaluation measures associated with it. Campaign analytics data and longitudinal hotline call volume data are used to explore correlations between the campaign and any changes in behavior. However, the primary data source is a survey developed by the evaluator to address the specific campaign objectives. To the extent possible, questions from validated instruments are used or modified to ensure that the survey is based on existing knowledge and practice. Each evaluation utilizes a retrospective pre-/post-intervention survey to help assesses reach, reaction among the target audience, as well as knowledge, attitudes, and likelihood to seek help for suicidal ideation and mental health challenges. If enough survey data is collected, outcomes are compared between survey respondents who report having been exposed to the campaign versus respondents who report no campaign exposure. Outcomes are also compared between cultural groups, such as U.S.-born and non-U.S.-born, or Spanish-speaking and non-Spanish-speaking survey respondents. In addition, although the survey is customized to address the unique aspects of each campaign, some items remain consistent across all campaigns to serve as another point of comparison. Evaluation data is collected in paper and online format from the middle of each campaign's airing to a few weeks after the campaign has ended. The aim is to collect the number of surveys that is statistically representative of each campaign's target audience size in the county. The evaluation agency analyzes the data and presents a report back to the Program and stakeholders a few months after each campaign has ended. This evaluation data informs further public awareness and communication efforts by the SP Program, particularly efforts to reduce stigma and increase help-seeking among cultural communities.
	Community outreach Suicide and crisis services	The SP Program regularly conducts community outreach through tabling at events and calls to providers. The outcomes of community outreach efforts alone are not measured, but are considered as part of all of the activities described in this section that are working to increase use of mental health services. The SP Program may partner with and utilize County-wide surveys conducted by other partners or agencies to measure population-level progress on the long-term outcome of increasing help-seeking. Namely, in 2022 the Behavioral Health Services Department (BHSD)'s MHSA team

		began conducting an annual County-wide survey assessing consumers' knowledge of and experience with BHSD services. Additional data on use of mental health services is provided directly by the services associated with the SP Program, namely Crisis Text Line and the Crisis and Suicide Prevention Lifeline. Crisis Text Line provides the SP Program with access to a real-time data dashboard that shows usage of the county's service, along with texter demographics and most common topics discussed. The Crisis and Suicide Prevention Lifeline provides call volume and demographics by request, especially to compare any effect on call volume while public awareness campaigns are on-air.
3: Reduce access to lethal means	Development of informational materials on ligature means safety for care providers and the public	The workgroup focused on ligature means safety attempted to use a combination of **evidence-based practice standards and practice-based evidence standards** to guide its work on hanging means restriction. The workgroup conducted a literature review and consulted with clinicians to determine what suicide prevention strategies could be utilized to address ligature means safety within community settings. In the face of scant or nascent evidence in this specific area of work, the workgroup developed pilot interventions based on existing evidence in suicide prevention and public health in general. The workgroup developed brochures for caregivers and providers designed to improve education and knowledge about suicides by ligature. A pre/post evaluation survey was designed and disseminated to collect feedback on the brochures; however, not enough data was collected to complete this analysis, and the evaluation was ended.
	Public awareness campaigns Distribution of gun locks and firearm safety resources	The Suicide Prevention Program evaluates some of the firearm safety activities that it leads, such as public awareness campaigns on safe storage. However, oversight of firearm safety for the County is led by the Public Health Department, and many of the activities are led by partner agencies and organizations who are responsible for evaluation of those activities. The Suicide Prevention Program plays a supporting role and reviews whatever evaluation data is available following the activity. See Section 8/Detailed Outcomes.
4: Improve safe messaging in the media about suicide	Rapid local media response regarding articles addressing suicide Development of tool to evaluate article/media adherence to safe messaging guidelines Safe messaging trainings for	Research shows that media adherence to the "Recommendations for Reporting on Suicide" (reportingonsuicide.org) can help to decrease the spread of suicidal behavior. However, traditional methods of measuring adherence to the Recommendations are not standardized and use binary measures for adherence (e.g. Yes/No, Present/Not Present) across several safe messaging characteristics. These measurement methods make it difficult for suicide prevention programs to evaluate long-term progress on safe messaging over time and across programs. Furthermore, binary measures of adherence fail to capture nuances in adherence to certain safe messaging guidelines, such as "Framing of Suicide" or "Sensationalism." The SP Program uses a mix of **evidence-based standards** and **promising practice standards** to evaluate its safe messaging efforts. To measure progress on its short- and medium-term outcomes on safe messaging, the Program developed a survey and collects pre/post data from the safe messaging trainings it conducts with media professionals, potential spokespeople, and journalism students in the county. The Program also

	media, local officials, youth Media interviews about suicide or suicide prevention	conducts regular monitoring of the local media and response to reporters for stories on suicide, and tracks reporters' responses to these outreach efforts. To address the long-term outcome evaluation challenges discussed above, the Program partnered with Stanford University's Center for Youth Mental Health and Wellbeing and developed the Tool for Evaluating Media Portrayals of Suicide (TEMPOS). The TEMPOS measures were developed directly from the "Recommendations for Reporting on Suicide," assessing adherence to each of the ten safe messaging recommendations on a three-point numerical scale and allowing for each article and publication to receive average ratings for safe messaging adherence. The tool was developed in consultation with field experts, including those involved in creating the "Recommendations for Reporting on Suicide." TEMPOS's purpose, content, and application are endorsed by these experts as both necessary and innovative for suicide prevention advancement. As a baseline measurement for its safe messaging efforts, the SP Program applied TEMPOS to a dataset of 226 suicide-related news articles from June 2018, when Anthony Bourdain and Kate Spade died by suicide and the CDC issued its annual suicide data report. An update to this analysis was completed in FY21, in alignment with upgrades to TEMPOS and publication of the tool in the International Journal of Environmental Research and Public Health: https://www.mdpi.com/1660-4601/19/5/2994. In FY23 the SP Program began designing a follow-up evaluation study, using TEMPOS to assess progress on its safe messaging work compared with the 2018 baseline evaluation. The follow-up evaluation study will be completed in FY24. References SAVE Reporting on Suicide. Available online: https://reportingonsuicide.org/ Sorensen, C.C.; Lien, M.; Harrison, V.; Donoghue, J.J.; Kapur, J.S.; Kim, S.H.; Tran, N.T.; Joshi, S.V.; Patel, S.G. The Tool for Evaluating Media Portrayals of Suicide (TEMPOS): Development and Application of a Novel Rating Scale to Reduce Suicide Contagion. Int. J. Environ. Res. Public Health **2022**, 19, 2994. https://doi.org/10.3390/ ijerph19052994

- **Additional Evaluation Activities funded by Substance Abuse Block Grant (SABG) Primary Prevention: Youth activities to increase protective factors, namely social-emotional health, resiliency/coping skills, connectedness, and sense of purpose**

5: Improve social-emotional skills and resiliency **6: Increase connectedness**	Youth Connect Youth Technology Incubator Friday Night Live Caminar	The SABG-funded primary prevention program providers use an **evidence-based standard** to determine the effectiveness of delivered activities. Program providers operate from an evidence-based foundation; directly address one or more of priority shared risk and protective factors for substance use and suicide; and focus on activities that are culturally relevant and appropriate for the community.

and sense of purpose	Kneaded Culinary Academy Youth leadership groups – Ollin/Xinachtli and El Joven Noble, Heroes, Leaders In Training Life Skills Group Botvins Lifeskills trainings	An external evaluation agency works closely with the Prevention Services Division and program providers to implement surveys (for youth programming) and an annual evaluation, designed to monitor program implementation and participant outcomes and to demonstrate program effectiveness. The evaluators began with a thorough literature review in pursuit of validated instruments and methodology used for evaluation of similar trainings and programs. They then developed an evaluation plan to track progress toward the specified outcomes and gathered the data needed to inform future decision-making. Learning questions are aligned with the decisions made during the logic model/strategic planning process, ensuring that methodology was in place to measure progress toward the Division's intended outcomes. Program and training providers submit quarterly report data that tracks program outputs, dosage, and reach. For outcomes measures, the primary data sources are surveys (see attached) designed by the evaluator, with input from providers and County staff. To the extent possible, questions and scales from validated instruments (e.g., the Annie E. Casey Foundation Youth Experience Survey, Youth Risk Behavior Survey, Developmental Assets Profile, the Children's Hope Scale, etc.) were used or modified to ensure that instrumentation was based on existing knowledge and practice. The survey instruments were designed to help assesses the relationship between program participation and any changes in knowledge, attitudes, behavior, and risk and protective factors. Program dosage is utilized during analysis to help determine, statistically, any differences in outcomes between high and low engagement with programming. Demographics are also folded into some analysis so that outcomes can be compared among different subgroups of respondents. Due to variations in program implementation, survey instruments will be updated in the next fiscal year to hone in more specifically on the most universal program outcomes. Survey data is collected online upon completion of programming. Hard copy versions of the surveys are also available to help address any barriers to completion (i.e., lack of Internet access). The expectation is for partners to have all active training and program participants complete a survey to allow for samples that are statistically representative of each program's reach within the county. The external evaluation agency knows how many individuals are served by each program and monitors survey completion to ensure that a representative sample is collected. The evaluation agency analyzes the data and presents a report back to the Prevention Services Division, programs, and stakeholders within a few months after the end of the fiscal year. By regularly monitoring progress toward decreased risk and increased protective factors, this evaluation data can inform individual program development, as well as future decisions about contracting by the Prevention Services Division. <u>References</u>

		The Annie E. Casey Foundation. (2012, November 6). Evidence2Success surveys track child development. The Annie E. Casey Foundation. https://www.aecf.org/blog/evidence2success-surveys-track-child-development Centers for Disease Control and Prevention. (2023, April 27). Youth Risk Behavior Surveillance System (YRBSS). Centers for Disease Control and Prevention. https://www.cdc.gov/healthyyouth/data/yrbs/index.htm Children's hope scale (CHS). RAND Corporation. (n.d.). https://www.rand.org/education-and-labor/projects/assessments/tool/1997/childrens-hope-scale-chs.html The developmental assets framework. Search Institute. (2019, November 5). https://www.search-institute.org/our-research/development-assets/developmental-assets-framework/ The drug-free community survey supplement. Pride Surveys. (n.d.). https://www.pridesurveys.com/index.php/dfc-core-measures-supplement/ Patton K; Connor JP; Rundle-Thiele S; Dietrich T; Young RM; Gullo MJ; (n.d.). Measuring adolescent drinking-refusal self-efficacy: Development and validation of the drinking refusal self-efficacy questionnaire-shortened adolescent version (DRSEQ-SRA). Addictive behaviors. https://pubmed.ncbi.nlm.nih.gov/29432915/ Robinson, S. (2017, July 30). Sheila Robinson. AEA365. https://aea365.org/blog/starting-at-the-end-measuring-learning-using-retrospective-pre-post-evaluations-by-debi-lang-and-judy-savageau/
	Trainings and consultations to school districts in social-emotional learning (SEL)	The HEARD Alliance SEL workgroup provides consultations and technical assistance supporting SEL implementation as a universal Tier 1 strategy in a comprehensive suicide prevention framework. Technical assistance includes but is not limited to: coordination of a professional learning network in Santa Clara County; trainings and train-the-trainers in restorative practices; individualized consultations to strengthen implementation capacity for local education agencies; and leveraging partnerships to strengthen district multi-tiered system of supports frameworks. To evaluate this work, the workgroup developed an evaluation survey to reflect on SEL consultation effectiveness and inform future team services. The HEARD Alliance workgroup also tracks implementation progress for all districts supported. In development for FY24 is a comprehensive logic model, which will be focused on aligning SEL and restorative practices work and will include short, medium, and long-term outcomes.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	110	7.28%
16 -25 years	228	15.09%
26- 59 years	985	65.19%
60+ years	119	7.88%
Prefer not to answer	69	4.57%
Unduplicated Total	1511	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	1	0.15%
Asian	151	23.37%
Black or African American	17	2.63%
Native Hawaiian or Other Pacific Islander	2	0.31%
White/ Caucasian	163	25.23%
Hispanic/Latino	226	34.98%
More than one race	64	9.91%
Prefer not to answer	22	3.41%
Unduplicated Total	646	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	1	

Central American	15	6.12%
Mexican/ Mexican-American/ Chicano	201	82.04%
Puerto Rican	3	1.22%
South American	3	1.22%
Cuban	2	0.82%
More than one race/ethnicity	14	5.71%
Salvadoran	4	1.63%
Spanish	1	0.41%
Other Hispanic/ Latino	1	0.41%
Hispanic or Latino Subtotal	245	100%
Non-Hispanic or Non-Latino as follows:		
African	1	0.25%
African American	28	6.98%
American Indian/Alaskan Native	11	2.74%
Asian Indian/ South Asian	38	9.48%
Cambodian	4	1%
Chinese	25	6.23%
Eastern European	24	5.99%
European	129	32.17%
Filipino	32	7.98%
Japanese	7	1.75%
Korean	5	1.25%
Middle Eastern	7	1.75%

Vietnamese	37	9.23%
Mien	1	0.25%
Native Hawaiian	1	0.25%
Samoan	1	0.25%
Other combined Non-Hispanic/ Non-Latino	13	3.24%
Non-Hispanic or Non-Latino Subtotal	364	90.77%
More than one ethnicity of Asian	11	2.74%
More than one ethnicity of African/African American/Black	5	1.25%
More than one ethnicity of White/Caucasian	21	5.24%
Unduplicated Total	401	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	140	21.67%
Female	496	76.78%
Prefer not to answer	10	1.55%
Unduplicated Total	646	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	133	20.59%
Female	445	68.89%
Transgender (Male to Female)	0	0%
Transgender (Female to Male)	0	0%
Transgender (Undefined)	0	0%
Genderqueer	9	1.39%

Questioning or Unsure	0	0%
Another gender identity	0	0%
Prefer not to answer	15	2.32%
Unduplicated Total	646	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	17	2.63%
Heterosexual/ Straight	525	81.27%
Bisexual	53	8.20%
Questioning/ Unsure	4	0.62%
Queer	11	1.70%
Another sexual orientation	0	0%
Prefer not to answer	36	5.57%
Unduplicated Total	646	100%

	FY 2023	
Primary Language	**# Served**	**% of Served**
American Sign Language	10	0.60%
Arabic	4	0.24%
Armenian	1	0.06%
Bangla	1	0.06%
Cambodian	3	0.18%
Cantonese	12	0.72%
Cebuano	1	0.06%
English	1249	74.66%
Farsi	5	0.30%
French	2	0.06%
Gujarati	1	0.06%
Hindi	6	0.36%

Ilocano	2	0.12%
Japanese	4	0.24%
Kannada	1	0.06%
Korean	7	0.42%
Lao	1	0.06%
Mandarin	9	0.54%
Marathi	2	0.12%
Mien	1	0.06%
Nepali	2	0.12%
Portuguese	1	0.06%
Romanian	1	0.06%
Russian	3	0.18%
Samoan	1	0.06%
Spanish	187	11.18%
Tagalog	30	1.79%
Tamil	1	0.06%
Telugu	2	0.12%
Thai	1	0.06%
Tigrinya	1	0.06%
Turkish	1	0.06%
Vietnamese	31	1.85%
Other	40	2.39%
Prefer not to answer	49	2.93%
Unduplicated Total	1673	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Current active duty	1	0.07%
Current reserve duty or National Guard	1	0.07%
Never served in the military	1403	92.85%
Veteran	24	1.59%

Served in another country's military	2	0.13%
Prefer not to answer	60	3.97%
Other	20	1.32%
Unduplicated Total	1511	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	43	2.79%
Difficulty hearing or having speech understood	35	2.27%
Physical/ Mobility disability	21	1.36%
Chronic Health Condition	43	2.79%
Developmental disability	3	0.19%
Learning disability	29	1.88%
No Disability	1210	78.57%
Other	35	2.27%
Prefer not to answer	121	7.86%
Unduplicated Total	1540	100%

*Participants may choose more than one option for Disability.

7. Group Services Delivered

FY 2023		
Duplicated* N = 1,189,689		
Number of Groups	**Attendance**	**Average Attendance per Group**
1 conference	60	60
43 community events	1940 who received resources	45.1 per event

5 talanoas for Pacific Islander community	16	3.2 per talanoa
4 primary care/behavioral health clinics/organizations provided with ongoing consultations on strengthening suicide prevention and crisis response	227	57 per consultation
1 safe messaging training	12	12
1 suicide prevention campaign targeting middle-aged men	Audio reach: 208,000 Display reach: 427,000	635,000
3 media campaign phases (promoting 988)	Estimated reach (calculated by reported exposure): 546,257	182,085.7 per campaign phase
1 Crisis Text Line service	231 texters	231
8 Be Sensitive, Be Brave: Mental Health trainings	100	12.5 per training
21 Be Sensitive, Be Brave: Suicide Prevention trainings	432	20.6 per training
6 ASIST trainings	148	24.7 per training
3,352 Kognito staff and student trainings in 20 school districts	3352	167.6 trained per district
2 Suicide 201 clinical trainings	75	37.5 per training
192 Online QPR trainings (individual)	192	1 per training
154 LivingWorks Start (individual)	154	1 per training
20 school district consulted and/or trained on crisis response	159	8 per consultation or training
5 school district training sessions on crisis response	466	93.2 per training session
1 Critical Incident Stress Management (CISM) training	48	48
75 CISM postvention responses	820	10.9 per CISM response

❖ Additional Group Services funded by SABG

i. 5 Professional Learning Network trainings on social-emotional learning (SEL) conducted for school districts – 55 attendees
ii. 36 school district consultations on SEL – 63 attendees
iii. 11 school district staff trainings in restorative justice – more than 125 attendees
iv. Youth activities to strengthen protective factors (all unduplicated): Youth Connect – 15 participants; Youth Technology Incubator – 473; Friday Night Live – 331; Caminar – 78; Kneaded Culinary Academy – 95; youth leadership groups – Ollin/Xinachtli, El Joven Noble, Heroes, Leaders in Training – 222; Life Skills Group – 272
v. Botvins Lifeskills trainings – 1998

8. Detailed Outcomes

Objectives	Activities	Detailed Outcomes
1: Strengthen community suicide prevention and crisis response systems	Trainings and consultations: Schools for Suicide Prevention (S4SP) partnership	The partnership supports school districts to follow a comprehensive, tiered approach to trainings in suicide prevention and mental health. This approach ensures that school personnel and mental health professionals are first trained to handle referrals of students who may be struggling with suicide, because student referrals tend to increase after students and families have received training. The main helper trainings for this work are the Kognito online health simulations, which are paired with Stanford HEARD Alliance technical assistance focused on establishing or updating suicide and crisis response forms and protocols. Pre- and post- training survey results from the Kognito "At-Risk" suite and "Emotional and Mental Wellness" online trainings indicated statistically significant improvements in suicide prevention helper-related competencies. **Change in Self-Report of Suicide Prevention-Related Competencies for Kognito "At-Risk" and "Emotional and Mental Wellness" online trainings (for elementary, middle, high school educators)**

	Pre-Training (N= 1605-1617)		Post-Training (N=1057-1067)				
Variables	M	SD	M	SD	t-test	Cohen's *d*	Effect Size
I know the warning signs for suicide.	3.56	0.83	4.04	0.7	-16.173***	-0.614884564	Medium
I am able to identify someone who is at risk for making a suicide attempt.	3.48	0.85	3.98	0.71	-16.489***	-0.627411455	Medium
I am aware of the resources necessary to refer someone in a suicide crisis.	3.48	0.9	4.02	0.72	-17.099***	-0.648372185	Medium
I am confident in my ability to make a referral for someone in a suicide crisis.	3.45	0.91	3.99	0.74	-16.562***	-0.638155474	Medium
I have the skills necessary to support or intervene with someone thinking about suicide.	3.32	0.93	3.91	0.77	-18***	-0.678517752	Medium
I understand and can identify ways in which culture affects how suicide is expressed and experienced.	3.36	0.93	3.83	0.79	-13.958***	-0.536096218	Medium
I feel prepared to apply concepts of culture and diversity in my efforts to help people with their suicidal distress.	3.31	0.93	3.83	0.8	-15.452***	-0.590667481	Medium

Notes. M=Mean. SD=Standard Deviation. Scores: 1=Strongly Disagree, 2=Disagree, 3=Neither disagree or agree; 4=Agree; 5=Strongly Agree. *** p < .001.
Note re: Cohen's d: A measure of the effect size of the difference between two pre-training and post-training mean scores, measured in standard deviations.

HEARD Alliance Technical Assistance
In FY23, the HEARD Alliance Crisis Response Team supported 20 districts and more than 625 (duplicated) school staff and school-based providers with consultations and trainings.

		See the table below for a summary of support and activity details highlighting district progress and/or participation in HEARD activities.

Crisis Response Services Provided by the HEARD Alliance

District	Consultations/ Trainings	District Activity Highlights
Berryessa Union	Training series participation; 31 attendees	- Meetings with Director of Student Services about forms/protocols - Training Series attendance - Sent updated and new resources throughout the year
Eastside Union HS District	1 consultation; 1 attendee	- Consultation to review various forms with district lead
Escuela Popular Charter (ESUHSD)	Training series participation/Consultation; 9 attendees	- Training Series attendance - Sent resources - Meeting with counselors
Evergreen Elementary SD	Training series participation; 1 attendee	- Team focused on other areas of work this year, did not revisit CRT efforts since this has been the focus of past years - Training Series attendance - Postvention resources sent following suicide loss and support offered
Franklin-McKinley	1 consultation; 3 Administrators	- Consultation/review of forms - Sent Toolkit forms
Fremont Union HS District	Training series participation; 1 attendee	- Reviewed district Toolkit - Consultation/review of the intervention forms - Postvention support following suicide loss - Training Series attendance
Gilroy Unified	Training series participation; 2 attendees	- Updates for sections of the toolkit - Sent and new resources
Los Altos Elementary School District	Training series participation; 2 attendees	- No consultations this year - Ongoing email communication with new resources and updated documents
Los Gatos Union School District	Training series participation; 2 attendees	- Email exchanges around various topics: anxiety/worry, SEL, mental health skills building curriculum, etc.

SCCOE Opportunity Youth Academy	Training series participation; 4 attendees	- Training Series attendance
Cambrian	Training series participation; 12 attendees	- Training Series attendance
Campbell Union	Training series participation; 2 attendees	- Training Series attendance
CHAC youth mental health services	*Training; 80 attendees*	- *Clinician Intervention training* - *CHAC contracted provider for many school district partners* - *Goal: ensure alignment and awareness of school protocols/forms*

Milpitas Unified	Training series participation; Consultation; 33 attendees	- Training Series attendance - Presentation for staff and administration
Morgan Hill Unified	Training series participation; 33 attendees	- Training Series attendance
Moreland	Consultation; 5 attendees	- Individualized staff training - Review of suicide response forms - Postvention presentation
MVLA	Training series participation; 2 attendees	- Training Series attendance - Tabling by HEARD - Out of the Darkness Walk event tabling
Mountain View Whisman	Training series participation; 1 attendee	- Training Series attendance

Palo Alto Unified	Training series participation/Meeting; 2 attendees	- Training Series attendance - Meeting with Director of Counseling Services
Santa Clara Unified	Training series participation; 2 attendees	- Training Series attendance
San Jose Unified	Presentation/Training; 6 attendees	- Initial consultation/offerings discussion via email thread - Presentation on postvention with district CRT leads - Presentation on Intervention/Forms with district CRT leads
Sunnyvale Elementary SD	N/A	- Sent new resources - Ongoing email communication
SCCOE Early Learning Program	Consultation; 5 staff attendees	- Consultation - Shared resources

Trainings and consultations: County Health System (Primary Care/Behavioral Health, Behavioral Health contractors)	In FY23, general aims were to collaboratively develop programs of action unique to each site using a number of engagement modalities: organizational assessment, staff education, data and evaluation, incorporation of cultural and diversity considerations, integration of evidence-based innovative approaches to culturally competent suicide assessment and management, and modification of screening and assessment protocols, clinical documentation, or intervention practices. The prior years' pilot (FY21) and full consultation engagement (FY22) efforts culminated in the formation of collaborative workgroups at each site who achieved a wide range of site-specific changes. Following on Year 2 efforts, FY23 focus was maintained on improving and supporting culturally competent suicide prevention and management in the county's clinical services, continuing to target both behavioral health and ambulatory care stakeholders as chosen for their potential to impact a large proportion of those receiving mental health services in the County of Santa Clara. • Deliverable #1: Multi-year workplan ongoing collaborative iteration.

Yearly aims were to maintain the previously-built collaborative relationships and build new such relationships in the service of maintaining, improving upon, and delivering the multi-year workplan to improve suicide practices for diverse client groups system-wide in behavioral health and ambulatory care.

- Deliverable #2: Provision of consultation services.

Sites or teams receiving continued services were each following their own site-specific goals as defined in their initial needs assessments. For each new site or team, aims were to perform program evaluation and/or consultation as collaboratively determined with the targeted clinical sites/teams. CCPA would provide consultation in a range of competency areas, including, but not limited to, the 13 consultation functions listed in Table 1. Actual implementation of these functions was site-specific, collaboratively determined, and tailored to fit each organization's identified needs. Details of consultation services at each site are provided in Table 2.

Table 1: List of organizational consultation functions / services

Function / Service #	Description
1	Mobilize efforts (e.g, increase awareness, foster buy-in) to analyze and refine or improve downstream suicide assessment, stabilization, and recovery services.
2	Identify gaps, strengths, and priorities for organizational improvement through collection and analysis of qualitative and quantitative needs assessment data.
3	Conduct consultation meetings on system improvements as indicated
4	Identify and implement the need for program adaptations, changes, or additions in the areas of culture and diversity (i.e., to prevent suicide and promote recovery in the diverse populations of the County).
5	Assist in development of suicide-relevant policies and procedures
6	Determine needs for training of clinic staff, providers, or other relevant stakeholders
7	Provide ongoing consultation regarding initial and booster training, and education
8	Collaboratively customize screening and assessment tools. Streamline processes to balance effectiveness with feasibility.
9	Implement evidence-based practices to assure referral, safe discharge, continuity of care and recovery to meet and exceed legal, ethical, and clinical standards.
10	Assess and modify forms and clinical notes to optimize clinical care, minimize clinician burden, and address legal and ethical standards.

11	Track outcomes on system improvements through collection and analysis of evaluation data.
12	Consult on the setup of a program evaluation and data collection, monitoring, and analysis system.
13	Provide individual and ongoing training.

Table 2a: Description of downstream suicide prevention consultation efforts in Ambulatory Care (FY 2023)*

Name of Site	FY 23 Status	Description of Downstream Work in FY2023	Functions/Services Performed in FY2022	Next Steps	# people served
Primary Care Behavioral Health (PCBH; part of the Valley Health Clinics)	Active	Developed detailed workflows and policies, including educational and orientation materials to facilitate roll-out to medical and mental health staff and patients, to create foundational processes that support improved suicide prevention practices.	3. Consultation meetings on system improvements 4. Culture/diversity adaptations 5. Policies and procedures 6. Determine training needs 7. Provide consultation on education/training needs 8. Screening/assessment tools 9. Evidence-based practices	Continue supporting roll-out of developed systems as the team requests. Engage in consultation efforts as needed to adjust program designs and roll-out to evolving program identity and needs. Enhance focus on suicide prevention/ management policy, procedures, practices, and training, with specific attention to substance use needs within the process of crisis assessment and management.	~6000

*Note: Provision of functions/services are listed in short-hand for the sake of brevity.

Table 2b: Description of downstream suicide prevention consultation efforts in Behavioral Health (FY23)*

Name of Site	FY23 Status	Description of Downstream Work in FY23	Functions/Services Performed in FY22*	Next Steps	# People served
Momentum for Mental Health (Contracted behavioral health community-based organization (CBO))	Maintenance / Supportive	Ongoing work via a now standing suicide prevention workgroup consisting of key organization staff representing all levels of care and management. Collaboratively designed and implemented a 6-month suicide prevention training series with an emphasis on staff accessibility and sustainability as determined in the FY22 post-test assessment. Continued support in suicide prevention resource library development and testing.	2. Identify gaps, strengths, and priorities 3. Consultation meetings on system improvements 4. Culture/ diversity adaptations 13. Provide ongoing training.	Collaboratively determine any remaining needs for support for the following year.	2000

		AACI (Asian Americans for Community Involvement; Contracted behavioral health community-based organization (CBO)	Active	Analyzed and reported back on results of needs assessment. Solidification of standing workgroup. Engaged in significant work this year to identify standing practices and to research and develop an entirely new suicide prevention policy, internal suicide prevention resource page, and electronic health record templates for use agency-wide. The policy lays out key elements of cross-cultural sophistication needed across all elements from initial screening to posthospitalization re-entry, with additional focus on the role of substance use. Development of training curriculum to roll-out new policies and procedures.	1. Mobilize efforts 2. Identify gaps, strengths, and priorities 3. Consultation meetings on system improvements 4. Culture/diversity adaptations 5. Policies and procedures 6. Determine training needs 7. Provide consultation on education/training needs 8. Screening/assessment tools 9. Evidence-based practices 13. Provide training	Collaboratively develop plan to roll out the new suicide prevention policy and procedures, internal resources website, and electronic health record templates via staff training. Focus specific attention on substance use needs within the process of crisis assessment and management.	1600
		*Note: Provision of functions/services are listed in short-hand for the sake of brevity.					

	Critical Incident Stress Management – community postvention responses and grief support trainings for providers	During the one CISM training this year, participants reported statistically significant improvements from pre- to post-training in six self-reported preparedness measures related to grief response. **Change in Self-Report of Grief Response Preparedness for CISM trainings**

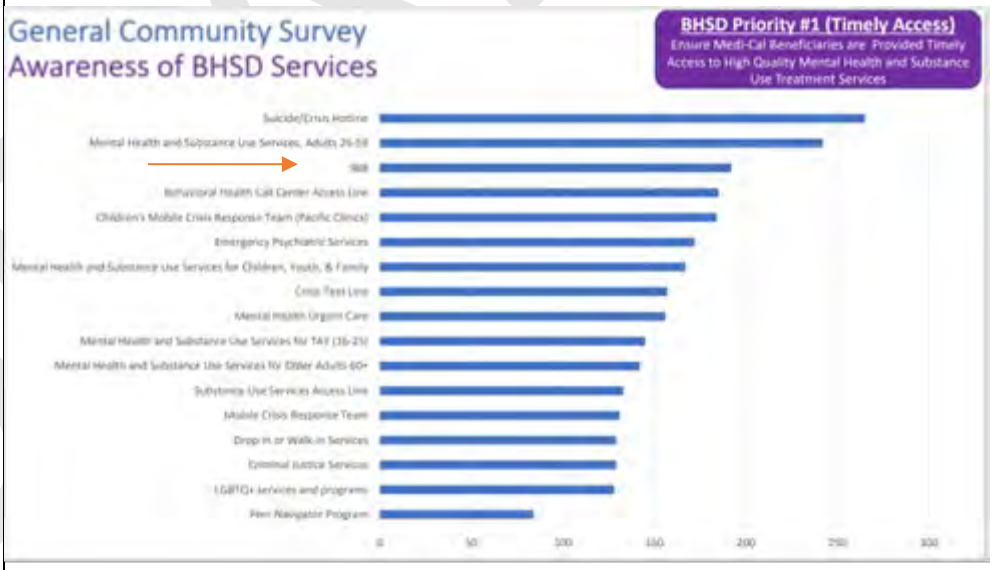
	Pre-Training (N= 31-32)		Post-Training (N=34)				
Variables	M	SD	M	SD	t-test	Cohen's *d*	Effect Size
I feel adequately prepared to identify the dynamics of the stress/grief response after change or loss.	3.59	0.95	4.59	0.78	-4.638***	-1.171936371	Large
I feel adequately prepared to recognize behaviors, thoughts and feelings related to stress/grief.	3.91	0.73	4.65	0.77	-3.9902***	-1.000775632	Large
I feel adequately prepared to articulate and practice effective techniques for responding to grief in children, youth and adults.	3.44	0.95	4.5	0.83	-4.8419***	-1.209277268	Large
I feel adequately prepared to identify specific dynamics of suicide grief and sudden or violent trauma.	3.48	0.89	4.41	0.89	-4.1956***	-1.061400641	Large
I feel adequately prepared to recognize and articulate stress responses in yourself and co-workers in the aftermath of a critical incident.	3.62	0.83	4.44	0.89	-3.8395***	-0.966631536	Large
I feel adequately prepared to apply principles and processes of stress management to build resiliency in the home and work environment.	3.53	0.95	4.53	0.83	-4.5455***	-1.140827612	Large

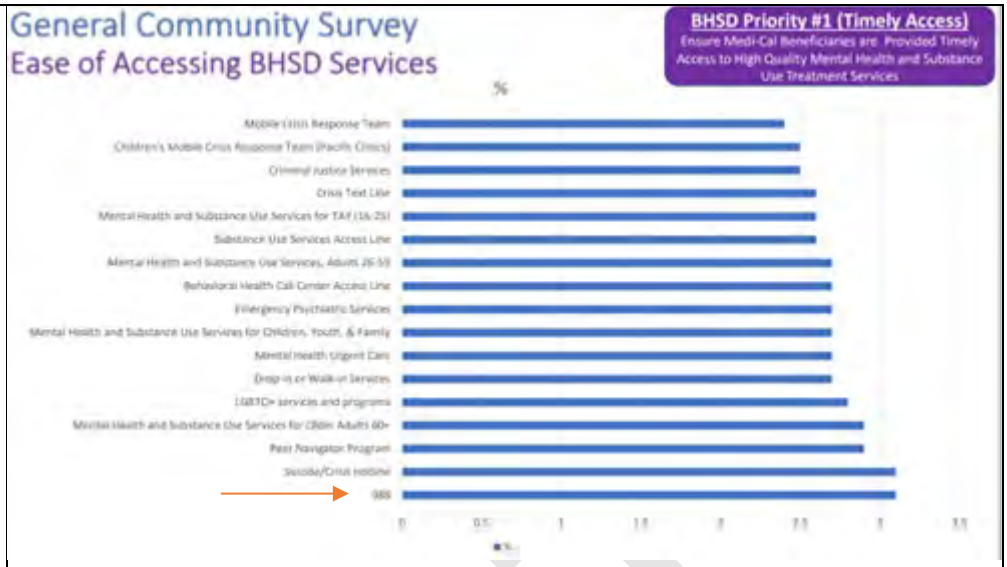
2: Increase use of mental health services	Helper/mental health trainings	<u>Community Helper Trainings</u> In aggregate, across suicide prevention helper trainings offered, participants reported statistically significant improvements from pre- to post-training in eight self-reported suicide prevention competencies related to knowledge, attitudes, and preparedness around being community helpers for suicide prevention. The trainings analyzed included: Question, Persuade, Refer (QPR); LivingWorks Start; Be Sensitive, Be Brave: Suicide Prevention; and Applied Suicide Intervention Skills Training (ASIST). **Change in Self-Report of Suicide Prevention-Related Competencies for trainings, July 2022- June 2023**

	Pre-Training (N= 452-454)		Post-Training (N=293-295)				
Variables	M	SD	M	SD	t-test	Cohen's *d*	Effect Size
I know the warning signs for suicide.	3.54	0.87	4.45	0.57	-17.156***	-1.189103729	Large
I am able to identify someone who is at risk for making a suicide attempt.	3.38	0.89	4.38	0.6	-18.256***	-1.269495371	Large
I feel prepared to discuss with someone my concern about the signs of suicidal distress they are exhibiting.	3.25	1.05	4.3	0.7	-16.44***	-1.132702638	Large
I am aware of the resources necessary to refer someone in a suicide crisis.	3.4	0.94	4.4	0.62	-17.543***	-1.208219663	Large
I am confident in my ability to make a referral for someone in a suicide crisis.	3.18	1.03	4.29	0.69	-17.666***	-1.219005567	Large
I have the skills necessary to support or intervene with someone thinking about suicide.	3.11	0.98	4.24	0.68	-18.653***	-1.294076211	Large
I understand and can identify ways in which culture affects how suicide is expressed and experienced.	3.3	0.94	4.21	0.63	-15.841***	-1.095558175	Large
I feel prepared to apply concepts of culture and diversity in my efforts to help people with their suicidal distress.	3.11	0.98	4.15	0.7	-16.959***	-1.182543597	Large

Notes. M=Mean. SD=Standard Deviation. Scores: 1=Strongly Disagree, 2=Disagree, 3=Neither disagree or agree; 4=Agree; 5=Strongly Agree. *** p < .001.
Note re: Cohen's d: A measure of the effect size of the difference between two pre-training and post-training mean scores, measured in standard deviations.

Public awareness campaigns	In response to the federal requirement that all states transition to 988 as the new phone number for the national suicide and crisis lifeline, the County of Santa Clara Behavioral Health Services Department (BHSD) launched 988 services in July of FY23. In March of FY22, the SP Program and BHSD leadership began planning a public awareness campaign promoting the County's transition to 988 and the new BHSD non-crisis phone line to access all County mental health and substance use treatment services. The primary campaign objectives were to, among Santa Clara County residents: drive awareness about the new 988 lifeline and consolidated non-crisis number for mental health or substance use service access; improve knowledge about where to seek help for non-crisis mental health and substance use treatment; improve attitudes and counter any negative perception towards seeking help for mental health services; and increase help-seeking behavior. The campaign was comprised of three six-week phases, airing throughout FY23. Each phase addressed both youth and adult audiences and targeted different County cultural communities. The first phase ran from September to October 2022, the second from January to March 2023, and the third from May to June 2023. The campaign included digital online, social media, radio,

		television, and print ads, as well as internal and public informational materials. In total, the campaign generated 26,250,225 impressions. The Program has contracted with a research agency to conduct a comprehensive evaluation of the campaign. The evaluation survey was designed to determine the campaign's reach, understand knowledge, attitudes, and behavior around calling 988, and explore community experiences with the 988 lifeline for those who have called. Survey distribution took place from July 14 to August 14, 2023. A comprehensive evaluation report is expected in late September 2023. While 988 campaign evaluation results have not yet been received, the Program has received community feedback on 988 services and accessibility through an FY22 County Mental Health Services Act (MHSA) consumer survey. In its FY23 Evaluation Report on the survey results, Community Connections Psychological Associates, Inc. (CCPA) recommended that BHSD "continue to increase community awareness and accessibility of BHSD services, particularly 988 and the peer navigator program. Stakeholders identified ease of access through many current County efforts as a strength, while also highlighting a strong need to continue expanding these efforts." Among survey respondents who utilized County behavioral health services, 988 was one of the three most-recognized services.  Figure 1: Awareness of 988 among MHSA survey respondents.

		 Figure 2: Ease of access to 988 among MHSA survey respondents. In FY23, the Program also planned and launched a public awareness campaign promoting suicide prevention among men ages 35-54 in the County. The campaign was comprised of both English and Spanish digital online ads and radio ads. The ads informed the audience that there is help available and encouraged them to seek it out. Campaign goals were to improve knowledge about when and where to seek help for suicide, to improve attitudes toward seeking help for suicide and reduce stigma, and to increase help-seeking behavior. The effort launched in the final week of FY23 and remained on air for six weeks into FY24. As of July 30, 2023, the campaign has delivered 2,188,500 impressions. The Program does not plan to evaluate the campaign as its materials were adapted from a prior program campaign that was researched before through focus groups (to inform its development) and evaluated afterward, with strong outcomes data.
3: Reduce access to lethal means	Development of informational materials on ligature means safety for care providers and the public	No outcomes (see Section 5/Evaluation Activities)
	Distribution of gun locks and firearm safety resources	The SP Program participates in gun buyback events organized by County partners. The Program coordinates with partners to provide and distribute suicide prevention and mental health resources, as well as gun locks to buyback event participants. At a County buyback event in 2022, the Program distributed 134 resource bags, each containing a gun lock and suicide prevention and mental health materials.
4: Improve safe	Rapid local media response	In its work addressing short- and medium-term outcomes, the SP Program conducts regular monitoring of the local media and response to reporters for

messaging in the media about suicide	regarding articles addressing suicide Development of tool to evaluate article/media adherence to safe messaging guidelines Safe messaging trainings for media, local officials, youth Media interviews about suicide or suicide prevention	stories on suicide, and tracks reporters' responses to these outreach efforts. In the most recent fiscal year, 27 separate communications were conducted with local and national reporters regarding their articles or prospective reporting on suicide and mental health. Of the 27 total communication efforts, the Program fielded nine follow-up messages, some resulting in continued dialogue and fostered relationships with journalists. Cultivating these relationships is a priority of the Program's media response work. In the coming fiscal year, the Program will offer its safe reporting training in each instance of outreach to media members. In FY23, the Program continued to gather pre- and post-training survey data from the safe messaging training conducted with communications professionals in the county. In FY23, the Program provided one safe messaging training attended by 12 veterans from the County of Santa Clara Office of Veterans Services, other county organizations, and affiliated individuals. According to the post-training survey data, 100% of respondents were somewhat or very familiar with the safe messaging recommendations for reporting on suicide after attending the workshop (see Fig. 1). All who responded to the post-training survey expressed that they were somewhat or very confident about conducting communications work about suicide, suicide prevention, or mental illness after the workshop (see Fig. 2). As shown in Fig. 3 below, 100% percent of survey respondents indicated that they were somewhat or very likely to apply safe messaging guidelines in their work. After taking the safe messaging training, most respondents (80%) reported that they were aware of gaps in how the media are currently reporting about suicide (see Fig. 4). In addition, 80% of survey respondents stated that they understood the potential impacts of reporting on suicide contagion (see Fig.5). Similarly, the same percentage of respondents said they understood the goals of "Recommendations for Reporting on Suicide: https://reportingonsuicide.org" (see Fig. 6). Safe messaging training survey results below (Fig.1-6).  Fig. 1  Fig. 2

Fig. 3

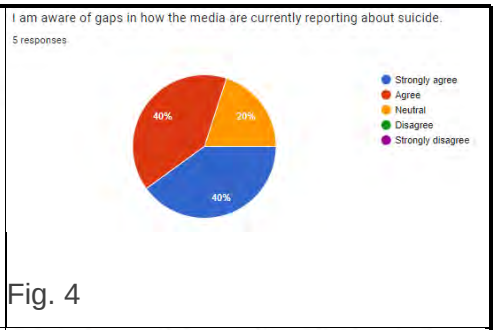


Fig. 4

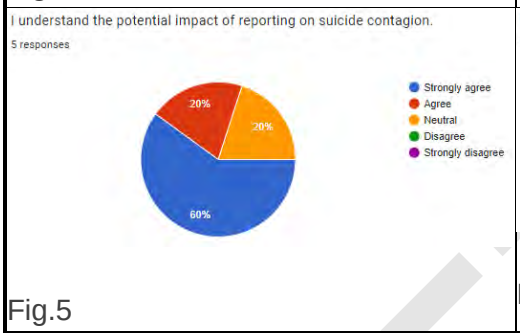


Fig.5

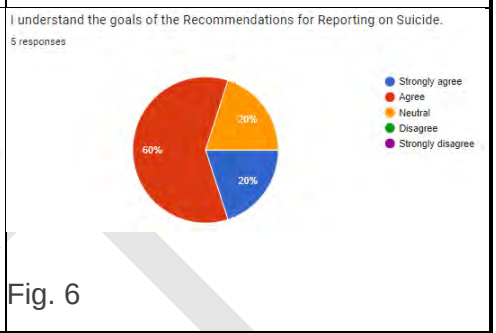


Fig. 6

To assess long-term outcomes of its safe messaging work, in FY23 the SP Program began planning a follow-up analysis of local and national suicide-related news articles using the Tool for Evaluating Media Portrayals of Suicide (TEMPOS) (see Section 5/Evaluation Activities). Working with partners, the program applied TEMPOS to a dataset of 220 suicide-related news articles from June 2018, when Anthony Bourdain and Kate Spade died by suicide. The resulting analysis provided baseline data, which was included in a published journal article detailing tool development, application, and potential areas of utilization.

For the follow-up analysis, the Program has engaged with an evaluation agency it contracts with and the Center for Urban Studies at the Federal University of Minas Gerais in Brazil. Through this collaboration, the Program aims to maintain scientific rigor of the follow-up analysis and ensure fidelity to the process used for the initial analysis. The purpose of the project is to ascertain changes in trends of reporting on suicide among media and to determine any impacts of the Program's safe messaging efforts since the 2018 baseline article analysis was conducted. Findings will help evaluate the impact of the Program's work with media on safe reporting and identify areas indicating progress and areas for improvement.

The Program has finalized a dataset of 97 local and national articles from March 2022 surrounding the high-profile suicide death of soccer player and Stanford University student, Katie Meyer. Article coding and analysis are set to take place in the coming months with a final report projected to be complete before the end of FY24.

❖ **Cross-cutting objective: Policy**

Policy implementation cuts across all objectives in the Suicide Prevention Program's logic model. In FY23, two major policy developments were achieved:

First, every city in Santa Clara County formally adopted a **city suicide prevention policy**. The development was a result of years-long work that began in 2012 by the Suicide Prevention Program and its stakeholders. By the end of 2020, seven city policies were in place. Then in 2021, six more were passed, with one more coming in 2022. The final city-level policy was formally adopted in February 2023. The policies promote suicide prevention in local communities and increase collaborative efforts with the Suicide Prevention Program, helping to fight the stigma against suicide and save lives. The policies commit cities to collaborate and engage in suicide prevention best practices, such as acknowledging suicide as a public health issue; educating residents on suicide, its warning signs, and where to seek help; establishing and following formal procedures to share resources and follow safe messaging best practices when communicating with the community; and adopting and activating postvention protocols. Most city suicide prevention policies in the county were adopted unanimously.

Second, the county's Behavioral Health Services Department (BHSD) adopted a policy on incorporating spirituality into mental health practice and treatment, following a two-year effort spearheaded by Suicide Prevention Program stakeholders. Research has demonstrated that for many individuals, recognition and acceptance of their spiritual beliefs may be a key component in helping them achieve their recovery goals. Inclusion of these beliefs in behavioral health treatment and/or interventions has been associated with successful outcomes. Religion and spirituality are also often associated with social support networks and community resources, which are important protective factors for mental health and suicide prevention. Inspired by the strong evidence base and by similar policies from LA, San Mateo, and Alameda Counties, the stakeholders researched, developed, and supported passage of a **spirituality and mental health policy** before the BHSD Policy Committee. The policy was approved by BHSD in May 2023.

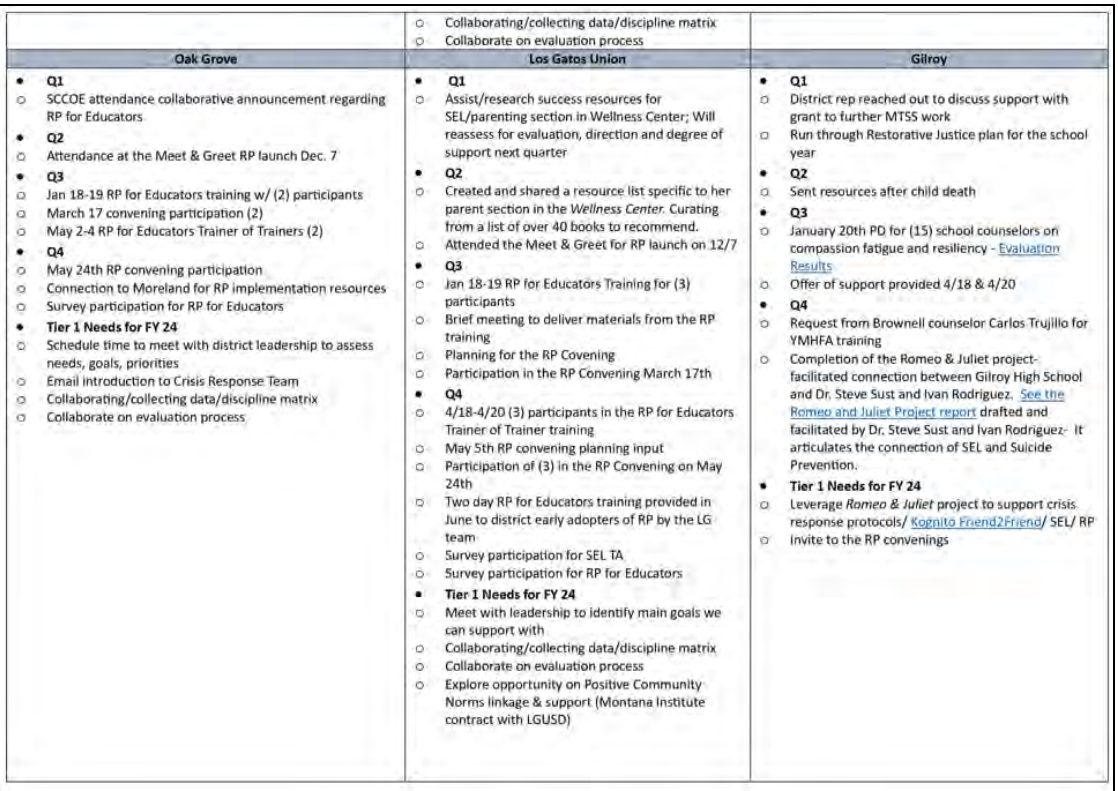
❖ Additional Detailed Outcomes funded by Substance Abuse Block Grant (SABG) Primary Prevention: Youth activities to increase protective factors, namely social-emotional health, resiliency/coping skills, connectedness, and sense of purpose

5: Improve social-emotional skills and resiliency **6: Increase connectedness and sense of purpose**	Youth Connect Youth Technology Incubator Friday Night Live Caminar Kneaded Culinary Academy Youth leadership groups – Ollin/Xinachtli and El Joven Noble, Heroes, Leaders In Training	Among the expected outcomes for youth alternative activities are that youth who participate will demonstrate lower risk factors and higher protective factors. Risk factors include: perceived risk of drug use; rebelliousness; and social isolation. Protective factors include: clear standards for behavior; emotional wellbeing; emotion regulation; positive social (prosocial) behavior; close relationships with adults and peers; hope; and positive attitudes toward mental health treatment[1]. In FY23 surveys were developed and piloted for middle school, high school, and young adults to measure change in youth risk and protective factors through participation in the youth activities. Although the surveys were designed to be administered as pre-post surveys, due to variations in programming and timelines only 18 middle school surveys were collected in this way. The majority of surveys were collected as post-only (n=94). Analysis of this year's surveys showed: i. Among the middle school youth who completed pre-post surveys (n=18), there was a statistically significant increase in the perceived risk of taking prescription drugs not prescribed to them, and a statistically significant increase in the belief that they can come up with lots of ways to solve their problems. Although not statistically significant, change for the majority (19) of remaining items on the survey trended in the desirable direction. A couple of prosocial behavior items, one item measuring positive relationships with adults, one help-seeking item, and two substance use items trended in the wrong direction.

	Life Skills Group Botvins Lifeskills trainings	ii. Middle school youth completing post surveys (n=37) perceived the use of prescription drugs not prescribed to them as being of great risk. All other risk and protective factor data trended in the desirable direction (i.e., means for risk factors were low, and for protective factors were high). iii. High school youth completing post surveys (n=34) perceived most substance use to be of moderate risk. Most other risk and protective factor data trended in the desirable direction, although these youth reported high levels of school-related stress. iv. Young adults (18-24) completing post surveys (n=23) similarly perceived most substance use to be of moderate risk. Most other risk and protective factor data trended in the desirable direction, although these youth reported high levels of stress in general. Some program partners also collected additional qualitative feedback from participants in their programs. The statements that youth provided are highly indicative of the powerful impact of programming on youth protective factors. The following is an example of a participant impact statement: "Last year, I remember walking home after doing nothing during my basketball games and feeling worthless…. The year concluded and on came 9th grade: this year. The first semester, I endured much pressure from my parents, who saw stories of kids being great, wanting me to do the same…. I remember seeing the Youth Connect application one day when scrolling through my phone, and telling my dad about it. He urged me to try it out, so I did. The voice in the back of my brain told me it was going to change my life, but I didn't think too much about it…. On that first day alone, I felt appreciated, and I had barely even been there! Youth Connect has allowed me to meet so many great people including the owners of other organizations and other peer leaders who have inspired me to be great…. All anyone ever needs to be great is appreciation, inspiration and motivation, and boy, does Youth Connect deliver. My brain was right: YCS has definitely changed my life." -9th grade program participant
	Trainings and consultations to school districts in social-emotional learning (SEL)	The HEARD Alliance SEL workgroup provided ongoing consultation and technical assistance to 14 school districts during FY23. Each district reflects unique starting points and progress which the workgroup tracked quarterly. See below for detailed progress and action items based on consultation and survey feedback. **District SEL Technical Support - District Progress**

Berryessa	Milpitas	Union
• **Q1** ○ Assist with 3 signature practices for leadership ○ Professional Development Day discussion • **Q2** ○ Met with district lead and discussed progress on previous PD day and options for the next professional day ○ Brief discussion providing suggestions for the Restorative Practices initiative (RP) ○ Participated in Meet & Greet RP launch 12/7 • **Q3** ○ Working with Piedmont MS in another capacity yet ensuring that we're highlighting the RP initiative in the Community Schools grant proposal ○ Getting permission from admin to have the HEARD Alliance support the Community Advisory Council being formed at PMS as pilot for the district w/in the Community Schools model ○ (3) participated in the two-day RP for Educator training January 18-19 ○ (3) Participated in the RP Convening on 3/17 connection at district MTSS Core Planning team • **Q4** ○ April 18-20 all day training with (2) principals and (1) school counselor in the Trainer of Trainer for RP for Educators ○ Support RP for Educators training for Berryessa Leadership team in June ○ Participation by (3) at the RP convening on 5/24 ○ Check in for support/email for support with training question/Met with Thomas Carrol- the new student services director ○ Survey participation for SEL TA ○ Survey participation for RP for Educators • **Tier 1 Needs for FY 24** ○ Meet with the new director/coordinator of Student Services to determine actual needs. ○ New director/coordinator would like to be added to the RP Cohort and train as a Training of Trainers (ToT) ○ Collaborating/collecting data/discipline matrix ○ Collaborate on evaluation process	• **Q1** ○ Discussed 3 signature practices observation tool ○ Created the observation tool and district is piloting it ○ Will support with Restorative Practices (RP)/Connect to trainer • **Q2** ○ Discussion providing suggestions for the RP initiative ○ Participation in 12/7 Meet and Greet for RP Launch • **Q3** ○ Planning for the RP Convening with ○ (3) participated in the RP Convening on 3/17 ○ Sharing staff trust building survey tools and resiliency materials • **Q4** ○ 4/18-4/20 all day RP for Educators Trainer of Trainer training for (1) administrator and (1) SLS Coordinator ○ Participation by (3) at the RP Convening on 5/24 ○ June 6-8 all day RP for Educator Trainer of Trainer training for (1) ○ Survey participation for SEL TA ○ Survey participation for RP for Educators • **Tier 1 Needs for FY 24** ○ Collaborating/collecting data/discipline matrix ○ Collaborate on evaluation process ○ Support with alignment of SEL/RP/PBIS ○ Support with district internal capacity building for Tier 1	• **Q1** ○ Discussion for SEL in district under unique challenges /trauma & recovery (staff & community grief, trust, overwhelm) ○ HEARD team discussing post-meeting - considering opportunities for HEARD ideas/support at Fall event • **Q2** ○ Thought processing Emailed parent resources • **Q3** ○ Invitation and participation in the 2-day RP for Educators training ○ Thought partners in planning for and debriefing the community health event ○ CHKS Data dive created (sharing asset-based results and possible applications for students, families and teachers) and has been shared (4/10/2023) • **Q4** ○ Support with building capacity in the district to support health and wellness ○ 5/30 & 6/2 email to plan Rotary connection ○ 6/28 met with Randy in person at morning Rotary meeting-introductions for Health & Wellness ○ Survey participation for SEL TA • **Tier 1 Needs for FY 24** ○ Identify and prioritize main areas in which they would like HEARD assistance - e.g. school structures, data sharing, RP, SEL, etc. ○ Utilize truncated TIPS tool to stay focused; track support and progress ○ Invite into the RP cohort

Sunnyvale	Cupertino	East Side
• **Q2** ○ Met to discuss SEL implementation in the district and requested that team share at the Professional Learning Network (PLN) ○ Created the PLN slide deck and integrated slides ○ Co-presented in the PLN • **Q3** ○ Email to offer space at RP for Educator training/declined • **Q4** ○ Brief discussion with Tasha Dean on 6/16 and connected her to a consulting resource to support with MTSS • **Tier 1 Needs for FY 24** ○ Schedule meeting with district leadership to identify goals and opportunities to support ○ Invite to the RP cohort	• **Q3** ○ Request to meet to discuss suicide prevention curriculum ○ Invitation/attended Health Advisory Committee ○ Email follow up with resource to support adult well-being • **Tier 1 Needs for FY 24** ○ Schedule meeting with district leadership to identify goals and opportunities to support ○ Invite to the RP cohort	• **Q1** ○ SCCOE attendance collaborative announcement regarding RP for Educator • **Q2** ○ 12/7 Meet & Greet RP Launch • **Q3** ○ Jan 18-19 RP for Educators training (3) ○ March 17th RP Convening (2) • **Q4** ○ April 18-20 RP for Educators Trainer of Trainers (2) ○ May 24th RP Convening (2) ○ (2) Trainings completed by TOTs in district ○ Survey participation for RP for Educators • **Tier 1 Needs for FY 24** ○ Meet with district team to assess needs (further progress) ○ Explore Kognito Friend2Friend opportunities (Alt Ed as well) ○ Collaborating/collecting data/discipline matrix ○ Collaborate on evaluation process ○ Explore presentation opportunity at RP symposium
Santa Clara Unified	**San Jose Unified**	**SCCOE**
• **Q1** ○ SCCOE attendance collaborative announcement regarding RP for Educators • **Q2** ○ 12/7 Meet & Greet RP Launch (3) • **Q3** ○ Jan 18-19 RP for Educators training (3) ○ March 17th RP Convening (3) • **Q4** ○ May 24th RP Convening (3) ○ June 6-8 RP for Educators Trainer of Trainers (3) ○ Survey participation for RP for Educators • **Tier 1 Needs for FY 24** ○ Schedule time to meet with district leadership to assess needs, goals, priorities ○ Collaborate on suicide prevention conference presentation ○ Collaborating/collecting data/discipline matrix ○ Collaborate on evaluation process	• **Q1** ○ SCCOE attendance collaborative announcement regarding RP for Educators/ Introduction through East Side • **Q2** ○ 12/7 Meet & Greet RP Launch (3) • **Q3** ○ Jan 18-19 RP for Educators training (3) ○ March 17th RP Convening (3) • **Q4** ○ May 24th RP Convening (3) ○ Training completed by TOTs in district ○ June 6-8 RP for Educators Trainer of Trainers (3) ○ Survey participation for RP for Educators • **Tier 1 Needs for FY 24** ○ Schedule time to meet with district leadership to assess needs, goals, priorities (All HEARD, Crisis Response and SEL/RP)	• **Q1** ○ Presentation at the Attendance collaborative • **Q2** ○ 12/7 Meet & Greet RP Launch (2) • **Q3** ○ Jan 18-19 RP for Educators training (3) ○ March 17th RP Convening (2) • **Q4** ○ April 18-20 RP for Educators Trainer of Trainers (2) • May 24th RP Convening (2) ○ Survey participation for SEL TA ○ Survey participation for RP for Educators • **Tier 1 Needs for FY 24** ○ Meet to clarify capacity for collaboration and intention around the work for FY24 ○ Collaborate on Restorative SARB process ○ Collaborating/collecting data/discipline matrix ○ Collaborate on evaluation process



	○ Collaborating/collecting data/discipline matrix ○ Collaborate on evaluation process	
Oak Grove	**Los Gatos Union**	**Gilroy**
• **Q1** ○ SCCOE attendance collaborative announcement regarding RP for Educators • **Q2** ○ Attendance at the Meet & Greet RP launch Dec. 7 • **Q3** ○ Jan 18-19 RP for Educators training w/ (2) participants ○ March 17 convening participation (2) ○ May 2-4 RP for Educators Trainer of Trainers (2) • **Q4** ○ May 24th RP convening participation ○ Connection to Moreland for RP implementation resources ○ Survey participation for RP for Educators • **Tier 1 Needs for FY 24** ○ Schedule time to meet with district leadership to assess needs, goals, priorities ○ Email introduction to Crisis Response Team ○ Collaborating/collecting data/discipline matrix ○ Collaborate on evaluation process	• **Q1** ○ Assist/research success resources for SEL/parenting section in Wellness Center; Will reassess for evaluation, direction and degree of support next quarter • **Q2** ○ Created and shared a resource list specific to her parent section in the *Wellness Center*. Curating from a list of over 40 books to recommend. ○ Attended the Meet & Greet for RP launch on 12/7 • **Q3** ○ Jan 18-19 RP for Educators Training for (3) participants ○ Brief meeting to deliver materials from the RP training ○ Planning for the RP Covening ○ Participation in the RP Convening March 17th • **Q4** ○ 4/18-4/20 (3) participants in the RP for Educators Trainer of Trainer training ○ May 5th RP convening planning input ○ Participation of (3) in the RP Convening on May 24th ○ Two day RP for Educators training provided in June to district early adopters of RP by the LG team ○ Survey participation for SEL TA ○ Survey participation for RP for Educators • **Tier 1 Needs for FY 24** ○ Meet with leadership to identify main goals we can support with ○ Collaborating/collecting data/discipline matrix ○ Collaborate on evaluation process ○ Explore opportunity on Positive Community Norms linkage & support (Montana Institute contract with LGUSD)	• **Q1** ○ District rep reached out to discuss support with grant to further MTSS work ○ Run through Restorative Justice plan for the school year • **Q2** ○ Sent resources after child death • **Q3** ○ January 20th PD for (15) school counselors on compassion fatigue and resiliency - Evaluation Results ○ Offer of support provided 4/18 & 4/20 • **Q4** ○ Request from Brownell counselor Carlos Trujillo for YMHFA training ○ Completion of the Romeo & Juliet project-facilitated connection between Gilroy High School and Dr. Steve Sust and Ivan Rodriguez. See the Romeo and Juliet Project report drafted and facilitated by Dr. Steve Sust and Ivan Rodriguez- It articulates the connection of SEL and Suicide Prevention. • **Tier 1 Needs for FY 24** ○ Leverage *Romeo & Juliet* project to support crisis response protocols/ Kognito Friend2Friend/ SEL/ RP ○ Invite to the RP convenings
Moreland	**Evergreen**	
• **Q1** ○ SCCOE attendance collaborative announcement regarding RP for Educators • **Q2** ○ Attendance at the Meet & Greet RP launch Dec. 7 • **Q3** ○ Series of emails for logistics RP for Educators training as host and for participant list ○ Hosted/attended the RP for Educators 2-day training ○ Attended the RP Convening (3) participants ○ Meeting with HEARD 2/15 to discuss alignment of initiatives ○ Request for additional support at district w/alignment ○ 3/17 (2) attended the RP Convening • **Q4** ○ Met with future Principal and future AP (Theresa and Yonit) - strategized approaches to help district/schools stay/move toward prevention vs reactive stage to address increases in school avoidance, turnover in leadership; discussed available data sources and creative use of student data to message, reinforce/increase trust and connection; focused on "structures" (existing and future) that could improve effectiveness, connection and fidelity to SEL, increase PCEs, etc.; shared outstanding, local social media resources for presentations to students and parents. ○ May 2-4 (2) participants in the RP for Educators Trainer of Trainers training ○ 5/24 (2) participants in the RP Convening ○ 5/25 emailed introduction to Oscar Ortiz at Oak Grove and Yonit Parenti at Moreland to share resources for RP training ○ Survey participation for SEL TA ○ Survey participation for RP for Educators • **Tier 1 Needs for FY 24** ○ Schedule time to meet with new district leadership to assess needs (Crisis Response and SEL/RP) ○ Get regular meetings on the calendar ○ Onboard new district leadership into RP cohort ○ Collaborating/collecting data/discipline matrix ○ Collaborate on evaluation process	• **Q1** ○ SCCOE attendance collaborative announcement regarding RP for Educators • **Q2** ○ 12/7 Meet & Greet RP Launch (3) • **Q3** ○ Jan 18-19 RP for Educators training (3) ○ March 17th RP Convening (3) • **Q4** ○ April 2-4 RP for Educators Trainer of Trainers (1) ○ May 24th RP Convening (2) ○ June 6-8 RP for Educators Trainer of Trainers (2) ○ Survey participation for RP for Educators • **Tier 1 Needs for FY 24** ○ Schedule time to meet with district leadership to assess needs, goals, priorities ○ Collaborating/collecting data/discipline matrix ○ Collaborate on evaluation process	

9. Evaluation Summary

The Suicide Prevention Program has a robust data and evaluation system and continues to strive to improve its data collection and program evaluation designs. Comments on each program objective follow below. The Program also engages in some meaningful work that is not currently evaluated or does not lend itself to formal

program evaluation; for example, its nascent hanging means safety efforts, and various city and departmental policy efforts (described in Section 8). In the coming year, additional data and evaluation work will be done to merge logic models with the Substance Use Prevention Services program, to form one logic model for the Prevention Services Division.

Objective 1: Strengthen community suicide prevention and crisis response systems

Schools: Encouraging and tracking progress among schools' suicide prevention and crisis response systems remains an ongoing challenge. On review of the evaluation results, the Program is interested in further improving tracking and reporting from school districts, particularly who from school districts and sites are participating in training and consultations, their level of commitment, and gathering self-assessment from the districts gauging their own progress in this work. The Program may also begin gathering qualitative data that may help to paint a fuller picture of the progress made at school districts.

Health systems: While some needs, gaps, and strengths appeared to be shared across sites, the structural and operational differences among sites meant that custom-built consultation work was necessary in order to even attempt change to strengthen suicide prevention services. While this level of customized consultation is high-touch work requiring very broad expertise, the model of detailed and customized, specialized-expertise consultation is effective in bringing about system-level change that is already positively impacting patient care and suicide risk management in the County.

Critical Incident Response Management: While pre-/post-training data shows statistically significant improvements in preparedness to provide grief support services, the wording of the training evaluation measures may need to be refined, in order to produce clearer/more precise results.

2: Increase use of mental health services

The program's trainings and public awareness campaigns have the strongest evaluation designs in place, and the community helper trainings offered consistently produce statistically significant improvements in the eight measures of interest. The Program may implement follow-up surveys to the trainings in order to better understand whether training effects are sustained over time and continue to compare the effectiveness of individual trainings.

3: Reduce access to lethal means

N/A (discussed above and in prior sections)

4: Improve safe messaging in the media about suicide

The Program continues to brainstorm ways to use evaluation data to improve its safe messaging efforts. Suggestions include polling or personally asking reporters why they responded to media monitoring messages sent to them by the Program, and increasing the number of survey respondents for safe messaging training evaluations. The follow-up evaluation using TEMPOS will also be completed in FY24 and will provide valuable information for program improvements.

(Activities funded by Substance Abuse Block Grant Prevention funds)

5: Improve social-emotional skills and resiliency

6: Increase connectedness and sense of purpose

This fiscal year's initial outcomes data indicates that the youth activities appear to be beneficial, particularly in strengthening some important protective factors such as internal coping skills, personal agency, willingness to seek help, and connectedness. However, survey response was low and so limited conclusions could be drawn from the data. For FY24, lessons learned from this year's piloting of survey instruments will be used to:

i. Blend surveys into one common instrument for all ages;
ii. Shorten the length to encourage greater participation;
iii. Focus on change in protective factors, as they are best aligned with the scope of programming;
iv. Feature a retrospective pre-post design to allow for greater analytical capabilities with post-only surveys;

v. Include qualitative, free-response items to encourage more feedback from participants in their own words about the impact of programming on their lives.

988 – Crisis And Suicide Prevention Lifeline

PEI Suicide Prevention Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Crisis and suicide prevention lifeline provides 24/7, toll-free, confidential phone line to help people in crisis, provide emotional support, suicide prevention, crisis intervention, and referrals to resources. Services are provided to the entire Santa Clara County community.

2. Program Indicators

988- Crisis and Suicide Prevention Lifeline assists individuals in an emotional or suicidal crisis by defusing and de-escalating the crisis and helping to return the individual to their usual level of functioning, connecting them with resources, and preventing suicide.

3. Program Goals, Objectives & Outcomes

❖ **Goal:**

i. Reduce mental/emotional crisis and prevent suicide in Santa Clara County

❖ **Objectives:**

i. Provide 24/7 suicide and crisis hotline to individuals in emotional or suicidal crisis

❖ **Outcomes:**

i. Crisis individuals returned to their usual level of functioning.
ii. Individuals in crisis get connected to resources for ongoing support.

4. Clients Served & Annual Cost per Client Data

FY 2023		
Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
56,843	**Refer to Cover Page**	**Refer to Cover Page**

5. Evaluation Activities

National 988 Suicide and Crisis Lifeline and the State closely monitored each of the 988 crisis centers by their monthly Key Performance Indicators (KPIs) including percentage of total call answer rate, average time call answered in seconds, call abandon (caller hang up) rate, and call rollover rate to back up crisis centers.
The State requires 988 call answer rate at 90%, 95% of calls answered are within 20 seconds, call abandon rate at 5% or lower, and call rollover rate at 5% or lower.
When 988 became effective in July 2022, Santa Clara County's 988 call answer rate was at 78%, average call answer time was 20 seconds, call abandon rate was at 7%, and call rollover rate was at 15%.
Santa Clara County's 988 crisis and suicide Prevention Lifeline developed and implemented call script to assist crisis counselors to assess callers' crisis risk early in the call and determine level of support accordingly. In addition, the County also increased staffing capacity by approved hiring of 9 additional full-time counselors for the crisis line. By June 2023, Crisis and Suicide Prevention Lifeline's call answer rate increased to 95%, average call answer time was at 8 seconds, call abandon rate was at 4%, and rollover rate was at 1%

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 5 years	83	.23%
6 -17 years	176	.49%
17- 25 years	1,702	4.8%
26+ years	2,932	8.2%
Prefer not to state	N/A	N/A
Unknown	30,914	86%
Unduplicated Total	35,807	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	7	0%
Asian	1987	5.5%
Black or African American	252	.7%
Native Hawaiian or Other Pacific Islander	6	0%

White/ Caucasian	2701	7.5%
Hispanic	770	2.2%
More than one race	No data	0%
Prefer not to answer	No data	0%
Unknown	30,078	84%
Unduplicated Total	35,807	100%

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:	770	2.2%
Caribbean	No Data	No Data
Central American	No Data	No Data
Mexican/ Mexican-American/ Chicano	No Data	No Data
Puerto Rican	No Data	No Data
South American	No Data	No Data
Hispanic/ Latino (undefined)	No Data	No Data
Other Hispanic/ Latino	No Data	No Data
Hispanic or Latino Subtotal	770	2.2%
Non-Hispanic or Non-Latino as follows:		
African	No Data	No Data
Asian Indian/ South Asian	No Data	No Data
Cambodian	No Data	No Data
Chinese	145	.4%

Eastern European	No Data	No Data
European	No Data	No Data
Filipino	2	0%
Japanese	No Data	No Data
Korean	1	0%
Middle Eastern	No Data	No Data
Vietnamese	126	.3%
Non-Hispanic/ Non-Latino (undefined)	No Data	No Data
Other Non-Hispanic/ Non-Latino	No Data	No Data
Non-Hispanic or Non-Latino Subtotal	274	.77%
More than one ethnicity	No Data	No Data
Prefer not to answer	No Data	No Data
Unknown	No Data	No Data
Unduplicated Total	35,807	100%

	FY 2023	
Gender (current)	**# Served**	**% of Served**
Male	6792	25.1%
Female	10,394	38.5%
Prefer not to answer	No Data	No Data
Unknown	9,785	36.2%
Unduplicated Total	26,971	100%

	FY 2023

Sexual Orientation	# Served	% of Served
Gay or Lesbian	No Data	No Data
Heterosexual/ Straight	No Data	No Data
Bisexual	No Data	No Data
Questioning/ Unsure	No Data	No Data
Queer	No Data	No Data
Another sexual orientation	No Data	No Data
Prefer not to answer	No Data	No Data
Unknown	No Data	No Data
Unduplicated Total	No Data	No Data

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	34,941	59%
Spanish	595	14%
Vietnamese	126	1%
Chinese	145	0%
Tagalog	No Data	No Data
Farsi	No Data	No Data
Other	No Data	No Data
Prefer not to answer	No Data	No Data
Unknown	No Data	No Data
Unduplicated Total	35,707	100%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	No Data	No Data
Veteran	No Data	No Data
Served in Military	No Data	No Data

Family of Military	No Data	No Data
No Military	No Data	No Data
Prefer not to answer	No Data	No Data
Unknown	No Data	No Data
Unduplicated Total	No Data	No Data

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability		
No Disability		
Prefer not to answer		
Unknown		
Unduplicated Total		

*Participants may choose more than one option for Disability.

7. Group Services Delivered

N/A

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
0	N/A	N/A

8. Evaluation Summary

When AB 988 became effective in July 2022, Santa Clara County Crisis and Suicide Prevention Lifeline (CSPL) experienced some challenges implementing 988 with required Key Performance Indicators (KPIs) ie. call answer rate at 90%, 95% of calls answered within 20 seconds, call abandon rate at 5% or lower, and call rollover rate at 5% or lower. CSPL then implemented 988 call script and retrained crisis counselors to assess mental health and suicide risk early in the call to determine risk level and then proceed to provide support accordingly. CSPL also

requested for additional staffing support was approved for 9 full time counselors. These efforts helped improved 988 operations significantly. CSPL currently meets all KPIs requirements.

Because 988 calls are routed by area codes (only callers with area code 408, 669, and 650 are routed to our local 988 center) rather than geo-location, many of Santa Clara County callers were routed to out of County's crisis centers. As a result, Santa Clara County Behavioral Health Services Department not only promoted 988 for mental health and suicide crisis but also a workaround by promoting 1-800-704-0900, press #1.

In addition, Santa Clara County CSPL-988 is part of California's 988 crisis center collaborative, we encouraged other CA's 988 centers to redirect/transfer calls back to our local crisis centers once determined the callers are from Santa Clara County.

IMPROVE TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATION PROGRAMS

Culture Specific Wellness Centers

PEI Improve Timely Access to Services for Underserved Populations Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2022 (JULY 1, 2021 – JUNE 30, 2022)

1. Program Description

Culture-Specific Wellness Centers offer space for un-, under-, and inappropriately served groups to gather and participate in community caregiving and healing. Wellness Centers are designed specifically for Latino, African American, LBGTQ+, Asian/Pacific Islander, and Native American populations and communities. Wellness Centers offer low-barrier access to mental health services, community building and culture-specific practices, and other recovery-oriented activities. Understanding that some populations have historically faced discrimination from government or mental health systems, Wellness Centers focus on building trust between the community and service providers. Unlike traditional Medi-Cal authorized services, Wellness Centers operate with an open-door policy. Clinical mental health services are co-located in the Centers with non-clinical cultural activities and programs. Individuals participating in these non-clinical cultural activities and programs are welcome to participate without limit.

Wellness Centers are culture-specific, embracing healing practices that may not necessarily be a part of un-, under-, and inappropriately served communities. Activities may include addressing the trauma related to immigration, family disruptions in LGBTQ+ communities, and healing circles. There are age-specific activities for youth, adults, and older adults. Additionally, opportunities for intergenerational sharing are encouraged. Wellness Centers recognize that a different kind of healing may occur when other age groups come together to talk about stress, trauma, and self-care.

One of the Culture-Specific Wellness Center's goals is to increase access to ethnic and culturally reflective, strength-based behavioral health treatment services, including outreach, education, and preventive counseling. Another goal is to build behavioral health PEI services capacity at a site where people go for other routine activities. A third goal is to ensure early access to behavioral health services to lower the incidence of behavioral health-related illness and suicide, enhance wellness, resilience while reducing stigma and discrimination.

2. Program Indicators

Outreach within the community to provide timely access to available services. This decreases prolonged suffering and suicide. By meeting individuals in the communities they congregate in, increasing the probability of receiving the services they need the first time.

3. Program Goals, Objectives & Outcomes

A variety of healing services, community engagement activities, and health education occurs specifically designed and implemented for specific cultural communities.

❖ Goals:

i. Increase access to ethnic and culturally reflective, strength-based behavioral health treatment services, including outreach, education, and preventive counseling.
ii. Build individual, community, and organizational capacity, knowledge, and skills that contribute to the prevention of behavioral health disorders.
iii. Decrease stigma and discrimination toward individuals experiencing behavioral health issues.
iv. Increase collaboration with community stakeholders and organizations to serve ethnic and culture specific communities identified in the target population.

❖ Objectives:

i. Behavioral health culture-based educational workshops on issues that focus on common responses to life stressors and education on benefits of behavioral health services;
ii. Psycho-educational workshops and drop-in support groups that address client/family behavioral health and various wellness topics;
iii. Outreach and education activities in community settings, such as childcare settings school community centers, and faith-based organizations;
iv. Referral and positive linkage to appropriate behavioral health services;
v. Delivery of outreach and education to hard-to-reach segments of the unserved and underserved community (e.g., home visits to reach isolated clients and family members); and
vi. Active and continuous promotion of services through various multilingual resource guides, newsletters, and social media platforms, etc., within communities and behavioral health organizations in Santa Clara County.

❖ Outcomes:

i. Provide un-, under-, and inappropriately served groups space for community caregiving
ii. Organize age-specific and intergenerational activities
iii. Encourage culture-specific forms of healing

❖ Additional objectives for American Indians/Alaskan Natives:

i. Serve as an access point where American Indians/Alaskan Natives individuals can receive culturally proficient referrals and services.
ii. Promote a holistic approach by addressing physical health, emotional, and spiritual well-being through collaboration with both mainstream and traditional health care providers.
iii. Reduce barriers to care through outreach and community gatherings including: Historical Trauma Conference, round dance, Honoring Sobriety Powwow, and dance presentations.
iv. Organize traditional dancing events, arts and crafts, ceremonies, and gatherings to identify and address early onset of behavioral health issues, counter stressors, and help clients build self-esteem and coping skills.
v. Evaluation Activities

4. Clients Served & Annual Cost per Client Data

FY 2022

Unduplicated N =		
Number Served	Program Expenditure	Cost per Person
Total- 57,565 197 – Indian Health Center 8379 – Mekong 8473 – Gardner African Descent 40,516 – Gardner Latino/Hispanic	**$1,170,938**	**$20.34**

5. Evaluation Activities

The Culture-Specific Wellness Centers program was designed to help create access and linkage to behavioral health services to raise mental health awareness empower individuals to take charge of their health and well-being and improve quality of life. The centers are committed to providing outreach to the community via phone call, online or in public in order to provide information and assistance that is needed to improve the well-being of all individuals and families in the community, especially those who come from disadvantaged backgrounds such as Latinos and African Descendent families who may not have the resources that they need. The Culture-Specific Wellness Centers have a monthly calendar that individuals can access and see the days/times of upcoming and future workshops/events. The center also has social media platforms such as Facebook, Link tree and Instagram's, making it more accessible for phone users. The Culture-Specific Wellness Centers are committed to meeting community members in their own places of socialization where they feel safe to receive that information and resources that we have to support them in improving their wellbeing and increase our efforts in reach out to all individual in the community. Those social media pages provide updates and remind views of workshops and event as well, along with detailed flyers. The Culture-Specific Wellness Centers also collaborate with other organizations such as other community nonprofit agencies and schools to further their commitment with outreach. The centers focus on building meaningful relationships with local organizations in order to increase future opportunities for collaboration. In-Person outreach allows staff to engage and listen to individuals in the community. Through this, staff is able to provide instant support, resources, and assist with referrals if needed. The Culture-Specific Wellness Center continues to push its outreach efforts in various ways in order to reach out to as many individuals as possible and will continue to work on accessibility. The center understands collaboration, team works, and use of social media platforms are all vital in helping to build and create a stronger and healthier community. The Culture-Specific Wellness Centers take on a practice-based approach since they are constantly finding ways to improve services and community outreach. The center understands and acknowledges personal hardships that many individuals go through, such as long works hours, taken care of young children, house chores, and other life responsibilities that makes it difficult and time for personal needs and self-care. Providing weekend outreach once or twice a month has proven to be effective. This allows the wellness center to bring its services and support to the community, through monthly tracking/data, outreach numbers have helped to improve the number of 838 individuals that the center can reach. In addition, the center utilizes participants' feedback through post surveys that helps us improve and provide services based in our community needs.

6. Demographic Data

	FY 2022

Age Group	# Served	% of Served
0 – 15 years	*26130*	*45%*
16 -25 years	*8557*	*15%*
26- 59 years	*16875*	*29%*
60+ years	*4197*	*7%*
Prefer not to answer	*37*	*0%*
Unknown	*1358*	*2%*
Unduplicated Total	*57565*	*100%*

	FY 2022	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	*135*	*0.2%*
Asian	*5360*	*9.3%*
Black or African American	*8576*	*14.9%*
Native Hawaiian or Other Pacific Islander	*211*	*0.4%*
White/ Caucasian	*564*	*1.0%*
Other	*42304*	*73.5%*
More than one race	*201*	*0.3%*
Prefer not to answer	*46*	*0.1%*
Unknown	*1372*	*2.4%*
Unduplicated Total	57565	100%

	FY 2022	
Ethnicity	**# Served**	**% of Served**

Hispanic or Latino:		
Caribbean	*43*	*0.1%*
Central American	*7177*	*12.5%*
Mexican/ Mexican-American/ Chicano	*22866*	*39.7%*
Puerto Rican	*135*	*0.2%*
South American	*11462*	*19.9%*
Hispanic/ Latino (undefined)	*70*	*0.1%*
Other Hispanic/ Latino	*225*	*0.4%*
Hispanic or Latino Subtotal	*41978*	*72.9%*
Non-Hispanic or Non-Latino as follows:		
African	*8483*	*14.7%*
Asian Indian/ South Asian	*517*	*0.9%*
Cambodian	*88*	*0.2%*
Chinese	*1281*	*2.2%*
Eastern European	*0*	*0.0%*
European	*59*	*0.1%*
Filipino	*396*	*0.7%*
Japanese	*16*	*0.0%*
Korean	*0*	*0.0%*
Middle Eastern	*8*	*0.0%*
Vietnamese	*3191*	*5.5%*
Non-Hispanic/ Non-Latino (undefined)	*32*	*0.1%*
Other Non-Hispanic/ Non-Latino	*841*	*1.5%*

Non-Hispanic or Non-Latino Subtotal	*14930*	*25.9%*
More than one ethnicity	*214*	*0.4%*
Prefer not to answer	*93*	*0.2%*
Unknown	*1554*	*2.7%*
Unduplicated Total	*57565*	*100.0%*

	FY 2022	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	*27917*	*48.5%*
Female	*29295*	*50.9%*
Prefer not to answer	*15*	*0.0%*
Unknown	*1542*	*2.7%*
Unduplicated Total	*57565*	*100.0%*

	FY 2022	
Gender (Current)	**# Served**	**% of Served**
Male	*27880*	*48.4%*
Female	*29288*	*50.9%*
Transgender (Male to Female)	*37*	*0.1%*
Transgender (Female to Male)	*42*	*0.1%*
Transgender (Undefined)	*0*	*0.0%*
Genderqueer	*31*	*0.1%*
Questioning or Unsure	*0*	*0.0%*
Another gender identity	*7*	*0.0%*
Prefer not to answer	*26*	*0.0%*
Unknown	*1458*	*2.5%*
Unduplicated Total	*57565*	*100.0%*

	FY 2022	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	*1994*	*3.5%*
Heterosexual/ Straight	*49538*	*86.1%*
Bisexual	*14*	*0.0%*
Questioning/ Unsure	*0*	*0.0%*
Queer	*2*	*0.0%*
Another sexual orientation	*159*	*0.3%*
Prefer not to answer	*334*	*0.6%*
Unknown	*6728*	*11.7%*
Unduplicated Total	*57565*	*100.0%*

	FY 2022	
Primary Language	**# Served**	**% of Served**
English	*18419*	*32.0%*
Spanish	*34786*	*60.4%*
Vietnamese	*2278*	*4.0%*
Chinese	*968*	*1.7%*
Tagalog	*264*	*0.5%*
Farsi	*0*	*0.0%*
Other	*375*	*0.7%*
Prefer not to answer	*13*	*0.0%*
Unknown	*1665*	*2.9%*
Unduplicated Total	*57565*	*100.0%*

	FY 2022	
Military Status	**# Served**	**% of Served**
Active Military	2	0.003%
Veteran	21	0.04%

Served in Military	0	0.0%
Family of Military	1	0.002%
No Military	5619	9.8%
Prefer not to answer	62	0.1%
Unknown	53064	92.2%
Unduplicated Total	57565	100.0%

	FY 2022	
Disability*	**# Served**	**% of Served**
Difficulty seeing	*3*	*0.0%*
Difficulty hearing or speaking	*1*	*0.0%*
Other communication disability	*16*	*0.0%*
Cognitive	*34*	*0.1%*
Physical/ Mobility	*4*	*0.0%*
Chronic Health Condition	*34*	*0.1%*
Other non-communication disability	*0*	*0.0%*
No Disability	*56091*	*97.4%*
Prefer not to answer	*60*	*0.1%*
Unknown	*2822*	*4.9%*
Unduplicated Total	*57565*	*100.0%*

*Participants may choose more than one option for Disability.

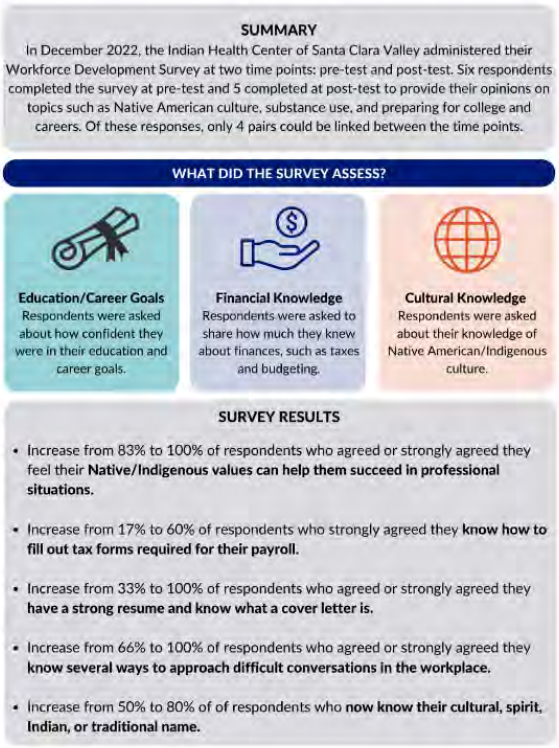
7. Referrals

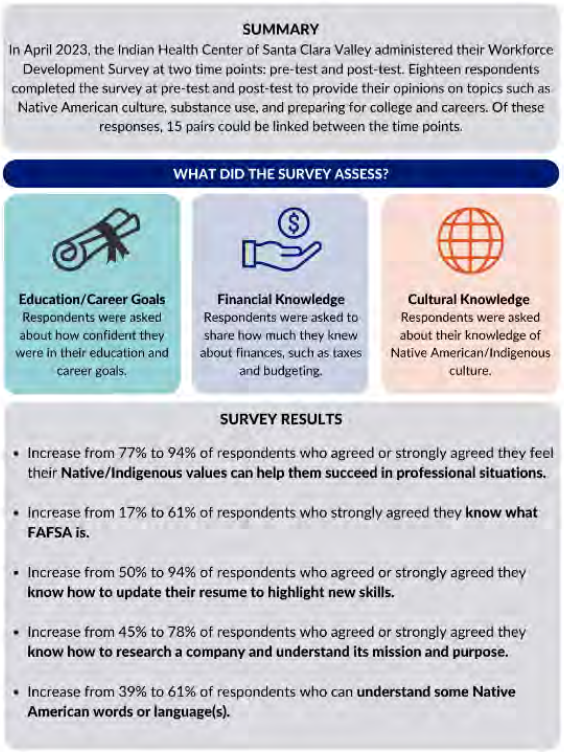
FY 2022				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or

treatment that is not)				overseen by county mental health)
5882	Counseling Housing Immigration Legal Services VASC Social Security VTA Social Worker	Not Available	Not Available	Not Available

8. Detailed Outcomes

❖ Indian Health Center





❖ Successes:

In September 2022, the Traditional Song and Dance Class hosted a Culture is Prevention Powwow to formally announce the return to in-person program at the Roosevelt Community Center. The outreach of this event was successful as there were 71 new participants that joined the program.

The Indian Health Center of Santa Clara Valley hosted a Healing of Healers workshop with 41 participants in October 2022.
Youth Workforce Development social media outreached successfully to 22 high school students and had 17 youth workforce development participants this year.
In May 2023, the Indian Health Center of Santa Clara Valley hosted the American Indian Graduation to congratulate and honor American Indian/Alaska Native students graduating and promoting to all grade levels from K-PhD. There were over 105 attendees at this event at San Jose City Hall.

- **Client Experiences and relevant examples of impact:**

Community members posted on social media that they were happy the American Indian Graduation was back and showed gratitude for the event. One mother thanked a staff member for the programs that are offered at the Indian Health Center of Santa Clara Valley specifically the Youth Group and Youth Workforce Development Program, because she noticed a change in her son that had graduated high school. She noticed an improvement throughout the years in his grades, his socialness, his confidence, and mental health.
With the help of their families, friends, and staff, two youth dancers from the Traditional Song and Dance Class prepared their regalia for their coming out, a powwow tradition for new dancers, at the Santa Clara and Stanford Powwows.
One of the dance class participants got an internship with the BAAITS Two Spirit powwow. She interviewed elders and helped at the powwow.

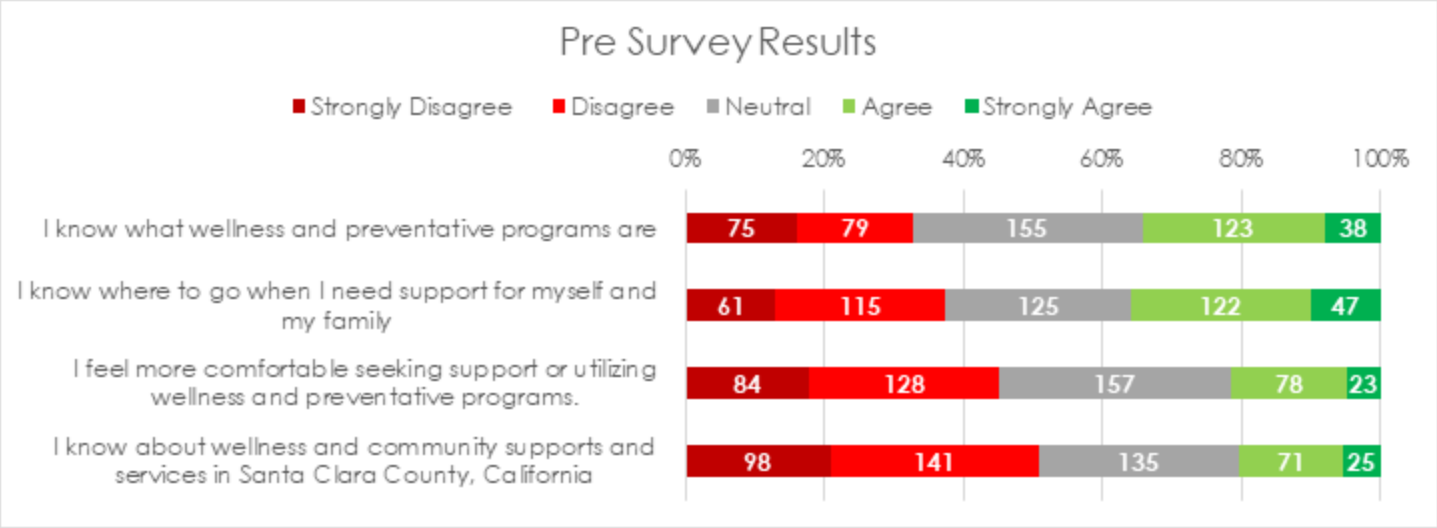
- **Mekong**

In the past, the wellness center was unable to collect as many surveys/feedback as it had intended to. The center is still in the process of developing strategies to enhance the quality of its post-survey to be given out via email and in-person. This will help increase accessibility and feedback. The wellness center understands the importance of having surveys to track outcomes and quality of services to meet participants' interests and needs. The center plans to use its new and improved survey beginning July 2023 and focus more on collecting significant data that will help to better understand the community and its needs.

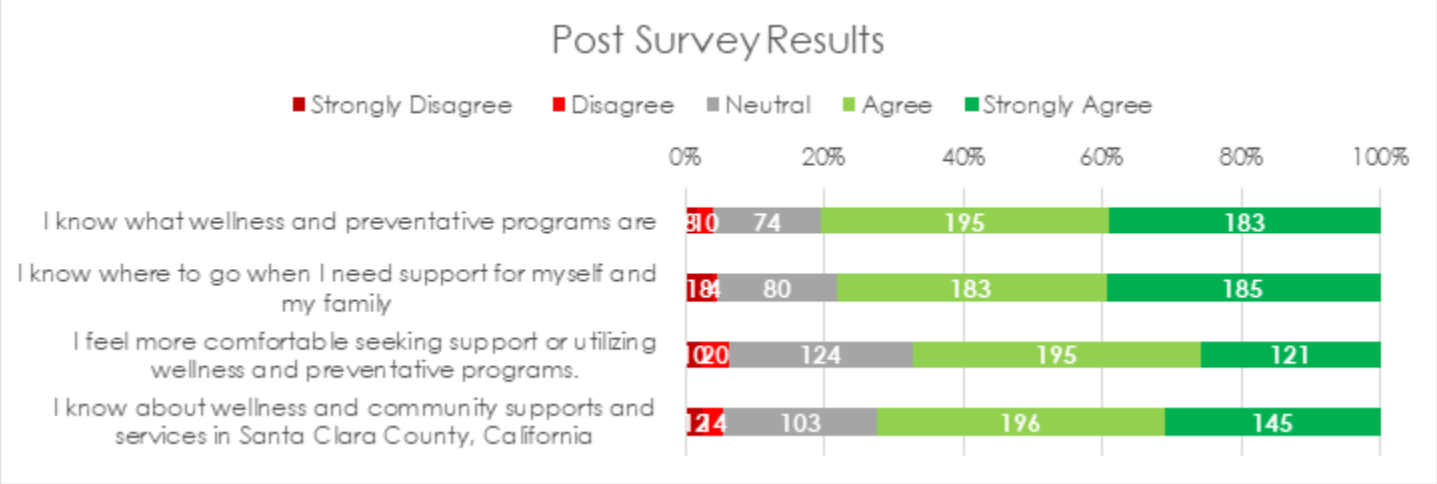
As mentioned, the center experienced a slowdown in workshops and resource events due to surpassing its goal earlier this year, but the team has been resourceful with their time and has worked on how to better collect data that will show the center's service and success. The wellness team plan to use an iPad that will display a survey (with Vietnamese translation) with is also thinking about having a comment box for all workshops and events for community members to share their experience/input. The wellness Center will work to improve its efforts with post-surveys to increase the number of responses from all participants, whether from workshops or public events, to gather sufficient feedback and help to build a successful wellness center for the community.

- **Gardner**
  - **African American**

Question – Pre Survey	Never (0 times a week)	Sometimes (1-4 times a week)	Regularly (5+ times a week)
In the last week, my family and I participated in wellness activities and programs	68.34%	24.89%	6.77%



Question – Post Survey	Never (0 times a week)	Sometimes (1-4 times a week)	Regularly (5+ times a week)
In the last week, my family and I participated in wellness activities and programs	20.43%	46.81%	32.77&

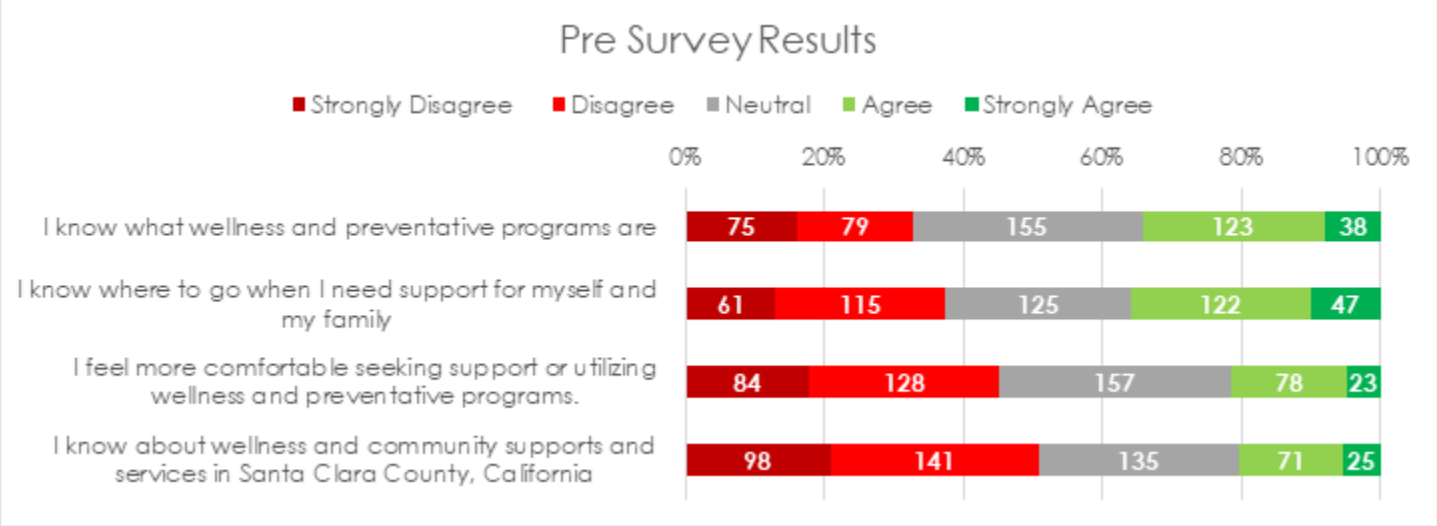


Question	Pre Survey - % Participants who Strongly Agree or Agree	Post Survey - % Participants who Strongly Agree or Agree	% Point Change
I know what wellness and preventative programs are	26.17%	41.49%	15.32%
I know where to go when I need support for myself and my family	25.96%	38.94%	12.98%
I feel more comfortable seeking support or utilizing wellness and preventative programs.	16.60%	41.49%	24.89%
I know about wellness and community supports and services in Santa Clara County, California	15.11%	41.70%	26.60%

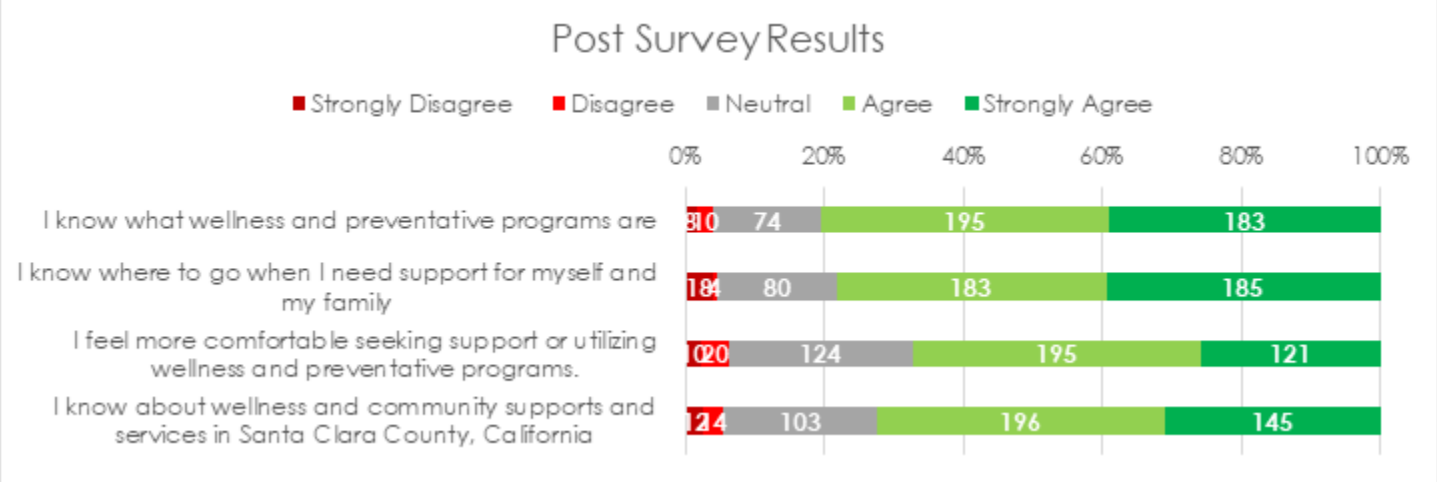
***Survey was completed by 470 clients

- **Latina/Hispanic**

Question – Pre Survey	Never (0 times a week)	Sometimes (1-4 times a week)	Regularly (5+ times a week)
In the last week, my family and I participated in wellness activities and programs	68.34%	24.89%	6.77%



Question – Post Survey	Never (0 times a week)	Sometimes (1-4 times a week)	Regularly (5+ times a week)
In the last week, my family and I participated in wellness activities and programs	20.43%	46.81%	32.77&



Question	Pre Survey - % Participants who Strongly Agree or Agree	Post Survey - % Participants who Strongly Agree or Agree	% Point Change
I know what wellness and preventative programs are	26.17%	41.49%	15.32%
I know where to go when I need support for myself and my family	25.96%	38.94%	12.98%

I feel more comfortable seeking support or utilizing wellness and preventative programs.	16.60%	41.49%	24.89%
I know about wellness and community supports and services in Santa Clara County, California	15.11%	41.70%	26.60%

***Survey was completed by 470 clients

9. Evaluation Summary

Although the wellness center provides services within its field of knowledge, it strives to learn/understand how to better support the community with needs that are not offered at the center. Staff have and will continue to join webinars, workshops, or special training so that they are more knowledgeable about the issues that many community members are facing. Although staff may not have all the answers, they continue to advocate for these individuals through support and help them to find the right resources. AOA Wellness Centers will continue to push its efforts in community outreach, partnership/collaboration with local organizations, and work on accessibility so that community members receive the support that they deserve. Most importantly, it will continue to spread mental health awareness, especially within the ethnic specific community, work relentlessly to eliminate the stigma and increase timely access to services.

MHSA ADMINISTRATION

Community Outreach and Education on Mental Health Rights And Resources Project

PEI Program

PREVENTION & EARLY INTERVENTION (PEI) 1-YEAR EVALUATION REPORT DATA: FY2023 (JULY 1, 2022 – JUNE 30, 2023)

1. Program Description

Description: The Mental Health Parity Project is a county-driven initiative, dedicated to educating the community about mental health, mental health resources, and how individuals can access the mental health services that they need. Collaboratively developed with the Santa Clara County Mental Health Parity Work Group, including the National Alliance on Mental Illness (NAMI) Santa Clara County and Bay Area Legal Aid, the project seeks to increase knowledge and awareness on mental health conditions, how to recognize signs and symptoms and the array of resources are available to access care specific to an individual's need or circumstance. The project also supports early intervention and improve access by fostering knowledge and awareness in the community on one's rights to mental health care, including mental health parity laws and regulations, and the steps people can take if they encounter issues accessing care. Education and outreach related to changes in recent laws and regulations related to mental health parity are critical for the community as this will assist with improving access and engagement into mental health services. Many community residents continue to request information on available mental health services and how to access services. Education and outreach related to mental health parity law will support acquisition of knowledge and information related to mental health services.

Project implementation started January 2023. After a need for community outreach and education, and tools to navigate accessing care, was identified by a group of stakeholders, a mid-year adjustment was made so that a project could be developed that could address these needs.

Community outreach and education is provided through presentations online and virtually for wide reach. Presentations, tools, and resources provided to the general public and staff members of community based organizations help individuals who may be experiencing a mental health condition, family/friends who's loved one might be living with a mental health condition, or members of the community who might serve as resource in their work or community navigate access to mental health care or steps and important timelines if facing issues with their care or accessing care.

- **Phases for the project are as follows:**

Phase I: Project and resources/tool development.

i. Key stakeholders provide insights into gaps in access to mental health care, how to address these gaps, and define key focus areas to develop framework for outreach and education to the community and specific target groups.
ii. Development materials of education materials (presentation and tools) through testing and stakeholder feedback.
iii. Outreach workplan and identification of target groups.

Phase II: Launch of outreach/ education and expansion.

i. Launch of outreach and education in the community through presentations.
ii. Expand outreach and education via partnerships, including contract with nonprofit partner NAMI- Santa Clara County.
iii. Expand outreach and education via development of a website to host resources, recording/posting the presentation, translation of materials into different languages and promotion of events, materials, and messaging via other channels such as newsletters and social media.

Phase III: Outreach/education continuation and expansion to additional groups and communication channels.
i. Continue outreach/ education to general public and community-based organizations.
ii. Modify materials to reach specific target groups such as parents and employers amongst others.
iii. Make resources and presentation available to diverse audiences through translated materials and presentation recording in multiple languages.
iv. Additional activities to expand outreach and education to be determined.

Status: Continuing (roll-over/ extension to FY 24)
Service Category: PEI- Prevention

2. Program Indicators

The County of Santa Clara Health System partnered with Bay Area Legal Aid and NAMI- Santa Clara County to conduct outreach and education for the Mental Health Parity Project through in-person and virtual educational presentations. Collaborative partnerships with organizations, such as the Santa Clara County Libraries, community-based service organizations and city libraries, help extend outreach countywide. The partners are assisting with the launch of educational activities at many locations across Santa Clara County, making information available and accessible to local communities.

Engagement of these and other trusted partners in the community provides unique opportunities to not only extend reach into the community but also strongly seed subsequent efforts with a variety of groups and diverse populations. In addition, utilizing a variety of touch points such as in-person and virtual sessions, online resources, recorded presentations, organizational newsletters, and social media, allowed the project to solidify strategies to connect the community through a variety of communication channels and extend reach to people who can access the information and resources provided; thereby increasing the likelihood that the community and individuals will be equipped with the tools and information necessary to identify mental health disorders early, know how to access mental health care and what resources are available to support, and to help navigate any challenges they may have accessing the care they or their loved ones need in order to ensure timely access to care. To that end, bringing community awareness to mental health issues and how people can access the care, including when facing challenges, ensures early access to behavioral health services to lower BH illness and suicide rates need, in addition reduces prolonged suffering. During phase III of the project, outreach and education efforts will target specific groups, including parents, and therefore children and youth, extending impact to also help prevent or reduce negative impacts felt at school such as school failure and dropout along with instability at home.

Presentations and tools developed and used for education efforts include: Your Rights to Mental Healthcare in California, Accessing Mental Health Care Resources, and Checklist/Tips Sheet: Steps to Take When Facing Issues with Access to Care. Additional tools and resources, including Frequently Asked Questions, a tool to help document/file a complaint, and modification of existing tools to reach specific target groups, such as to parents, are in development.

3. Program Goals, Objectives & Outcomes

Project implementation started January 2023. After a need for community outreach, education and tools to navigate accessing care was identified by stakeholders, a mid-year adjustment was made so that a project could be developed that could address these needs. Initial months were used to identify specific focus/content areas, design and test presentation and tools to be understandable and accessible to a variety of audiences in Santa Clara County.

❖ Project Goals:

i. Increase knowledge, awareness and understanding on the signs of mental health care conditions and where to go to access care in order to support early identification and early intervention.
ii. Enhance community awareness and understanding on one's rights related to mental health care, including steps to take if those rights are violated, in order to prevent delays in accessing care.
iii. To provide information, resources and tools that support access to behavioral health services, that support early intervention to help conditions from progressing, enhance wellness and resilience, and reduce barriers to health education/services.
iv. Reduce disparities in access to related information, services, and supports by making information easy to understand, and accessible to a variety of audiences.

❖ Project Objectives:

i. Inform and educate on signs of mental health care conditions.
ii. Inform and educate on resources available to access mental health care, as appropriate to an individual's situation or circumstance.
iii. Increase awareness and understanding on one's rights related to mental health care.
iv. Increasing knowledge and understanding on steps and resources to access mental health care, including steps to take if one encounters problems.

❖ Expected Outcomes:

i. Increased knowledge and understanding of signs of mental health care conditions.
ii. Increased knowledge and understanding on how and where to go to access care.
iii. Increased knowledge and understanding on one's rights related to mental health care.
iv. Increased knowledge and understanding on steps one can take if encountering problems accessing needed care.

4. Clients Served & Annual Cost per Client Data

FY 2023 (Jan 2023 to June 2023)		
Unduplicated N = 103		
Number Served	Program Expenditure	Cost per Person
103	**$2500**	**$24.27**

For FY 23 reporting period, because outreach and education was new, launched to specific groups and organizations, and because the number was small, it was possible to note that all participants were

unduplicated. In the future, the project will not be able to differentiate among duplicated individuals as no identifying information is collected through education and outreach activities.

5. Evaluation Activities

The project is designed to create and enhance access and linkages to behavioral health services to raise mental health awareness, empower individuals to advocate their needs. The project is committed to providing outreach to the community via presentations and online in order to provide information and assistance that is needed to improve access to all individuals. The project also is designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory, through presenting information in a simple and accessible way, through translation of material to reach additional audiences, and distribution of material in a variety of ways so that the project can reach diverse audiences and groups.

Project implementation started January 2023 as a mid-year adjustment. The Santa Clara County Mental Health Parity Work Group identified a need in the community and this project was designed to fulfill that need. Initial months were used for stakeholder feedback to identify specific focus/content areas that would provide the most utility and impact, and to design, develop and test educational resources and tools. The following key focus/content areas were defined: 1. Providing the range of mental health conditions and how to recognize signs and symptoms, 2. Sharing methods to access mental health care, 3. Raising awareness regarding laws, regulations and rights related to mental health care, and 4. Educating on steps that people can take if they experience any issues accessing care.

During Phase I of the project, the presentation was tested to learn what information was the most useful and how best to present in a way that was easy to understand, so that the presentation and associated tools would be accessible to a variety of audiences in Santa Clara County. Translating the legal and medical language associated with mental health rights into terms laypeople can understand along with outlining language people can use when communicating or advocating on their care, was also especially important to develop a presentation that would have impact.

From the outset, Bay Area Legal Aid and the local Santa Clara County NAMI, and other stakeholders participating in the County's Mental Health Parity Work Group, have been invaluable partners, offering critical insights on the issues people are facing in the community, providing their expertise on shaping/refining content that would be most helpful to the community, helping to identify and create supplementary tools and resources. Both organizations also serve as critical resources in the community. NAMI offers support and guides community members to mental health resources and Bay Area Legal Aid offers free legal services related to accessing healthcare.

In partnership with the County, the following materials to support project efforts were developed and are attached: Your Rights to Mental Healthcare in California, Your Rights to Mental Healthcare in California, Accessing Mental Health Care Resources, and Checklist/Tips Sheet: Steps to Take When Facing Issues with Access to Care.

Phase II, launch and expansion of the outreach and education, is currently in progress. The project leveraged strong relationships in the community, such as with Community Health Partnerships and The Health Trust, to launch the initiative. Subsequent to finalizing the presentation materials, through June 30, 2023, ten (10) presentations we conducted, reaching and providing valuable resources and information to 103 people. Feedback and results have been extremely positive and are outlined in the detailed outcomes section. The Santa Clara County libraries are eager to host presentations and active efforts are currently underway to

schedule in-person presentations at all seven (7) county libraries in July- October and additional presentations are being planned.

In line with our expansion plans, the County is hiring intern support to be able to assist with project needs. The County is also pursuing a formal contract with a community partner to help expand outreach and education in addition to hosting material online.

To evaluate the effectiveness and assess knowledge gained as a result of going through the presentation, a pre survey and post survey are administered to each individual who attends. Beyond collecting demographic information, the survey asks 4 questions to understand the attendee's familiarity with mental health care and rights to mental health care before the presentation. The same 4 questions, are asked after they complete the presentation. Data is collected for all participants whether conducted virtually or in person. Feedback and results have been extremely positive and are outlined in the detailed outcomes section.

- **The following pre-presentation and post presentation are asked:**

Pre- Presentation Survey Questions:

i. How familiar are you with knowing what mental health are and signs of mental health conditions?
ii. If you or someone you knew needed mental health services, do you know where to go for help?
iii. How familiar are you with your rights related to mental health parity?
iv. If you are facing trouble accessing mental health care, do you know what steps you can take?

Post- Presentation Survey Questions:

i. After this presentation, how familiar are you with knowing what mental health are and signs of mental health conditions?
ii. After this presentation, if you or someone you knew needed mental health services, do you know where to go for help?
iii. After this presentation, how familiar are you with your rights related to mental health parity?
iv. After this presentation, if you are facing trouble accessing mental health care, do you know what steps you can take?

On the post-presentation an open ended question was also included for attendees to share their feedback on the presentation or the topic itself.

- **Implementation Challenges/ Project Barriers:**

Phase II encountered unforeseen challenges. At the outset, there were limited resources/ trained staff capable of presenting the material.

In response, we sought community partners, with content familiarity on presented topics to help fill this gap. However, securing a formal partnership, contract negotiations, along with defining a scope of work is taking significantly more time then imagined. In addition, the project experienced extensive delays through the County's procurement process. We are currently in the process of securing a contract with a key partner, who will have a defined scope of work to support outreach and education efforts.
Despite these challenges, we used the extended timeframe to develop necessary materials that would lay a solid foundation for expansion of outreach efforts. We are exploring other was to expand the number of presenters now that the presentation, script, and resources are final.

- **Activities under Phase II and Phase III which were not covered in FY 2023 will be covered in FY 2024.**

For example, there are several plans currently underway including:

i. From July 2023 – October 2023, a series of 7 workshops across Santa Clara County, will be conducted in partnership with Santa Clara County Library system.
ii. The County of Santa Clara will be contracting with a partner organization to support education and outreach to the community through in-person and virtual presentations and sharing resources on their website
iii. Additional tools to support access to care 1. A FAQs document to address common questions and 2. Fillable form, to help and individual communicate care needs/issues and to help file a complaint if needed.
iv. Translation of materials into Spanish, Vietnamese and other languages as possible.
v. Creation of a modified presentation and resources, specific to parents.
vi. A recording of the presentation is being planned in English and Spanish and if possible other languages.

6. Demographic Data

A total of 103 individuals participated in our educational presentations and demographic data was gathered for 47. It's important to note that the formal pre-post survey, which includes demographic data collection, was not administered at the outset of the presentations. In addition, while we make concerted efforts to encourage all participants to complete the pre and post surveys and allocate time at the beginning and end of the presentation, not all individuals opt to do so.

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	0	0%
16 -25 years	4	8%
26- 59 years	31	66%
60+ years	12	26%
Prefer not to answer	0	0
Unknown	0	0%
Unduplicated Total	47	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native	1	2%

Asian	8	17%
Black or African American	1	2%
Native Hawaiian or Other Pacific Islander	2	4%
White/ Caucasian	24	51%
Other	1	2%
More than one race	7	15%
Prefer not to answer	3	6%
Unknown	0	0%
Unduplicated Total	47	

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean	0	0%
Central American	3	17%
Mexican/ Mexican-American/ Chicano	14	78%
Puerto Rican	0	0%
South American	0	0%
Hispanic/ Latino (undefined)	0	0%
Other Hispanic/ Latino	1	5%
Hispanic or Latino Subtotal	**18**	38%
Non-Hispanic or Non-Latino as follows:		
African	0	0%

Asian Indian/ South Asian	3	10%
Cambodian	0	0%
Chinese	1	3%
Eastern European	2	7%
European	12	41%
Filipino	1	3%
Japanese	1	3%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	3	10%
Non-Hispanic/ Non-Latino (undefined)	0	0%
Other Non-Hispanic/ Non-Latino	3	10%
Non-Hispanic or Non-Latino Subtotal	29	**62%**
More than one ethnicity	0	0%
Prefer not to answer	3	10%
Unknown	0	0%
Unduplicated Total	47	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	7	15%
Female	40	85%
Prefer not to answer	0	0%
Unknown	0	0%

Unduplicated Total	47	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	7	15%
Female	40	85%
Transgender (Male to Female)	0	0%
Transgender (Female to Male)	0	0%
Transgender (Undefined)	0	0%
Genderqueer	0	0%
Questioning or Unsure	0	0%
Another gender identity	0	0%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	47	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian	1	2%
Heterosexual/ Straight	41	89%
Bisexual	2	4%
Questioning/ Unsure	0	0%
Queer	0	0%
Another sexual orientation	1	2%
Prefer not to answer	1	2%
Unknown	0	0%
Unduplicated Total	47	99%

	FY 2023

Primary Language	# Served	% of Served
English	37	79%
Spanish	4	8%
Vietnamese	2	4%
Chinese	0	0%
Tagalog	0	0%
Farsi	0	0%
Other	4	8%
Prefer not to answer	0	0%
Unknown	0	0%
Unduplicated Total	47	99%

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military	0	0%
Veteran	0	0%
Served in Military	0	0%
Family of Military	0	0%
No Military	46	98%
Prefer not to answer	1	2%
Unknown	0	0%
Unduplicated Total	47	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing	2	4%
Difficulty hearing or speaking	0	0%
Other communication disability	0	0%
Cognitive	1	2%
Physical/ Mobility	1	2%
Chronic Health Condition	6	13%
Other non-communication disability	0	0%

No Disability	36	77%
Prefer not to answer	1	2%
Unknown	0	0%
Unduplicated Total	47	100%

*Participants may choose more than one option for Disability.

7. Referrals

Not applicable to this project.

FY 2023				
Unduplicated N =				
Number of individuals with serious mental illness referred to treatment (Separate out treatment that is provided, funded administered, or overseen by county mental health versus treatment that is not)	**Kind of treatment to which the individual was referred**	**Number of individuals who followed through on the referral and engaged in treatment** (for treatment that is provided, funded administered, or overseen by county mental health)	**Average duration of untreated mental illness** (for referrals to treatment that are provided by or overseen by county mental health)	**Average interval between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation** (for referrals to treatment that are provided by or overseen by county mental health)
N/a	N/a	N/a	N/a	N/a

8. Group Services Delivered

FY 2023 (January 2023 – June 2023)		
Unduplicated N = 103		
Number of Groups	Attendance	Average Attendance per Group
10 Presentations	103	10

9. Detailed Outcomes

As outlined previously, early months were used to convene key stakeholders, identify key focus areas, and design and test the presentation and supporting tools. In addition, the project experienced contract delays. For this reason, there is limited data to present for this reporting period.

To assess knowledge gained as a result of going through the presentation, a pre survey and post survey were administered to each individual who attended. Beyond collecting demographic information, the survey asked 4 questions to understand the attendee's familiarity with mental health care and rights to mental health care before the presentation. The same 4 questions were asked after they completed the presentation. For both survey's, respondents used a Likert scale to answer how familiar they were with each of the 4 areas: 1. Mental health conditions and signs, 2. Where to go to access mental health care, 3. Mental health care rights, and 4. What steps to take if experiencing any issues accessing care. Depending on the type of presentation give, data was collected online or in-person.

- **The following pre-presentation and post presentation were asked:**

Pre- Presentation Survey Questions:

i. How familiar are you with knowing what mental health are and signs of mental health conditions?
ii. If you or someone you knew needed mental health services, do you know where to go for help?
iii. How familiar are you with your rights related to mental health parity?
iv. If you are facing trouble accessing mental health care, do you know what steps you can take?

Post- Presentation Survey Questions:

i. After this presentation, how familiar are you with knowing what mental health are and signs of mental health conditions?
ii. After this presentation, if you or someone you knew needed mental health services, do you know where to go for help?
iii. After this presentation, how familiar are you with your rights related to mental health parity?
iv. After this presentation, if you are facing trouble accessing mental health care, do you know what steps you can take?
v. Please share any comments or feedback you may have on the presentation or topic itself.

While a total of 103 individuals participated in our educational presentations pre and post survey data was not collected on every individual that attended. The survey was not administered at the outset of the presentations and not all individuals opt to complete the survey. The pre-survey had 47 respondents and the post survey had 37 respondents completed the post survey.

Quantitative data

Early results show people's knowledge and understanding on the 4 areas increased when comparing pre- and post- presentation surveys. Note that this assessment is based on aggregated data analysis or and group-level analysis and not based on individual-level analysis.

Below presents the aggregate analysis of the 4 questions, including pre/post comparison:

1. **How familiar are you with knowing what mental health conditions are and signs of mental health conditions?**

Response	Pre	Percent	Post	Percent	% Change
Extremely familiar, Very familiar, or Moderately familiar	41	87%	35	94%	+7%
Slightly familiar, Not familiar at all	6	13%	2	5%	-8%
Total	47	100%	37	99%	1%

2. **If you or someone you knew needed mental health services, do you know who to call or where to go for help?**

Response	Pre	Percent	Post	Percent	% Change
Extremely familiar, Very familiar, or Moderately familiar	29	62%	36	97%	+35%
Slightly familiar, Not familiar at all	18	38%	1	3%	-35%
Total	47	100%	37	100%	0%

3. **How familiar are you with your rights related to mental health parity?**

Response	Pre	Percent	Post	Percent	% Change
Extremely familiar, Very familiar, or Moderately familiar	25	53%	34	92%	+39%
Slightly familiar, Not familiar at all	22	47%	3	8%	-39%
Total	47	100%	37	100%	0%

4. **If you are facing trouble accessing mental health care do you know what steps you can take?**

Response	Pre	Percent	Post	Percent	% Change
Extremely familiar, Very familiar, or Moderately familiar	27	57%	36	97%	+44%
Slightly familiar, Not familiar at all	22	47%	1	3%	-44%
Total	47	100%	37	100%	0%

When asked "**How familiar are you with knowing what mental health conditions are and signs of mental health conditions?",** before the presentation most people, 87%, indicated that they were "Extremely", "Very", or "Moderately familiar". This increased slightly after the presentation.

When asked "**If you or someone you knew needed mental health services, do you know who to call or where to go for help?**", before the presentation 38% indicated that they were slightly or not "Slightly" or "Not familiar at all". This decreased to 3% after the presentation. Concurrently, 62%, indicated that they were "Extremely", "Very", or "Moderately familiar" which increased to 97% after the presentation.

When asked "**How familiar are you with your rights related to mental health parity?**", before the presentation 47% indicated that they were slightly or not "Slightly" or "Not familiar at all". This decreased to 8% after the presentation. Concurrently, 53%, indicated that they were "Extremely", "Very", or "Moderately familiar" with the topic before the presentation which increased to 92% after the presentation.

When asked "**If you are facing trouble accessing mental health care do you know what steps you can take?"**, before the presentation 47% indicated that they were slightly or not "Slightly" or "Not familiar at all". This decreased to 3% after the presentation. Concurrently, 57%, indicated that they were "Extremely", "Very", or "Moderately familiar" with the topic before the presentation which increased to 97% after the presentation.

❖ Qualitative data

Qualitative data supports similar findings people's knowledge and understanding on the 4 areas increased after having attended the presentation and individuals found the information valuable.

At the end of the formal post-presentation an open-ended question was included for attendees to share their feedback on the presentation or the topic itself. Some of the comments that were made included:

i. I liked what you stated about what time is required until the patient gets a response from whomever was notified about the patients' rights I did not know what the specific numbers and websites were. Thank you for the information I received tonight.
ii. Thank you for the resources, the timelines were especially good to know. The easier the better since most of us with ill family members need ease of access during times of distress.
iii. Thank you for this informative session. It is appreciated :)
iv. This presentation was very helpful and specific.
v. Very informative

Prior to the formal administration of the pre and post survey, the presenter asked groups and collected anecdotal information informally at the end of the presentation on the same 4 areas: The presenter asked,

i. Do you feel more familiar with mental health conditions & knowing the signs?
ii. Do you feel more familiar with knowing where to go if you/someone you know needs mental health services?
iii. Did you gain knowledge about your mental health parity rights?
iv. Did you gain knowledge about your mental health parity rights?

Similar results to the formal survey were shared anecdotally when asked these questions informally. Most if not all participants raised their hands, “yes” after each question. In addition, one audience member remarked that they felt “empowered” and now knew to call her health plan and ask for a care manager to assist her in securing a non-physician mental health appointment within 10 business days.

10. Evaluation Summary

The project's overarching goal is to improve access to behavioral health services and raise mental health awareness while empowering individuals to advocate for their needs. This is achieved through community outreach efforts, including presentations and online resources, which prioritize accessibility and inclusivity. The mental health parity project has already seen positive outcomes on its 4 objectives since its launch in January 2023, driven by its focus on areas such as recognizing mental health signs, accessing care, understanding mental health laws, and addressing care access issues. Collaborations with Bay Area Legal Aid and the NAMI and the Santa Clara County Mental Health Parity Work Group have been instrumental in providing expertise and resources and facilitating the creation of impactful educational materials.

Phase I of the project involved testing and refining presentations to ensure they were both informative and accessible, with particular attention given to simplifying complex legal and medical language. The feedback received from stakeholders and participants has been encouraging, underscoring the positive impact of the project. Looking ahead to Phase II, the project intends to expand its reach through partnerships with Santa Clara County libraries, enhance resources, offer tailored presentations for parents amongst other groups, and provide multilingual content.

Despite initial challenges such as limited resources, staffing constraints, and prolonged contract negotiations, the project has managed to utilize this time to set a solid foundation. While there is currently limited data, both quantitative and qualitative feedback indicate increased knowledge and empowerment among participants. The project is committed to promoting mental health awareness and improving access to care within the community as it moves into FY 2024.

County of Santa Clara Health System
Behavioral Health Services Department (BHSD)
Mental Health Services Act (MHSA) Annual Plan Update for FY 23
Reporting Period: July 1, 2022 - June 30, 2023

Workforce Education and Training (WET) Annual Update FY23

WET Action Plans

Category	WET Programs
Administrative	W1: Training Coordination
Trainings	W2: Promising Practice-Based Training W2: Improved Services and Outreach to Unserved W2: Welcoming Consumers and Family Members W2: WET Collaboration with Key Systems Partners
Student & Peer Intern Program **Scholarship Program**	W3: Mental Health Career Pathway W3: Stipends and Incentives to Support Mental Health Career Pathway

WET Workplan (W1) – Administrative

Program Name: Workforce Education & Training (WET) Coordination
Program Manager: Jeannette Ferris

Program Description

Workforce Education and Training Coordination - Positions budgeted for Workforce, Education and Training infrastructure and are charged entirely to this budget. The infrastructure is to support the education and training efforts for underrepresented populations to enter the Behavioral Health Workforce and advance within the system as desired.

FY 2023 Recommendations

Continue and increase funding so that WET program staff can implement WET plan.

WET Workplan (W2) - Trainings

WET Workplan (W2)

Program Name: Promising Practice & Evidence Based Training
Program Manager: Danielle Bone-Hayslett

Program Description

Promising Practice-Based Training in Adult Recovery Principles & Child, Adolescent & Family Service Models - This WET Workplan expands training for Behavioral Health Services Department (BHSD) and County Contract Providers (CCP) workforce that includes, direct service providers, administrative and management staff, consumers, clients and family members and other key stakeholders. The training workplan will promote and encourage the integration of wellness and recovery methods and the value of providing peer support and the use of staff with "lived experience" via a continuous learning model.

Program Information

- **Goal**

WET trainings will be directed towards practice change and augmentation that supports and embraces the principles of strengths and resiliency-based practice, cultural humility/competency practice, quality practice, behavioral health practice and accountability.

- **Objectives**

1. By the end of FY 2023 BHSD will conduct annual needs assessments (surveys & meetings) on training needs.
2. By the end of FY 2023, based on data collected develop annual training plan.
3. By the end of FY 2023, the effectiveness of the trainings plan will be evaluated by review of training evaluations and on-line surveys.

Process Measures

1. Training surveys
2. Post-tests
3. Training evaluations

Program Outcomes

1. FY 2023 Workforce Members Served
   i. FY 2023 Total workforce training participants 6,322 (duplicated)
   ii. FY 2023 provided 209 trainings.
   iii. FY 2023 Total workforce training participants QP 3,733 (duplicated)
   iv. FY 2023 QP 99 trainings
2. Describe Achieved Outcomes
   i. Improved outcomes for clients – clients are receiving higher quality of services by a trained and competent workforce.
3. Barriers to Success

ii. No shows & poor attendance rate of trainings - due busy schedules and workforce demands. For FY 2022, we had an average no-show rate of 24%. For FY 2023 we had an average no-show rate of 23%. No change

FY 2024 Recommendations

Continue funding for workforce training as staff are required to attend evidenced based trainings and collect continuing education units to maintain their licensure and certifications. Community training recommendations include more Co-Occurring trainings.

FY 2024-2026 Recommendations

- Develop a new training team to provide internal trainer for the Learning Partnership that supports both County and CCP workforce. Proposing the following staffing model:
    - 2.0 FTE Program Manager I
    - 2.0 FTE Training and Staff Development Specialists and
    - 2 Student Intern III -521 (annually).

This recommendation is on hold due to budget limitations.

Client Impact as result of proposed recommendation

Improved outcomes for clients – clients are receiving higher quality of services by a trained and competent workforce.

WET Workplan (W2)

Program Name: Improved Services and Outreach to Unserved and Underserved Populations
Program Manager: Danielle Bone-Hayslett

Program Description

Improved Services & Outreach to Unserved and Underserved Populations – This WET Workplan will expand specialized cultural humility/competency training to all staff to improve services to ethnic and cultural populations. Ethnic and cultural populations are broadly defined to include marginalized populations such as Black, Indigenous, and People of Color (BIPOC), the Elderly, Youth, People with Disabilities, LGBTQ+ individuals, Immigrant and Refugee populations.

Program Information

- **Goals**

WET trainings will be directed towards practice change and augmentation that supports and embraces the principles of strengths and resiliency-based practice, cultural competency practice, quality practice, behavioral health practice and accountability.

- **Objectives**

1. By the end of FY 2023 BHSD will conduct annual needs assessments (surveys & meetings) on training needs.
2. By the end of FY 2023, based on data collected develop annual training plan.
3. By the end of FY 2023, the effectiveness of the trainings plan will be evaluated by review of training evaluations and on-line surveys.

Process Measures

1. Training surveys
2. Post-tests
3. Training evaluations

Program Outcomes

1. FY 2023 Workforce Members Served
    i. FY 2023 Total workforce training participants 1,683 (duplicated) – we increased by 50% the number of training participants for Cultural Humility from last year.
    ii. LGBTQ+ training participants 1,108
    iii. Cultural Humility training participants 575
2. Describe Achieved Outcomes
    i. Improved outcomes for clients – clients are receiving higher quality of services by a trained and culturally competent workforce.
3. Barriers to Success
    i. No shows & poor attendance rate of trainings - due busy schedules and workforce demands. For FY 2023, we had an average no-show rate of 28%.

FY24 Recommendations

Continue funding for workforce training as staff are required to annually attend culturally competent/cultural humility/CLAS trainings and collect continuing education units to maintain their

licensure. Community training recommendations included more trainings for LGBTQ+, Older Adults, TAY, Outreach Workers, & Faith Based trainings.

Client Impact as result of proposed recommendation

Improved outcomes for clients – clients are receiving higher quality of services by a trained and culturally competent workforce.

WET Workplan (W2)

Program Name: Welcoming Consumers and Family Members
Program Manager: Danielle Bone-Hayslett

Program Description

Welcoming Consumers and Family Members - This action will develop and implement training, workshops and consultations that promotes an environment that welcomes consumers, clients, and family members as contributing members of the public behavioral health system. Trainings will focus on advancing the educational, employment, and leadership opportunities for consumers, clients, and family members public mental health.

Program Information

- **Goals**

WET trainings will be directed towards practice change and augmentation that supports and embraces the principles of strengths and resiliency-based practice, cultural competency practice, quality practice, behavioral health practice and accountability.

- **Objectives**

1. By the end of FY 2023 BHSD will conduct annual needs assessments (surveys & meetings) on training needs.
2. By the end of FY 2023, based on data collected develop annual training plan.
3. By the end of FY 2023, the effectiveness of the trainings plan will be evaluated by review of training evaluations and on-line surveys.

Process Measures

1. Training surveys
2. Post-tests
3. Training evaluations

Program Outcomes

1. FY 2023 Workforce Members Served
    i. FY 2023 Total workforce training participants 515 (duplicated)
2. Describe Achieved Outcomes
    i. Improved outcomes for clients – clients are receiving higher quality of services by a trained and competent peer workforce.
3. Barriers to Success
    i. No shows & poor attendance rate of trainings - due busy schedules and workforce demands. For FY 2023, we had an average no-show rate of 8%.

FY24 Recommendations

Continue funding for workforce training to further the skills and expertise of peer staff in BHSD. Provide support for the Peer Certification so that Peer Support Workers are to be certified.

Client Impact as result of proposed recommendation

Improved outcomes for clients – clients are receiving higher quality of services by a trained and competent peer workforce.

WET Workplan (W2)

Program Name: WET Collaboration with Key System Partners
Program Manager: Position cut due to budget reductions

Program Description

WET Collaboration with Key System Partners - This action will build on the collaboration between the Behavioral Health Services Department and key system partners to develop and share training and education programs so that consumers and family members receive more effective integrated services.

Program Information

- **Goals**

WET trainings will be directed towards practice change and augmentation that supports and embraces the principles of strengths and resiliency-based practice, cultural humility practice, quality practice, behavioral health practice and accountability.

- **Objectives**

1. By the end of FY 2023 BHSD will work provide 5150 trainings and review needs assessment to assess the continual training needs
2. By the end of FY 2023 BHSD will provide4-6 behavioral health informational sessions.
3. By the end of FY 2023, develop annual training plan.
4. By the end of FY 2023, the effectiveness of the trainings plan will be evaluated by review of training evaluations and on-line surveys.

Process Measures

1. Training surveys
2. Post-tests
3. Training evaluations

Program Outcomes

1. FY 23 Workforce Members Served
    i. Total 5150 training participants 391
    ii. Total Behavioral Health Informational Session participants 149
    iii. No-show rate was 14%.
    iv. Percentage of training participants that attended 5150 training is 6%
2. Describe Achieved Outcomes
    i. Improved outcomes for clients – clients are receiving higher quality of services by a trained and competent workforce.
3. Barriers to Success
    i. The Program Manager code for this action item was deleted for budget reductions. Currently relying on external vendor and only able to provide contracted number of 5150 trainings. Since the deletion of this position the department has not been able to provide CIT training for local law enforcement/peace officers.

FY24 Recommendations

When possible, work with Sherriff's Office to restart Behavioral Health sponsored CIT trainings. Continue providing 5150 training for our workforce and system partners.

Client Impact as result of proposed recommendation

Improved outcomes for clients – clients are receiving higher quality of services by a trained and competent workforce.

WET Workplan (W3): MH Career Pathways & Stipends and Financial Incentives to Support Mental Health Career Pathway

WET Workplan (W3)

Program Name: Mental Health Career Pathways
Program Manager: Chiaki Nomoto

Program Description

Comprehensive Mental Health Career Pathway Model - Position and overhead budgeted to support the development of the model. The model supports BHSD commitment to developing a workforce that can meet the needs of its diverse population and is trained in the principles of recovery and strength-based approaches and culturally appropriate interventions. The needed "cultural change" in the transformation process is expected to occur as the workforce's composition changes to include more individuals who have "lived experiences" as consumers and family partners, and who come from the diverse cultural, ethnic, and linguistic underserved and unserved communities that BHSD seeks to serve.

Program Information

- **Goals**

Develop a comprehensive Mental Health Career Pathway Model for consumers, family partners and individuals from served and underserved communities in Santa Clara County, interested in careers in BHSD. Develop a career pathway for newly graduating students who want to work the public behavioral health system.

- **Objectives**

1. By the end of FY 2024, to continue advocating for additional levels to be added to the Mental Health Peer Support Worker code.
2. By the end of FY 2024, 75% of eligible former graduate level student interns will be hired as PSW I or MFT I.
3. By the end of the FY 2024, 75% of BA scholarship recipients will be planning or be enrolled in MSW program.

Process Measures

1. Agendas
2. Meeting minutes
3. Program logs & reports

Program Outcomes

FY 23 County Intern Program

1. In FY 2023, County's Student Intern program trained 14 total students. Roughly 80% of the student interns were offered a full-time position within the BHSD within two months of graduation. One student is still working on fulfilling their 1-year requirement, one student is on

medical/personal leave, and the other student was from out of the county and obtained a job in their home county.
2. In FY 2023, County's Peer Intern Program trained 3 peer interns. One peer intern was hired into a permanent position within BHSD, one peer intern is transitioning into pursuing higher education, and one peer intern transitioned to another position within BHSD.

FY 2023 County Contract Providers (CCP) Intern Program

1. In FY 2023, the CCP Intern program had 12 total students. While we were budgeted to have 48 CCP student interns, we were in competition with CCP's receiving funding from the Department of Health Care Service (DHCS) Behavioral Health Workforce Development Mentored Internship Program. Momentum for Health, Gardner Health Services, Community Solutions, and Rebekah Children's Services declined using WET stipends as they were awarded funding from the Mentored Internship Program, which provided a higher amount of funding for stipends. While the CCP's continued participating in the Intern Collaborative, they declined using BHSD WET Stipend slots.
2. In FY23, the CCP Intern program had 1 peer intern out of a possible 24 peer interns. To help with promoting the role of peer interns, BHSD recruited CCP programs to participate in Peer Intern Collaborative and held informational sessions. During our meeting with our community partners, the below barriers were identified in recruiting peer interns and participating in the Peer Intern program:
    1. Lack of infrastructure to support peers in agencies.
    2. Need more information and guidance on the value, role, and function of peer support.
    3. Need more support in the supervision of peer support workers.
    4. Challenge in identifying where and how to recruit peer interns.
    5. Need to identify in their agency how they will use peers.
    6. Mentoring Internship Program took priority over using peer intern funding.
    7. County position that was support the CCP's expansion of peer interns was deleted.

Achieved Outcomes

BHSD successfully established a career ladder process for student interns to become employed in the department after graduation. During their internship, WET Manager facilitated a panel of speakers to introduce students to the different BHSD programs; had a County Job Application seminar that was facilitated by an Employment Services Agency representative who explained the application process, and provided mock interviews to help prepare student interns for their interviews so that they can interview well and be hired within BHSD. Ten master level graduates (MSW/MFT) and 1 BASW graduate obtained a job within BHSD. Five of them passed the bilingual exam in their threshold languages before graduation, and two of them are working on passing the bilingual exam.

Three (3) new BHSD Programs were identified for Peer Intern Placement and the three Peer Interns were accepted to work in the respective programs. The Peer Interns were provided training and field experience. Successful outcomes for the three peer interns are indicated below:

- Hired into a County coded position,

- Transitioned into a different BHSD position, and
- Pursuing higher education in a related health field.

Barriers to Success

1. Time frame to develop career ladder for the Mental Health Peer Support Worker is longer than expected due to budget reductions and difficulty in hiring Peer Support Workers.
2. The Management Analyst position that provided support for the Career Pathways program was deleted due to County budget cuts. The WET program continues to advocate for creating a new position as this position was assigned the task in establishing the Peer Collaborative with CCPs and to provide additional support to the CCPs with the recruitment of Student and Peer Interns.
3. County and CCP's need to identify and address the barriers that they both experience in recruiting student interns in their respective programs.
4. Lack of supervisors able to provide support for both student and peer interns. More research is needed to implement strategies to increase the number of intern supervisors.

Impact of Deleted Position

- If the reinstatement of the position is not approved, the BHSD Intern Program will need to pause the Career Summer Institute high school program; and pause any expansion of internship program and stipend program, so that the program is able to continue providing high quality training to interns.

FY 2024 Recommendations

Maintain funding for the Intern and Scholarship programs to address substantial workforce shortage that exists in Santa Clara County. Provide more support to the CCPs with the recruitment of Student and Peer Interns. The CCPs report having difficulty in identifying and recruiting peer interns. County and CCP's need to identify and address the barriers that both experience in recruiting student interns in their respective programs. More research needed to implement strategies to increase the number of intern supervisors.

FY24-26 Recommendations

The recommendation that was approved during the 3-year Community Planning Process is paused due to budget issues with the County.

Develop a new peer mentoring program for High School (HS) and Community College (CC). Students to be engaged earlier to promote working in the Behavioral Health system and expanding partnership to more high schools and community colleges will help promote interests in behavioral health careers. Proposing to hire Program Manager I to oversee program for 8 high school students and 16 Community College students.

Client Impact as result of proposed recommendation

These recruitment efforts will fill vacant codes that will then provide critical services for BH clients.

WET Workplan (W3)

Program Name: Stipends and Financial Incentives to Support Mental Health Career Pathway
Program Manager: Chiaki Nomoto

Program Description

Stipends and Incentives to Support Mental Health Career Pathway - This action is intended to provide financial support through stipends and other financial incentives to attract and enable consumers, family members, and college students to enroll in a full range of educational programs that are prerequisites to employment and advancement in the public behavioral health system.

Program Information

- **Goal**

This action is intended to provide financial support through stipends and other financial incentives to attract and enable consumers, family and college students focusing on Behavioral Health to enroll in a full range of educational programs that are prerequisites to employment and advancement in the public behavioral health system.

- **Objectives**

1. By FY 2023 there will be fourteen (14) scholarships slots available for Jr. and Sr. college students pursuing Bachelor of Art degree in Social Work at San Jose State University.
2. At the end of FY 2023 there will be 18 paid CCP Student Interns.
3. By FY 2023 there will be 8 slots available for County and CCP Peer Interns.
4. By FY 2024, the pending Program Manager I position to be approved and filled.
5. By FY 2025, there will be fourteen (14) scholarship slots available for Jr. and Sr. college students pursuing Bachelor of Art degree in Social Work at San Jose State University.
6. By the end of FY 2024, Peer Intern Collaborative will be formed if the previously deleted AMA/MA position is approved for reinstatement.
7. By the end of FY 2024, 4 slots filled for County Peer Interns.

Process Measures

Post internship survey is being implemented to determine if student and peer interns were able to be hired in the Public Behavioral Health System. Recipients of scholarships are required to complete their internship with the Public Behavioral Health System - report from SJSU Intern Coordinator.

County stipend recipients and CCP participating agencies are required to submit employment verification until required 12-month employment is met.

SJSU Scholarship Coordinator will provide reports for scholarship recipients. The student receiving scholarships are required to complete their volunteer experience/internship with the Public Behavioral Health System. They are also strongly encouraged to pursue a graduate degree in a related field or obtain employment with the Public Behavioral Health System in a clinical capacity.

Program Outcomes

FY 2023 Program Participants

Scholarship Program: In FY 2023, there were 3 students who received the County scholarship who attend SJSU and in the BASW program. One student obtained a job with a County Contract Provider, one student is planning to apply for the MSW program, and one student is still enrolled in SJSU BASW program. During January 2023, the previous SJSU Program Coordinator stepped out of her position. Due to this transition, the recruitment process for students for the academic year 2022-23 was interrupted and therefore impacted. We are currently meeting with the new SJSU coordinator and the Director of School of Social Work at SJSU bi-monthly to develop volunteer opportunities and projects for the scholarship recipients, as well as conducting informational sessions. In addition, SJSU School of Social Work representatives are joining our Workforce Development Committee to further collaborate.

- County Intern Program was restarted in FY 2023 after being paused for 1 year.
- County Student Interns Program: Fourteen (14) student interns
- County Peer Intern Program: Three (3) County Peer Interns
- County Contract Provider Student Interns Program: Twelve (12) student interns
- County Contract Provider Peer Intern Program: One (1) Contract Provider Peer Intern

As discussed previously in this report, recruitment and hiring challenges existed for the CCPs in engaging peer interns.

Workforce Development Retention Strategy Programs
In addition to the financial incentives provided in this workplan, Santa Clara County participated in the Greater Bay Area Region grant opportunity with the Department of Health Care Access and Information to bring in additional funding for a Loan Repayment Program and Stipend Program for Master's & PhD students who are currently in the workforce. We had a total of 150 workforce members participate in the loan repayment program (148 participants) and workforce tuition program (2 participants).

Achieved Outcomes

- Increase workforce capacity by hiring student and peer interns into the workforce.
- Better client outcomes will be achieved by having sufficient staff to provide client support and services.

Barriers to Success

External organizations offer competitive internship opportunities that include increased or 100% telehealth opportunities. Another barrier for BHSD, is that it will not be able to expand the Intern Program due to the impact of the County budget reductions process. The Intern Program's Management Analyst position that was vacated in December 2022 was deleted on July 1, 2023. Therefore, the projects managed by this position were placed on hold. The Intern program is using temporary help until the position can be reinstated.

FY 2024 Recommendations

Maintain funding for the Intern program to address the substantial workforce shortage that exists in Santa Clara County. Provide support for CCP and County to increase the number of intern supervisors so that more interns can be brought into the Behavioral Health system. To continue looking for additional funding to increase workforce recruitment and retention strategies. Reinstate the deleted Management Analyst position to maintain the capacity of the current internship program and to explore expansion. Recruit and expand intern collaborative agencies to maximize the use of CCP WET Stipends.

Client Impact as result of proposed recommendation

Improved outcomes for clients – clients are receiving higher quality of services by a trained and culturally competent workforce.

FY 23 WET Expenditures

Program Name	Number Served	Program Expenditure	Cost per person
W1 WET Coordination	-	$627,325.75	-
W2 WET Training	5000	$1,014,444.45	$202.89
W3 Career Pathways & Development	69	$725,679.23	$10,517.09
WET Administration		-	

Innovation

The California Code of Regulations (CCR) section 3200.184 defines an “Innovative Project” as a project that the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports. During Fiscal Year 2023 (FY23), the County of Santa Clara Behavioral Health Services Department (BHSD) had five (5) ongoing projects (INN 12, INN 13, INN 14, INN 15, and INN 16). The chart below outlines the annual cost per project as well as the cost per client.

Program	Annual Amount*	Clients Served**	Cost per Client
INN 12 PERT	$892,484	918	$972
INN 13 Allcove	$3,098,655	477	$6,496
INN 14 ILEP	$370,184	300	$1,234
INN 15 TRUST	$6,893,470	1488	$4,633
INN 16 ATSVAAC	$499,227	1097	$455

* Client Numbers in **RED** are estimates, while those noted in **BLACK** are actuals from FY23

PERT & Peer Linkage Evaluation

COUNTY OF SANTA CLARA,

MHSA INN ANNUAL REPORT FY 21-22

RDA CONSULTING

COUNTY OF SANTA CLARA
Behavioral Health Services

Psychiatric Emergency Response Team & Peer Linkage Evaluation

County of Santa Clara,

MHSA INN Annual Report FY 21-22

This report was developed by RDA Consulting under contract with County of Santa Clara's Behavioral Health Services Department.

RDA Consulting, 2022

RDA CONSULTING

COUNTY OF SANTA CLARA
Behavioral Health Services

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Executive Summary

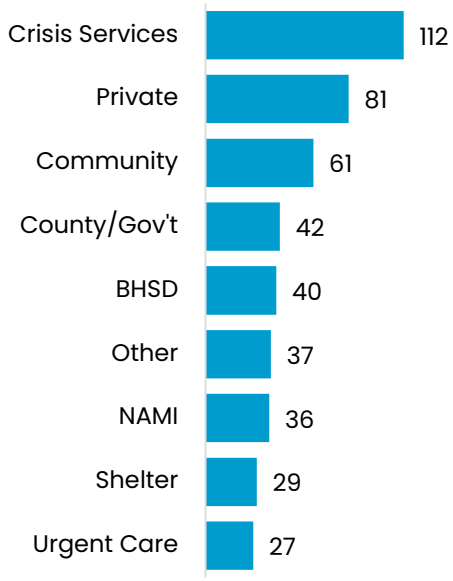
The Psychiatric Emergency Response Team (PERT) and Peer Linkage project provides behavioral health crisis response services as well as post-crisis follow-up referrals. Within each PERT, a mental health clinician and police officer work in close collaboration to respond to mental health crises, de-escalate a variety of crisis situations, and provide appropriate on-site services. After a crisis, additional support and referrals are provided through follow-up contacts with consumers and/or consumer family members. The following key activities took place during FY 21-22:

455
Total Number of PERT Incidents

13 min
Average PERT Response Time

44 min
Average PERT Encounter Time

PERT Resources Provided



- Several new PERT clinicians and officers were hired, creating a total of 5 PERTs stationed within the Sheriff's Office, Palo Alto Police Department, Morgan Hill Police Department, and San Jose Police Department.
- PERTs provided support for a total of 455 mental health crisis incidents.[1] This includes support, services, resources, and referrals provided on-site during crisis encounters and via phone in response to deputy referral and/or as part of follow-up with consumers and family members.
- Most on-site incidents that PERTs responded to took place in Palo Alto and Cupertino. PERTs responded to crisis incidents in an average of 13 minutes and encounters lasted an average of 44 minutes. Over half of PERT incidents ended with PERTs either diverting, providing resources or services, or de-escalating crises such that other services were not immediately necessary.
- PERTs provided a variety of resources and services to consumers during crises and at follow-up, and they tended to provide multiple resources per incident. Most PERT

[1] This metric does not include incidents for the San Jose PERT. Given the later timing of its launch and the analysis for this evaluation, quantitative data on PERT incidents for San Jose's PERT were not included in this report.

incidents involved consumers who were White or Asian, and nearly half involved consumers who were between 26 and 59 years old.

- PERT demonstrated several key program strengths:
  - PERT's integrated program model was viewed as key for communication and relationship-building among staff and stakeholders, and critical for successful crisis response.
  - PERT Law Enforcement officers and leadership were found to hold generally non-stigmatizing views toward people with mental illness.
  - The program has garnered wide-ranging support from stakeholders and is seen as the future of policing by broadening a traditional approach to crisis response.
- PERT learned several key lessons throughout implementation:
  - The program faced initial and ongoing challenges in its efforts to launch and implement the peer linkage component.
  - The absence of peer linkage has impacted PERT program implementation and role clarity among staff.
  - Regional differences complicate efforts to standardize PERT across departments and jurisdictions.

In the coming months, until the anticipated project end date in June of 2023, BHSD plans to continue developing and launching additional PERTs in other police departments within the County. In addition, a focus of the work will be on integrating peers into the program to provide additional support, referrals, and navigation following crisis incidents.

MHSA INN Project Description

Project Category: Makes a change to an existing mental health practice that has not yet been demonstrated to be effective

Primary Purpose: Increase access to services

Project Innovation: While there is exisiting research and literature demosntrating the success of both the PERT model and peer support, these techniques have not been integrated and there is no research on the potential compound effectiveness of using these methods together. This adaptation of integrating a peer linkage component to PERTs is the first of its kind.

Program Overview

Santa Clara County's (SCC) Psychiatric Emergency Response Team (PERT) and Peer Linkage Project was designed by Santa Clara County Behavioral Health Services Department (BHSD) and community stakeholders as part of their Mental Health Services Act (MHSA) Innovation (INN) Plan. As designed, SCC's PERT and Peer Linkage project has two connected but distinct phases and operating teams: (1) the crisis response team (PERT), and (2) the linkage and peer support team (Peer Linkage).

Each PERT consists of a licensed mental health clinician employed by Santa Clara County BHSD and a deputy or officer employed by the designated law enforcement agency. The PERT model uses this clinician-officer collaboration to respond to a variety of mental health crises in the field and provide on-site services and support. PERT responses are most commonly initiated by emergency calls for service (routed through 911 dispatch), referrals obtained from other officers or community members, or based on incidents observed in the field during patrol. PERT Law Enforcement also uniquely responds to PERT incidents in plain clothes, or "dressed down" attire, and in an unmarked vehicle. PERT serves adults and older adults, but no person is turned away based on age. PERT will serve youth if a provider is not available and the youth is in crisis or at risk.

Once on scene, the PERT law enforcement officer (LEO) assesses the safety of the scene and determines what crimes, if any, have taken place. The PERT clinician then assesses the individual experiencing a mental health crisis. Following this assessment, the clinician provides crisis intervention and de-escalation services. If the individual responds well to these services and does not pose a threat to themselves or others, or is not gravely disabled, the PERT clinician will make one or more referrals based on the individual's needs. If the individual is determined to be a danger to themself or others, or if the PERT LEO determines an arrest is necessary, the PERT will transport the individual to the appropriate location (e.g., Emergency Psychiatric Services, jail).

Program Activities

PERT:
- MH clinician paired with law enforcement officer de-escalate crises in field
- MH clinician conducts brief assessment and refers to MH service, as appropriate

Peer Linkage:
- Peer provides post-crisis support to assist with recovery
- Peer facilitates linkage and ensures warm-handoff to appropriate services

Intended Outcomes

1. Increase access to and use of mental health services, particularly for transitional age youth (18 to 25), by connecting individuals to peer support services after crisis episodes to assist individuals with their recovery
2. Improve law enforcement officer's knowledge, attitudes, and behaviors in response to mental health issues
3. Improve outcomes for consumers using crisis services, including reduced hospitalizations and incarcerations

Following the incident, the PERT develops a report detailing the encounter and resources provided to the individual, which is to be sent to the Peer Linkage team. At the time of this report, the Peer Linkage component of the project was not yet operational. As a result, the PERT clinicians conduct both the crisis response and follow-up services. PERT consumers may receive a variety of follow-up support, resources, and services, such as: in-person meetings and/or phone calls; assistance connecting with treatment services; and support with scheduling follow-up appointments and attending services. PERT clinicians may initiate follow-up contact with PERT consumers within 24 hours or longer, depending on the PERT's perceived severity of the consumer's final disposition and appropriateness for follow-up services.

The intent behind the PERT and Peer Linkage program is to assist residents with immediate psychiatric services, de-escalate incidents involving someone in crisis, provide the best quality of care, and connect consumers to appropriate services. The overarching goals of the PERT and Peer Linkage Project are to:

1) Increase access to and use of mental health services, particularly for transitional age youth (18 to 25);
2) Reduce stigma for consumers in crisis by having law enforcement respond to incidents in plain clothes and unmarked vehicles;
3) Promote help-seeking behavior by individuals, families, and the community;
4) Improve law enforcement officers' knowledge, attitudes, and behaviors in response to mental health issues; and
5) Improve outcomes for consumers using crisis services, including reduced hospitalizations and incarcerations.

The PERT and Peer Linkage program began with a pilot of two Santa Clara County Sheriff's Office-operated PERT teams during FY 20-21. BHSD used the preliminary results from this initial implementation phase to adjust the PERTs and their processes. During FY 21-22, the project launched three new PERTs in Palo Alto, Morgan Hill, and San Jose. BHSD and each law enforcement agency (LEA) jointly operate each respective PERT.

Both PERT LEOs and clinicians received training on the PERT model, including Santa Clara County BHSD 5150 Certification Training, Crisis Intervention Training (CIT), and FBI Crisis Negotiation/Hostage Negotiation Training, among others, and worked collaboratively to establish trust as partners. The teams also received training in the evaluation and data collection requirements. The PERTs operate on different days and times, tailored to their local community's need for responding to crisis calls. PERTs spend most of their time in the field, responding to calls for service, and providing follow-up supports when available.

Evaluation Approach and Methods

In June 2019, Santa Clara County BHSD contracted RDA Consulting (RDA) to conduct a multi-year evaluation of the PERT and Peer Linkage Project, including the development of annual reports and a final cumulative report. The PERT and Peer Linkage Project evaluation is intended to:

1) Evaluate implementation, outcomes, and impact of the PERT and Peer Linkage Project and support continuous program improvement for BHSD;
2) Assess the efficacy of the PERT and Peer Linkage Project as a potential new approach to support learning across the state; and
3) Comply with MHSA INN regulatory requirements, including annual reports to the Mental Health Services Oversight and Accountability Commission (MHSOAC).

RDA's evaluation works to support BHSD's learning goals and document lessons learned through implementing this novel program. The evaluation includes assessment of both the project's implementation to support continuous program improvement, as well as project outcomes to understand the extent to which intended goals of the project are met. The evaluation was designed to address the following research questions (those in bold are addressed in the current report):

1) How has the PERT and the Peer Linkage Project been implemented? To what extent has implementation followed the original program model? What changes, if any, were necessary?
2) What successes and challenges have program partners experienced implementing the PERT and Peer Linkage Project?
3) Who is being served by the PERT and Peer Linkage Project, what types of services are they receiving, and with what duration and frequency?
4) To what extent does the PERT and Peer Linkage project increase access to mental health services? If so, for which populations?
5) To what extent does the PERT and Peer Linkage project contribute to reductions in crises requiring emergency interventions, psychiatric hospitalizations, and criminal justice involvement? If so, for which populations?
6) To what extent does the PERT and Peer Linkage project lead to positive consumer satisfaction with the crisis response experience?
7) To what extent does the PERT and Peer Linkage project increase law enforcement partners' knowledge, attitudes, and ability to safely and appropriately respond to mental health-related calls?
8) How does the PERT and Peer Linkage crisis response compare to the stand-alone Mobile Crisis Response Team (MCRT) efforts?

Data Collection & Analysis

RDA conducted a mixed-methods evaluation using both qualitative and quantitative data to triangulate findings and deepen our understanding of them. RDA synthesized findings to learn about PERT's implementation, including its process and reach, characteristics of PERT incidents and consumers, as well as successes and challenges the program has faced.

PERT Services Database: RDA worked with BHSD and PERT staff to develop a service log that tracks information about PERT requests and encounters. Currently, the service log is not integrated into BHSD's EHR system but held in separate databases by each PERT. Information tracked within the databases includes variables such as the date, time, location, source, and reason for PERT requests and encounters; consumer date of birth and race; final disposition of encounters (e.g., consumer remained in community, transport to hospital); and referrals to behavioral health or other social support services and resources.

Stakeholder Focus Groups and Key Informant Interviews: RDA conducted two focus groups and five interviews with program staff and stakeholders in the Fall of 2022, including two interviews with BHSD leadership, two interviews with Law Enforcement Agency (LEA) leadership, a focus group with PERT Law Enforcement Officers (LEOs), a focus group with PERT Clinicians, and an interview with the Emergency Psychiatric Services (EPS) Receiving Center. These discussions provided insights into program workflow and services, implementation successes and challenges, as well as perceptions of the impact of services on consumers' wellness and recovery. Additionally, stakeholders discussed the ways in which clinicians and LEOs collaborate as part of the program, impacts of efforts to implement peer linkage, and perceptions of community support for the program.

LEA Attitudes and Knowledge Survey. The evaluation team used a survey based on the Attitudes to Severe Mental Illness Scale[2] (ASMI) that assesses law enforcement officers' attitudes toward people with mental illness. A total of 11 PERT officers and supervisors completed the survey electronically between April and May of 2022 for the current annual report. Scores calculated for this report serve as a baseline that will be compared to future scores to assess changes in LEO attitudes throughout program implementation.

In addition to the data sources listed above, RDA used a variety of other sources to further triangulate and contextualize metrics and themes within the findings presented. These sources included PERT Activity Logs, which the teams use to track aggregated quantitative data on PERT incidents (e.g., total monthly calls for service, referrals, resources offered). Additionally, BHSD

[2] The original source for the Attitudes to Severe Mental Illness Scale (ASMI) may be located here: **https://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S0213-61632012000100006**

provided RDA with a variety of relevant presentation materials, email communications, and newspaper articles, in addition to their newly developed PERT manual, that served to further develop and contextualize findings.

For the forthcoming final cumulative process and outcome evaluation, RDA also plans to collect the following data sources in addition to those described above:

- LEA 911 Dispatch Call Databases
- BHSD Electronic Health Records
- Mobile Crisis Response Team Database
- Sheriff's Office Jail Management System
- Superior Court Case Management System
- Consumer Satisfaction Survey
- PERT Team Debrief Survey
- Focus Group with staff at County/CBO outpatient service providers

Table 1 in the Appendix provides examples of the indicators and data measures that were and will be used to answer the research questions listed above, as well as the data sources for each measure. As RDA conducts the evaluation and data become available, the way each indicator is measured may evolve.

Limitations

As with any evaluation or research project, limitations exist. Of the five PERTs that were operational during FY 21-22, only three of them were operational during the entirety of this period. Additionally, due to perceived invasiveness of interviewing PERT consumers and families about their experiences (expressed both by consumers and staff), the evaluation team was unable to obtain the perspectives of PERT consumers or their families for the current evaluation. Finally, additional ongoing challenges in obtaining and matching specific quantitative data sources (e.g., 911 dispatch data, electronic health records, court case management system data) meant that consumer outcomes are not assessed in this the current evaluation report. The evaluation team has discussed alternative approaches and solutions to collecting data on consumer experiences and outcomes for inclusion in the final cumulative evaluation report.

A key component of the PERT and Peer Linkage project, the Peer Linkage component, was not operational during FY 21-22. Therefore, some consumer information, including demographics and engagement with services, is limited for this report. The PERT and Peer Linkage project was designed to have peers collect detailed demographic information as PERT staff are focused on de-escalation and connecting a consumer to appropriate services. The current report therefore provides information on available consumer demographics, including race and age. Further, the PERT clinicians tracked the services and referrals they may have provided to

consumers during follow-up but were unable to monitor whether a consumer received those services after a referral. Due to the delay in launching the Peer Linkage component, the evaluation team has updated the PERT Services Database to have clinicians begin collecting additional consumer demographic information included in the MHSA reporting requirements; this information will be included for the final cumulative evaluation report.

While the PERT program was operational during FY 21-22, the ongoing COVID-19 pandemic continued to be a confounding factor that impacted mental health in the community, the mental and physical health of staff, as well as program operations. It is therefore not possible to separate the impacts of COVID-19 from the impacts of PERT.

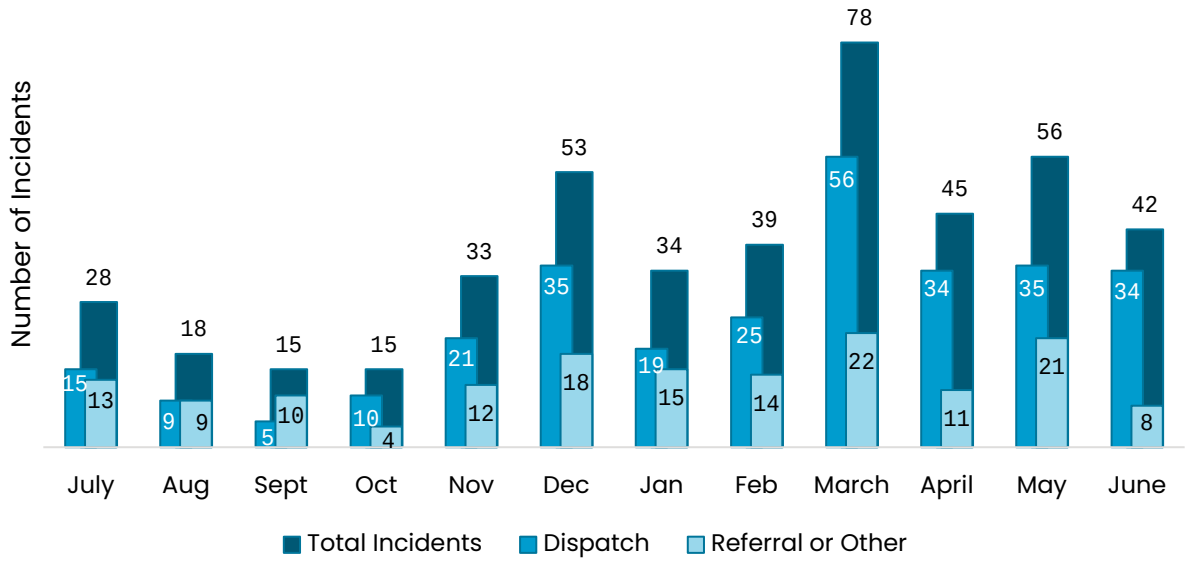
PERT Services and Consumer Characteristics

Santa Clara County's PERT Project operated a total of five Psychiatric Emergency Response Teams across four law enforcement agencies in Santa Clara County during the 2021-2022 fiscal year. Two of these teams operate within the Sheriff's Office and launched in FY 20-21. Three new teams launched during FY 21-22, including one with the Palo Alto Police Department (beginning November 2021), one with the Morgan Hill Police Department (beginning March 2022) and one with the San Jose Police Department (beginning July 2022). Given the timing of its launch and the analysis for this evaluation, quantitative data on PERT incidents for San Jose's PERT were not included in this report.

Incidents and Location

Collectively, the four SCC PERTs supported a total of 455 crisis and follow-up incidents (i.e., in-field encounters, deputy referrals, telephone follow-ups) during the 2021-2022 fiscal year. The majority of these incidents were supported by the Sheriff's Office teams (n=236, 52%), followed by the Palo Alto (n=197, 43%) and Morgan Hill (n=22, 5%) teams.

Figure 1. Total PERT Incidents for all Teams by Month and Source, FY 21-22 (N=455)

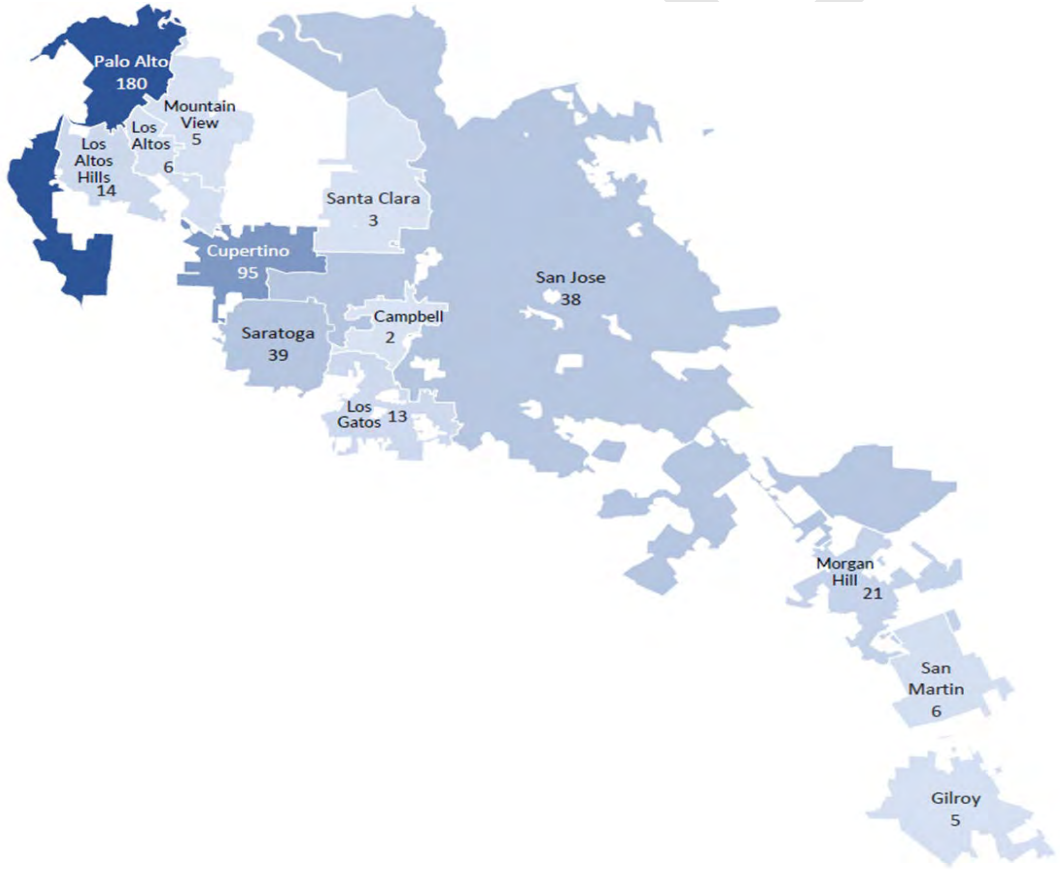


As shown in Figure 1, the PERTs collectively supported fewer incidents in the Fall of 2021 relative to the Winter and Spring of 2022, with the highest number of incidents taking place in March

2022 (n=78, 17%).[3] Throughout the fiscal year, incidents were most often initiated via police dispatch (n=299, 66%), followed by deputy referral and other sources (n=157, 34%). For team-specific month-by-month PERT incident breakdowns, see Figures 1-3 in the Appendix.

Figure 2 shows the number of PERT incidents that took place in different geographic areas within the county. Of the 455 PERT incidents that took place during FY 21-22, approximately 40% of them took place in Palo Alto and were supported by the Palo Alto PERT (n=180). Another 21% of PERT incidents took place in Cupertino, all of which were handled by the Sheriff's Office PERTs (n=95, 21%). Other somewhat common locations of PERT incidents included Saratoga (n=39), San Jose (n=38), Morgan Hill (n=21), Los Altos Hills (n=14), and Los Gatos (n=13).[4] One incident took place in Watsonville (not shown in Figure 2), demonstrating the capacity of PERT to reach relatively distant and remote areas for crisis response, even areas that may be outside of a particular PERT's jurisdiction but still within the County.

Figure 2. Location of total PERT Incidents, FY 21-22



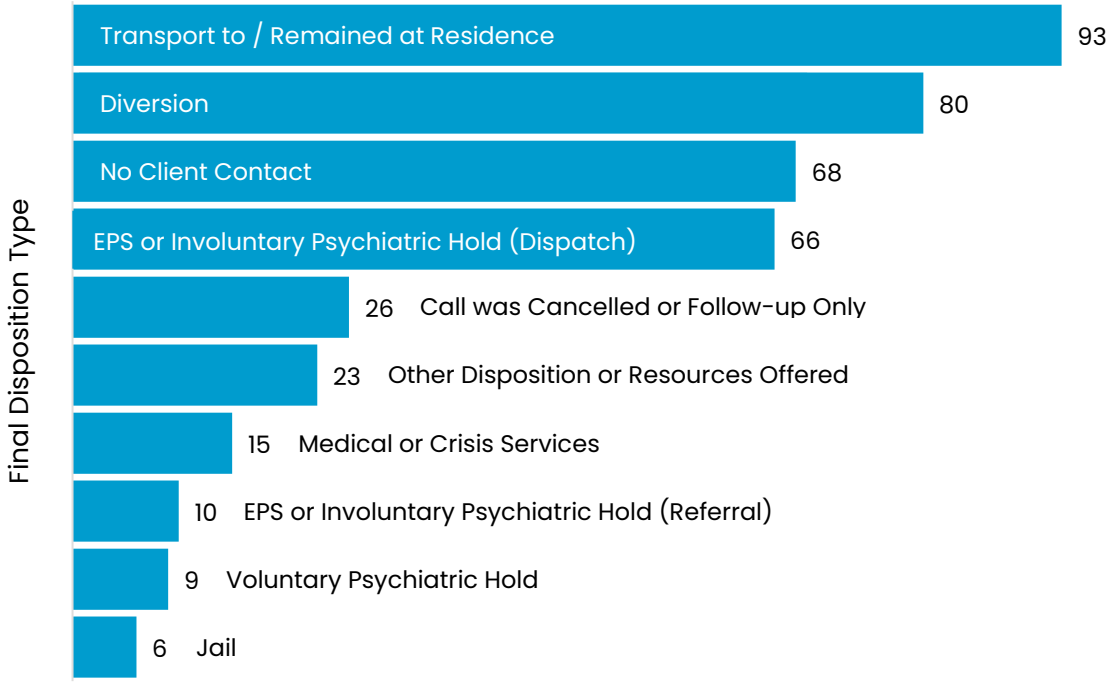
[3] Readers should note that the Palo Alto and Morgan Hill PERTs did not launch until November of 2021 and March of 2022, respectively. Therefore, quantitative data included in this FY 21-22 report represents just eight (8) and four (4) months of PERT incidents for the Palo Alto and Morgan Hill PERTs, respectively.

[4] This figure does not include 1 PERT incident that occurred in Watsonville, and 27 other incidents for which a location was not applicable (i.e., a telephone follow-up incident) or whose locations were missing from the available dataset.

Final Dispositions

Final dispositions of PERT incidents indicate the last location in which PERT members interacted with or transported the consumer during a crisis encounter. Of the 455 total PERT incidents, 87% had a known final disposition (n=396). As shown in Figure 3, about 23% (n=93) of PERT incidents ended with transport to or remaining at a residence (e.g., consumer home, friend's house). Another 20% (n=80) of PERT incidents resulted in consumer diversion. In other cases, PERTs had no contact with the consumer[5] (n=68, 17%) or the incident ended with transport to Emergency Psychiatric Services (EPS) or an involuntary psychiatric hold after a dispatch/call for service[6] (n=66, 16%). Less than 2% of PERT incidents resulted in consumer transport to jail (n=6). Overall, more than half of crisis incidents ended with PERTs either diverting, providing resources or services, or de-escalating crises such that other services were not immediately necessary.

Figure 3. Final Disposition of PERT Incidents, FY 21-22 (N=396)[7]



[5] Examples of PERT incidents with no consumer contact included situations in which consumers refused to cooperate or permit PERT staff entry or access, or consumers left the area and were unable to be located.

[6] In Figure 3, final dispositions involving "EPS or Involuntary Psychiatric holds" are divided by incident sources involving direct dispatch or calls for service (Dispatch) or referrals made by other deputies (Referral). Decisions regarding EPS/involuntary holds for referred cases are not always determined by PERT staff.

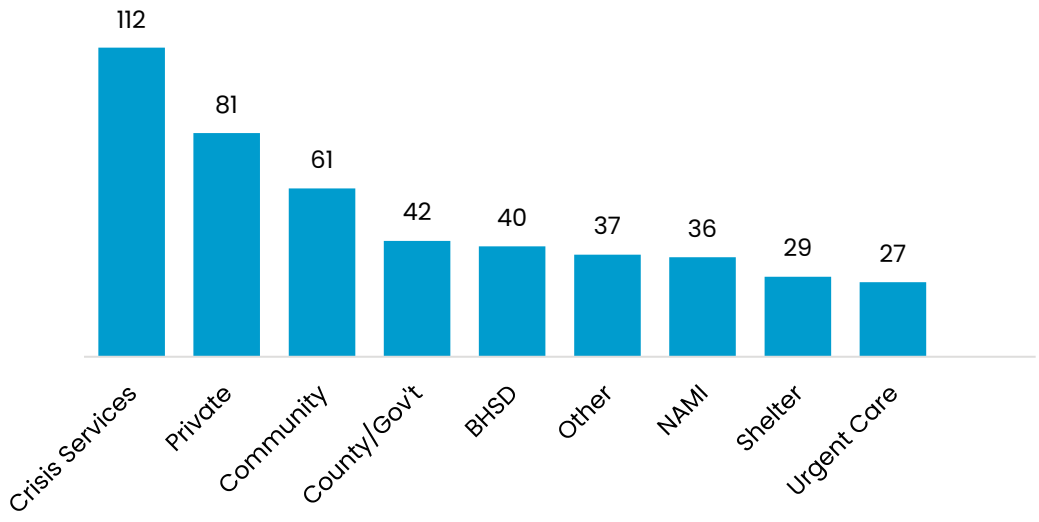
[7] This figure does not include 59 PERT incidents for which the final disposition was missing from the PERT Services Database.

Resources Provided

Following a crisis incident, PERT clinicians provide resources and referrals to consumers and family members willing to accept services. These referrals may take place in the field during a crisis encounter, or as part of follow-up after an encounter. In general, the PERTs tended to provide multiple resources per incident during this fiscal year.

In total, the PERTs collectively provided 465 referrals and resources during 214 crisis incidents[8] to meet the immediate needs of consumers and family members. As shown in Figure 4, the PERTs most frequently provided consumers with crisis service resources, such as crisis call lines and the Mobile Crisis Response Team (MCRT) (n=112), as well as private providers, doctors, and therapists (n=81). PERTs also provided consumers with community-based agency resources and services (n=61), such as Uplift, the Recovery Center, and resources for domestic violence. County and/or government agency resources and services provided (n=42) included the VA, Office of Family Affairs, and Adult Protective Services, to name a few. Other referrals and resources provided included BHSD resources (n=40), other or unspecified resources (n=37), NAMI information (n=36), shelter resources (n=29), and Urgent Care (n=27).

Figure 4. PERT Referrals and Resources Provided, FY 21-22



When family members are present or involved at the time of consumer crises, PERT also staff work to support family members by providing relevant resources and information (e.g., NAMI information, psychoeducation) and including them in safety planning.

[8] For all other PERT incidents (n=241), resources were either not provided, could not be provided due to call cancellation or lack of consumer contact, or information about resources provided was missing from the dataset.

Arrival and Encounter Times

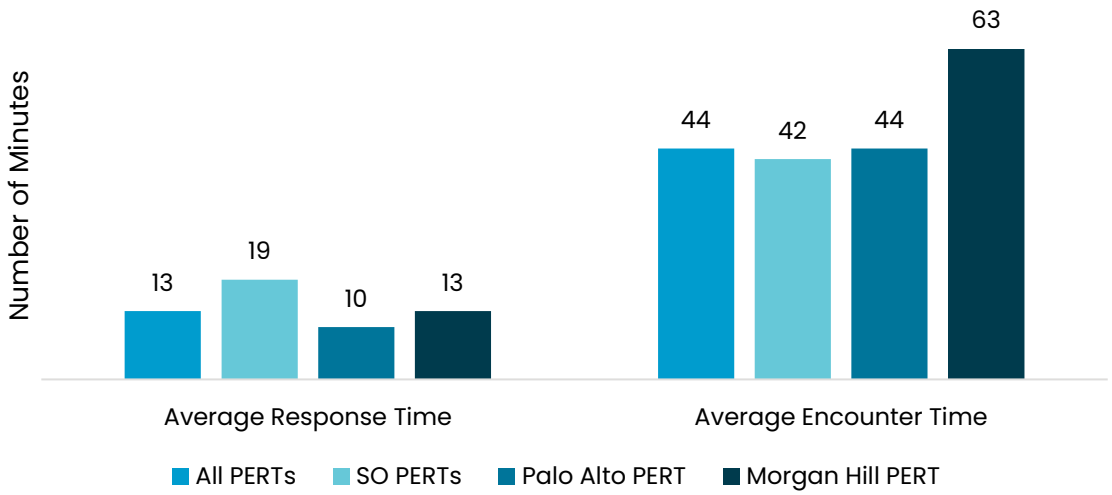
When responding to calls for service from dispatch, the PERTs collectively arrived onsite in an average of 13 minutes (SD=12, n=260), with arrival times ranging from less than a minute to over an hour (see Figure 5). PERTs usually respond to crises without operating lights and sirens in their unmarked vehicles, which may impact their average response time.

While on scene during encounters, PERT clinicians and officers provided support for an average of 44 minutes (SD=39, n=261), with encounter times ranging from less than a minute to several hours, depending on the nature of the encounters and consumers' needs (see Figure 5).

Compared to the average for all PERTs, the Sheriff's Office had a slightly higher average arrival time of 19 minutes (SD=15, n=102), which reflects the larger relative geographic size of their jurisdiction. The Sheriff's Office PERT response time was 13 minutes or less for nearly half their incidents (48%). Average arrival times for the Morgan Hill and Palo Alto PERTs were similar to the overall PERT average, at 13 minutes (SD=14, n=15)[9] and 10 minutes (SD=7, n=143), respectively.

With respect to encounter times, the Sheriff's Office and San Jose PERTs average encounter times were similar to the combined PERT average at 42 minutes (SD=43, n=111) and 44 minutes (SD=33, n=134), respectively. The Morgan Hill PERT's average encounter time was a bit over an hour (63 minutes, SD=50, n=16)[10] (see Figure 5).

Figure 5. Average PERT Arrival and Encounter Times, FY 21-22



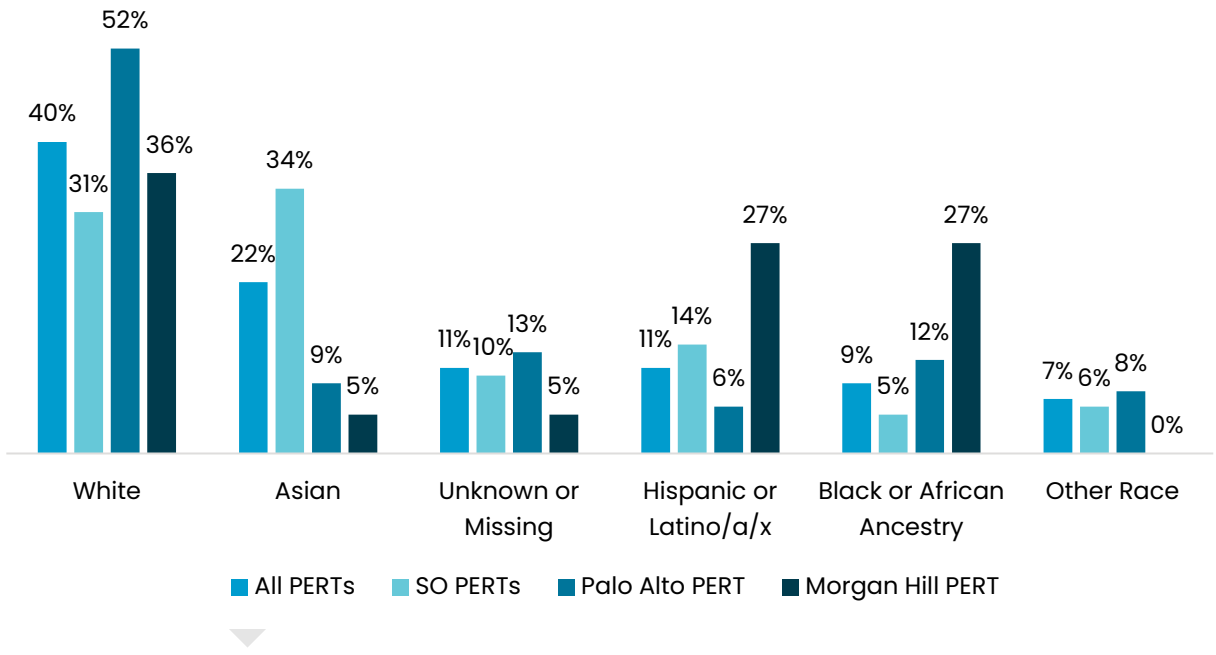
[9] The relatively low number of encounters supported by the Morgan Hill PERT (driven by its later launch, in March 2022) is sensitive to outliers and should be interpreted with caution. The median arrival time (which accounts for outliers better than the average) for the Morgan Hill PERT was 9 minutes, with a range of less than a minute to about an hour.
[10] As with average response time, the average encounter time for the Morgan Hill PERT is sensitive to outliers and should be interpreted cautiously. The median arrival time for the Morgan Hill PERT was 44 minutes.

Consumer Demographics

As shown in Figure 6, most of the total 455 PERT crisis incidents involved consumers who identified as White (40%, n=183) or Asian (22%, n=100).[11] According to census estimates, residents of Santa Clara County identify as majority White (51%) or Asian (41%).[12] Approximately 11% (n=50) of all PERT incidents involved consumers identifying as Hispanic or Latino/a/x, and 9% (n=40) identifying as Black or of African Ancestry. Census estimates indicate that 25% of the County population identifies as Hispanic or Latino/a/x and 3% as Black or African American.

Relative to the combined PERT totals, the Sheriff's Office PERTs responded to a slightly higher proportion of PERT incidents involving consumers who identified as Asian (34%), and the Palo Alto PERT responded to a greater proportion of incidents with consumers identifying as White (52%). Although the rates for Morgan Hill's PERT should be interpreted cautiously due to low number of incidents, this team responded to relatively higher proportions of incidents with consumers identifying as Hispanic or Latino/a/x (27%) and Black or African Ancestry (27%).

Figure 6. PERT Consumers' Race, FY 21-22



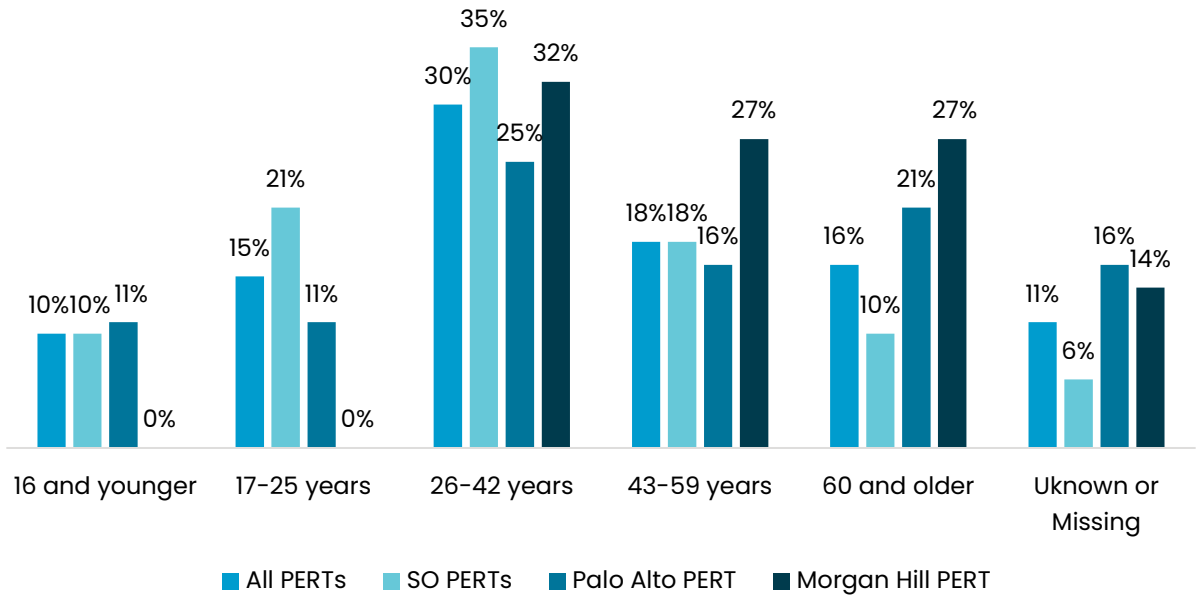
[11] Because unique personal identifiers were missing from the dataset, calculations of race for PERT incidents were made at the incident level instead of the consumer level.

[12] Census Data from Santa Clara County:
https://www.census.gov/quickfacts/fact/table/santaanacitycalifornia,santaclaracountycalifornia/PST045221

As shown in Figure 7, nearly half of the total 455 PERT incidents involved consumers who were between the ages of 26 to 59 years old (48%, n=218). Approximately 15% (n=70) of incidents involved consumers who were transition-aged youth (TAY) between 17-25 years old, and another 10% (n=46) involved children ages 16 and younger. A total of 16% of all PERT incidents involved older adults ages 60 and older (n=72). The average overall age for consumers across all PERT incidents was 39 years old (SD=19, n=406).[13]

Compared to the combined PERT sample, the Sheriff's Office PERTs had a slightly higher proportion of incidents with consumers who were between 17-25 (21%) and 26-42 years old (35%). Likewise, the Palo Alto and Morgan Hill PERTs had slightly higher proportions of incidents with consumers 60 and older (21% and 27%, respectively).

Figure 7. PERT Consumers' Age, FY 21-22



[13] This average was calculated from the 406 PERT incidents with known consumer ages. Information about consumer age was missing for 49 incidents.

Key Program Implementation and Operational Learnings

The following section details the PERT and Peer Linkage project's successes and challenges. Stakeholders believe PERT's integrated model has facilitated improved program coordination and consumer outcomes and has garnered positive responses from the community. At the same time, regional differences and the absence of the Peer Linkage component have provided insight into lessons learned and areas for potential growth moving forward.

Program Strengths

PERT's integrated model is viewed as critical to successful crisis response.

Clinicians, law enforcement officers (LEOs), and program leadership alike view PERT's integrated model as beneficial in supporting effective implementation and crucial for its success in crisis response. That each PERT's clinician and officer are in close physical proximity while traveling to and from each PERT incident facilitates easier information-sharing and opportunities for incident debrief. En route to incidents, clinicians access individual electronic health records (EHR) and provide information to their LEO partners that the officers would "otherwise be trying to figure out" with the consumer and team while working to secure the scene upon arrival. PERT LEOs further shared that the ability to readily obtain this crucial background information prior to arrival allows them to "reassess and slow down" in taking a careful and measured approach during crisis response encounters.

Likewise, clinicians shared that the close presence of their LEO partners during crises allowed them to "never have to worry about safety" while on-scene during crisis response incidents. In turn, clinicians said they were able to do their job more effectively, as they did not have to assess their safety in tandem with assessing and engaging PERT consumers on-site. This level of security also provided time and space for clinicians to "be creative and think outside the box of how to help [consumers]" during crisis response. Of this integrated approach, one clinician stated, "This is the model I need to feel I can do my job most effectively."

PERT's integrated model facilitates communication and relationship-building within teams, departments, and the County.

From inception and launch, each PERT is fully integrated into their respective police department. As part of initial and ongoing staff training, clinicians and LEO partners cross train and learn about each other's roles. Trainings involving stress inoculation scenarios allow clinicians to understand the "law enforcement side of things," while officers learn to recognize mental health signs and symptoms via mental health simulator training. This training period

allows clinicians and officers necessary time for relationship-building, giving team members a "good level of connectedness and mutual understanding of [their] respective jobs." Clinicians and LEOs stated that, in developing working relationships—a process that "could not be rushed"—they also developed shared nonverbal and shorthand communication, serving to further support effective and efficient joint crisis response.

The physical integration of the PERTs within police departments creates additional opportunities for relationship-building and communication that further supports LEOs and mental health consumers. When not responding to PERT calls, clinicians provide consults to non-PERT LEOs in their departments, offering advice about specific cases and training on crisis response. This allows non-PERT LEOs to incorporate a PERT clinician's perspective into their own responses to calls as well. Non-PERT officers may also make referrals to PERT clinicians for specific mental health-related cases. LEOs and leadership emphasized that the PERT clinicians have integrated very well into the police departments, and officers feel comfortable asking clinicians questions and referring cases to PERT. Moreover, PERT officers expressed that they themselves also become a resource to other LEOs based on what they have learned from their clinician partners' approaches to crises.

PERT's integrated model has also been associated with positive relationship-building among program leaders. Communication between BHSD and PERT LEO leadership has been constant and respectful throughout implementation. Both groups commended each other for going "above and beyond" in the work they do and stated that execution of the PERT program was significantly smoother due to "the openness [that Law enforcement and BHSD] have with one another."

PERT staff highlighted several exemplary cases that demonstrated their successful crisis response coordination efforts within their teams and the County. In one instance, an individual was actively discharging a firearm and threatening the lives of those on a property in North County. Non-PERT LEOs responded and secured the area while the PERT self-dispatched and arrived at a command post established nearby. The PERT worked proactively to gather information on the consumer and was able to contact several of their neighbors and friends. PERT discovered previously unknown information about the consumer, including that they possessed tactical equipment and training that presented a danger to the responding deputies, as well as sensitive family dynamics, suspected substance abuse, and recent emotional trauma. The PERT clinician reached the consumer by cell phone, providing instructions about how to comply with the deputies on scene. Following the clinician's phone call, the consumer was safely apprehended and was placed on a 5150 hold, resolving the incident safely and without the use of any force. After an extensive

debrief of the event, patrol deputies and supervisors expressed gratitude for PERT's involvement in the incident.

Another case of multi-agency collaboration involved a consumer with a history of brandishing and firing imitation firearms (airsoft guns) at people in the community, despite multiple warnings and confiscations by deputies. Investigation by PERT revealed that the consumer possessed a ballistic vest. PERT evaluated the consumer during a subsequent contact with law enforcement but were unable to convey a plan to stop the behavior, noting the consumer's lack of judgement and insight when confronted about potentially dangerous consequences of their behavior. The consumer was arrested and detained, but team members had concerns that they would be able to post bail and that their behavior would escalate. The PERT deputy contacted the District Attorney to request probation and Mental Health Court for the consumer, with conditions prohibiting possession of imitation firearms. The PERT clinician provided the jail's clinical staff with pertinent background information on the consumer's behavior and recommended psychological testing to inform recommendations for rehabilitation. As a result of PERT's involvement, the consumer received psychological testing, and the consumer was recommended for probation and mental health court.

PERT Law Enforcement were found to hold generally non-stigmatizing attitudes toward people with mental illness.

Law enforcement leadership and officers working with each PERT were found to hold generally non-stigmatizing attitudes and opinions toward people with mental illness, as measured by the *Attitudes to Severe Mental Illness* (ASMI) scale. Higher scores to questions on the 30-item ASMI indicate stronger agreement with non-stigmatizing views toward people with mental illness. The average total score for all 11 LEOs who completed the survey was 3.67 on a scale ranging from 1 (disagree with non-stigmatizing statements) to 5 (agree with non-stigmatizing statements).[14]

Most of the 11 LEOs who completed the survey expressed agreement with a majority of statements supporting non-stigmatizing attitudes toward people with mental illness, including that people with mental illness are able to work, be trained in an occupation, cope with life difficulties, and should not give up. Importantly, PERT LEOs each voluntarily applied to and were carefully selected for their positions after an interview process that involved questions from

[14] Average ASMI total scores for the 11 LEOs ranged from 3.10 to 4.50 (M = 3.67, SD = 1.39, N = 11) signifying a modest level of overall agreement with non-stigmatizing attitudes among PERT officers.

BHSD and PERT clinicians. The teams took a mindful and intentional approach to identifying LEO partners that were a good fit for PERT.

Despite their overall agreement with non-stigmatizing views, officers' views were more divided in a few specific instances. For example, 36% of officers agreed and 45% disagreed with the idea that someone who has experienced severe mental illness will suffer for the rest of their life. Similarly, 55% of officers agreed and 36% disagreed with the notion that it is difficult for others to understand those who suffer from severe mental illness.

PERT has garnered wide-ranging support and is seen as the future of policing by broadening crisis response.

By having clinicians and LEOs uniquely integrated and embedded within police departments, PERT staff see the model as taking a novel approach to crisis response. Namely, PERT focuses on consumer safety planning and resource distribution rather than more quickly resorting to psychiatric holds (e.g., 5150) or arrest and incarceration. In this way, clinicians and officers viewed the PERT approach as "slowing things down" compared to what might be considered typical responses to calls for service. With PERT, priority is placed on disengagement, de-escalation, and if possible, further resolving situations via phone or email follow-up, along with providing safety planning and community resources.

In recognition of growing mental health needs within the community, PERT leadership and staff alike view a PERT model as the future of policing. One clinician noted that PERT "feels like a new wave in law enforcement that wasn't maybe taken as seriously as it should have been before. [There is a] huge stigma with mental health, [and] I feel like it is important for officers to embrace it because it's not going anywhere." PERT members unanimously expressed a desire to see PERT continue to expand within the County as needs present and grow across jurisdictions.

As PERT has grown within the County, its success has garnered wide-ranging recognition from council members, state representatives, other police departments, local media, and the community. Both LE and BHSD leadership shared that they have received inquiries for information and establishment of new PERTs from police departments that have not yet adopted the model. State representatives have authored letters of support for the Santa Clara County's PERT program and local newspapers have highlighted PERT stories and impact. The PERTs have also started receiving referrals from non-law enforcement agencies such as Fire departments and EMS. With its growing acceptance, PERT leadership and staff believe that PERT has the ability to dismantle preconceived negative notions about law enforcement and crisis response.

Lessons Learned

PERT has faced ongoing challenges in efforts to implement Peer Linkage.

Although Peer Linkage was conceived as the PERT program's key innovation when applying for MHSA funding, a dedicated peer support staff was not originally incorporated into the grant from the onset. During the initial planning and launch of the program in 2018, BHSD leadership cited early challenges with departmental reorganization and staff turnover as contributing to a lack of clarity on program roles and authority, impacting the program's ability to hire a peer specialist and implement the planned peer linkage component.

The COVID-19 pandemic further complicated efforts to build out the peer linkage component, forcing the program to pause and creating subsequent ongoing challenges in hiring staff, including peer support staff. From the BHSD leadership perspective, uncertainty persisted with respect to County leadership support and whether PERT funds could be reallocated to support a peer position for the program. The team determined that building a dedicated peer support staff member into the grant from the onset might have eased some of the challenges BHSD experienced in launching the peer linkage component of PERT.

Absence of the peer linkage component has impacted role clarity and program implementation.

The PERT program was initially designed to contract peer support staff to provide consumer follow-up support, resources, and data collection after PERT incidents. As challenges to hire peer staff persisted, PERT clinicians readily assumed the role of providing post-encounter follow-up support to consumers in the interim. Clinicians viewed the absence of this Peer Linkage component as partly contributing to blurring the boundary of their role as crisis responders versus case managers. Further, because clinicians were stepping in to fulfill a role intended for peer support staff, some protocols and approaches to follow-up were not formally standardized across PERTs.

Clinician provision of follow-up support in the absence of peer linkage was also seen as potentially associated with a lack of role clarity among consumers and other community members. PERT staff found that consumers often assumed or expected that PERT's role included provision of case management after crisis encounters. PERT staff emphasized that repeated education about what PERT does and boundary-setting during crisis encounters and follow-ups were essential for clarifying their role to the consumers and the community. Said one clinician, "Educating the public is also a big part of this, in addition to staff and clients. People often don't know what our limits are."

The lack of Peer Linkage also complicated data collection for evaluation and continuous quality improvement. PERT's evaluation was designed to include collection of specific MHSA-required

demographic information by peer support staff during encounter follow-up. By having a peer collect this information post-crises, clinicians and LEOs could focus on the immediate crises in front of them. This client-centered approach was also intended to increase both consumer comfort and data quality with respect to personal and potentially sensitive questions (regarding sexual orientation, disability status, etc.). The absence of Peer Linkage created gaps in this data collection, and the evaluation team subsequently moved to having PERT clinicians take on this additional role moving forward.

Regional differences complicate efforts to standardize PERT across departments.

As Santa Clara County has continued to develop new PERTs, the program has worked to formalize and standardize practices and procedures across its teams and jurisdictions. A key manifestation of these efforts included the development of a County Operations Policy and Procedures Manual developed collaboratively by PERT staff and informed by policies from other County PERTs. As SCC PERT was implemented, the program learned that diversity in regional and jurisdictional needs complicated efforts to standardize the PERT model across departments. One officer shared that "each community is different", which makes it challenging to "apply a one size fits all" to PERT in across the County.

Regional differences impacted PERT's approach in many ways. For example, the frequency and timing of clinician follow-up after PERT incidents was often shaped by call volume, proportion of repeat consumers, and the extent of consumer needs and/or resources needed. Some PERTs were able to facilitate a higher level of resource coordination following crises due to lower call volumes and many repeat consumers. Palo Alto's PERT became a primary contact for chronic homelessness due to its high number of unhoused people. As the County grew in its awareness of these key differences, the program also learned how to adjust and be flexible in effectively carrying out the mission of PERT while also meeting unique regional needs.

Future Directions

In the Fall of 2022, the PERT program was made aware that the County had not recommended the program to continue with implementation through MHSA funding. Although their MHSA funding will continue through the end of June 2023, the program is working to identify other potential sources of funding to grow and sustain the program beyond this point.

In the 2022-2023 fiscal year, the PERT and Peer Linkage project has and will continue to expand the number of PERTs in the County. In November of 2022, Santa Clara BHSD finalized an MOU with Santa Clara Police Department for the development of a new PERT in the upcoming new year. With recruitment currently in the beginning stages as of this writing, BHSD hopes to have this PERT launched by early 2023. BHSD is also currently having discussions with other jurisdictions about their interest in launching a PERT with the County.

In the next fiscal year, BHSD will also continue their efforts to hire and integrate peers into the program to provide consumer post-crisis follow-up. The BHSD PERT project team will continue to collaborate and work to create solutions to implement the Peer Linkage component of the program.

In addition, the PERT project team and Santa Clara County BHSD as a whole is considering and planning for the continuum of behavioral health crisis response services available. The Mobile Crisis Response Team (MCRT), the Mobile Response and Stabilization Services (MRSS), the In-Home Outreach Team (IHOT), and the Trusted Response Urgent Support Team (TRUST) each provide mobile response services throughout the County and are dispatched through the 988 Crisis Lifeline.[15] PERT is the only mobile response team in the County that uniquely embeds mental health clinicians with law enforcement and is dispatched through 911. In turn, PERT can respond to higher-exigency calls that require both mental health and law enforcement presence, beyond what BHSD and community providers are equipped to provide. Given the multiple crisis response teams and programs available, coordination and collaboration are at the forefront of BHSD's vision for the future.

Program Changes from Initial Design

As discussed, the follow-up and referral aspect of the PERT and Peer Linkage program is currently being conducted by PERT clinicians rather than peer specialists. This is a temporary solution and the program plans to have peer specialists hired and begin providing these follow-up services and supports during FY 22-23.

[15] To read more about Santa Clara County BHSD's community mobile response teams, visit this page: **https://bhsd.sccgov.org/programs-services/community-mobile-response-teams**.

Appendix

Figure 1. Total PERT Incidents for the Sheriff's Office PERTS by Month and Source, FY 21-22 (N=236)

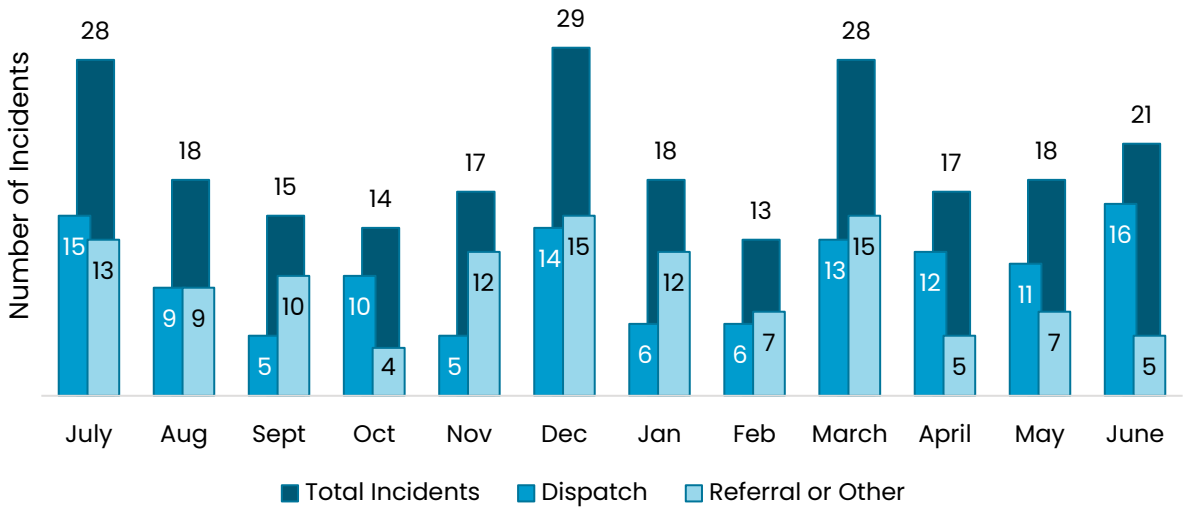


Figure 2. Total PERT Incidents for the Palo Alto PERT by Month and Source, FY 21-22 (N=197)

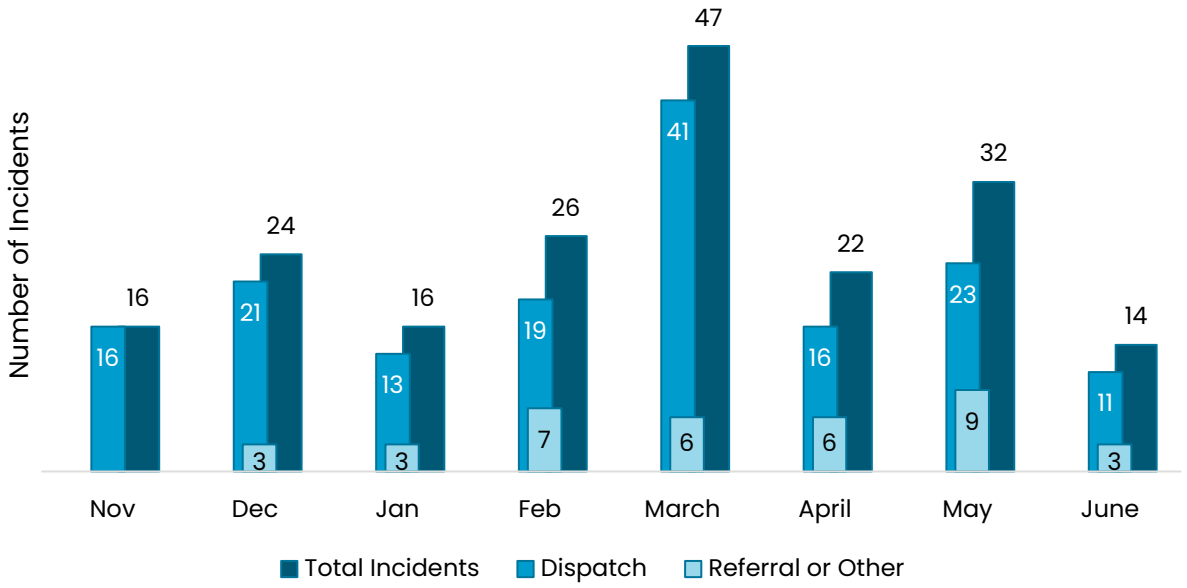


Figure 3. Total PERT Incidents for the Morgan Hill PERT by Month and Source, FY 21-22 (N=22)

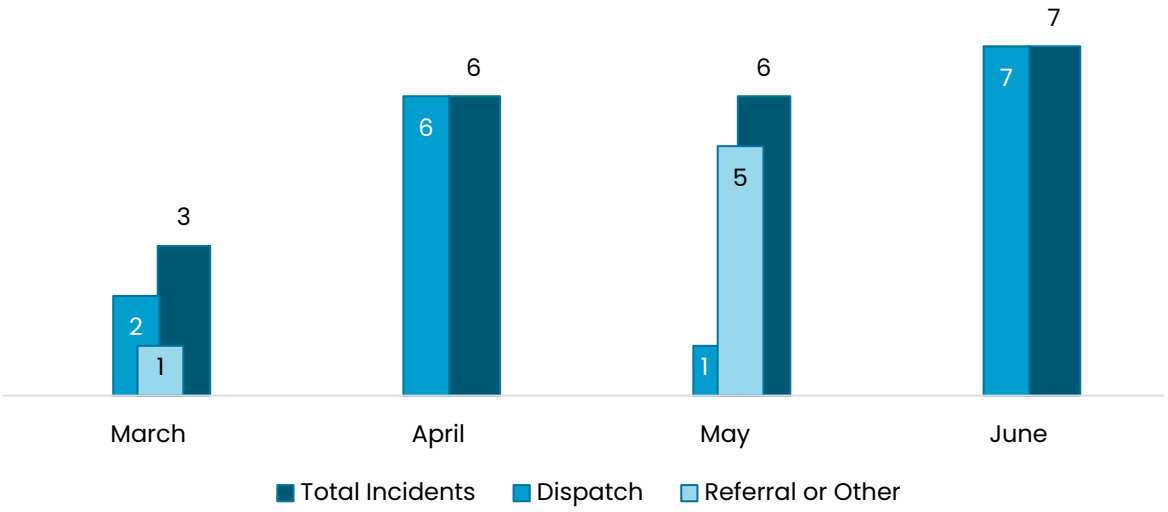


Table 1. Indicators and Data Measures for Evaluation Questions

	Question	Indicators & Data Measures	Data Sources
Process	1	Documentation of PERT and Peer Linkage Project	Plans, Theory of Change, Implementation
		Reasons for any changes to program	Focus Groups (& KIIs), Debrief Survey
	2	PERT & Peer Linkage implementation successes & challenges	Focus Groups (& KIIs), Debrief Survey
	3	Number of mental health-related call to LEAs & the number the PERT team responds to	Dispatch and/or PERT database
		Source, reasons, time, & location for PERT requests	Dispatch and/or PERT database
		Disposition of PERT encounters (e.g., remained in community, EPS, hospital, sobering center, jail, other community-based programs or services)	Dispatch and/or PERT database
		Number & demographics of consumers receiving PERT & Peer Linkage services	PERT database & EHR
		Response time to requests (i.e., time from dispatch to arrival) & duration of encounters	Dispatch and/or PERT database
		Number & type resources & referrals provided during PERT encounters & through post-crisis Peer Linkage services	PERT database and/or Peer Linkage database
Outcome	4	Number of consumers linked to behavioral health services and/or community-based resources post-crisis	PERT database and/or Peer Linkage database
		Time from PERT encounter to linkage to resources	Peer Linkage database
		Types, intensity, & frequency of behavioral health services and/or community-based resources received post-crisis	Peer Linkage database & EHR
	5	Changes in number of consumers experiencing crises, psychiatric hospitalizations, & criminal justice involvement after receiving PERT & Peer Linkage services	EHR, Jail and Court Databases
		Changes in number and/or length of crisis, psychiatric hospitalization, & arrests and/or incarcerations episodes after receiving PERT & Peer Linkage services	EHR, Jail and Court Databases
	6	Consumer perception & experience of services, including the most helpful aspects of services & areas for improvement	Focus Groups (& KIIs), Consumer Satisfaction Survey
	7	Changes in LEO knowledge of mental illness, how to respond safely & appropriately to mental health-related calls, & available mental health resources	Focus Groups (& KIIs), LEA & Debrief Survey
		Changes in LEO attitudes about mental illness	Focus Groups (& KIIs), LEA & Debrief Survey
		Changes in LEO response to mental health-related calls	Focus Groups (& KIIs), Dispatch & LEA database
	8	Number of consumers linked to behavioral health services and/or community-based resources post-crisis (PERT and MCRT)	PERT database and/or Peer Linkage database, MCRT database
		Types, intensity, & frequency of behavioral health services and/or community-based resources received post-crisis (PERT and MCRT)	Peer Linkage database & EHR, MCRT database
		Changes in number of consumers experiencing crises, psychiatric hospitalizations, & criminal justice involvement after receiving services (PERT and MCRT)	EHR, Jail and Court Databases
		Changes in number and/or length of crisis, psychiatric hospitalization, & arrests and/or incarcerations episodes after receiving services (PERT and MCRT)	EHR, Jail and Court Databases

allcove Evaluation

COUNTY OF SANTA CLARA,

Mental Health Services Act INN Cumulative Evaluation Report FY19-23

RDA CONSULTING

COUNTY OF SANTA CLARA
Behavioral Health Services

Acknowledgments

The RDA team would like to extend our gratitude to the partners of this project who have contributed to the evaluation. This report was developed on behalf of RDA Consulting under contract with the County of Santa Clara, Behavioral Health Services Department.

allcove Evaluation

County of Santa Clara,

MHSA INN Cumulative Evaluation Report FY19-23

Presented By:

RDA Consulting

RDA CONSULTING

COUNTY OF SANTA CLARA
Behavioral Health Services

Table of Contents

Executive Summary

Background: allcove in Santa Clara County

Santa Clara County's (SCC) Innovation Project (INN-13) was a collaboration between the Behavioral Health Services Department (BHSD) and community stakeholders as part of their Mental Health Services Act (MHSA) Innovations (INN) Plan. BHSD recognized the importance of seeking new and innovative approaches to providing comprehensive and accessible services to youth in Santa Clara County. In partnership with the Center for Youth Mental Health and Wellbeing's (CYMHW) Central allcove Team (CaT), a special initiative of the Chairman of Stanford University's Department of Psychiatry and BHSD brought a novel program, *headspace*, first developed in Australia, to SCC. The headspace model, now known as the allcove model in California, provides integrated care designed by and for youth. The YAG developed the following descriptions of the services offered at allcove Palo Alto:

Community Space

allcove Palo Alto has intentionally created a quiet space for young people to read, study, or meditate. Young people can also find social support at allcove Palo Alto through connection to services in the community. Finally, community gatherings, weekly support groups, classes, recreational activities, and events occur at the center.

Health and Wellness Services

Young people can access safe, confidential, and judgment-free access to sexual and reproductive health testing, medication information, and connections to care.

Substance Use Services

Screening and information or treatment opportunities to navigate alcohol and substance use through counseling or peer support groups.

Mental Health Services

Screening and counseling services that offer support, treatment, and tools for young people to care for their mental health.

Peer Support Services

Young people come to allcove Palo Alto to connect with peers who have lived experience and can provide support and help in navigating them to other services.

Supported Education and Employment (SEE) Services

SEE services provide young people with education support by helping youth prepare for college, vocational programs, assistance with school reentry, and a non-traditional secondary education program.

In accordance with the allcove model the allcove team work to identify the needs of young people and connect them to comprehensive and accessible services to meet individual needs. To accomplish this goal, BHSD has engaged with several partners, including CYMHW, Alum Rock Counseling Center (ARCC), Santa Clara Valley Medical Center (VMC), and Lucille Packard Children's Hospital (LPCH).

Evaluation Overview

The County of Santa Clara BHSD contracted RDA Consulting (RDA) as the external evaluator of the County MHSA Innovation project. The local evaluation included an implementation and process evaluation that explored the following evaluation questions:

allcove Model

1. Based on the allcove integrity model created by CaT, to what extent is the allcove model in SCC being implemented to fidelity? What are the successes and challenges in allcove implementation?
2. To what extent are local community contexts and pressures being addressed by allcove? How are allcove partners collaborating with the local community?
3. To what extent are youth satisfied with the allcove centers?

Public and Private Financing

4. What are the models of public-private financing and funding streams for allcove? What are the benefits and challenges of these models?
5. How does the public-private funding model impact confidential continuity of care and informed consent?

Access and Engagement

6. Who is being served by allcove? What type and how many services are allcove clients receiving? To what extent does the program reach young people from priority populations and reflect the community's diversity?
7. To what extent are youth connected to appropriate services that meet their clinical needs and individual goals?
8. To what extent do youth perceive that allcove services are culturally sensitive?
9. To what extent does allcove reduce symptoms and improve youth development and health outcomes (including mental, physical, social-emotional, and functional well-being)?

Client Outcomes

10. How do these outcomes differ based on client demographics, levels of need, and dosage?

Key Findings

The local evaluation plan explored the successes and key lessons learned to identify recommendations for BHSD to consider as they strengthen their sustainability plans and

recommendations for the state and other stakeholders to consider. This is particularly important as SCC is the first county in California to conclude its initial MHSA INN funding period and can provide feedback on the successes and barriers to the successful implementation of the model.

- Youth have expressed overwhelming satisfaction with allcove Palo Alto staff and the allcove center itself with 95% of youth indicating that they would recommend SCC allcove services to a friend.
- The SCC allcove team and BHSD have implemented the allcove model with integrity.
- The continuity of care that allcove Palo Alto has been able to establish is one of the centers strongest features.
- According to youth surveys and focus groups, the mental health and peer support services are the two most popular service streams offered by allcove Palo Alto.
- Youth reported that services were tailored to their needs and that they were able to access services in which they were interested.
- The intake process allows allcove Palo Alto staff to identify young people that may need further assessment and potential referral(s) for more intensive services, ensuring that young people are able to get timely access to care.
- Creating a space centering young people's sense of belonging and safety has been a priority from the beginning.
- Youth feel comfortable "easing their way" into mental health services at allcove Palo Alto after visiting the space or engaging in activities and events.
- allcove Palo Alto staff and clients have reported seeing improvements in clients' confidence in social settings, developing skills to express their emotions in a healthy way, and learning how to better communicate with family.

Summary of Recommendations

- **Santa Clara County Specific Recommendations**
  - BHSD should continue to pursue a uniform and global personal health information sharing form to streamline the information sharing process.
  - BHSD recently completed a community needs survey of the larger Santa Clara community. The information from this survey should be reviewed to understand gaps in community services, as well as the strengths and assets in the community. This would help to inform discussions about needed services and where the allcove model may provide a solution to any protentional gaps.
  - Modify the allcove Palo Alto website to be more relatable to youth and to clearly describe the variety of services offered at allcove Palo Alto. Engage YAG and youth to assist with website updates to ensure descriptions are written for youth.
  - When appropriate, consider including providers in addition to YAG and PSS at community events, allowing community members to engage with and learn about the allcove model and Palo Alto location from different perspectives.
- **allcove model - Considerations/Recommendations for statewide implementation**
  - Consider holding information gathering sessions with allcove sites about the medical/physical health component that is being/has been developed at their sites. These conversations should focus on needs, challenges, successes, barriers to implementation, and sustainability.
  - During information gathering sessions, collect feedback on adaptations sites have made to the medical components of their programs and what drove those decisions.
  - With multiple allcove sites in operation there may be an opportunity for the sites to enter into negotiations with insurance providers collectively, as allcove centers of care. This could be facilitated by the state.
  - Additional funding opportunities could be identified to assist in the long-term sustainability of allcove sites.
  - Consider updating data collection instruments to reflect measures that are representative of all young people and their identities as well as measurable outcomes.

Introduction

allcove Background

In 2006, Australia's National Youth Mental Health Foundation established an innovative model called "headspace." Designed to support early intervention mental health services for youth and young adults in a universal health care setting, the model aims to address multiple need areas and provide clients with the tools necessary to manage their mental health in the future successfully. As of 2022, headspace has grown to serve thousands of young people and their loved ones, both in-person and virtually, across 154 communities in Australia. Since its founding, the headspace model has been considered for adoption in other countries and jurisdictions with universal health care, including the "Foundry" integrated services program in Canada. State funding opportunities have since paved the way for adopting this integrated early intervention model in the United States.

allcove in SCC

Young adults in the U.S. have high rates of mental health disorders, yet many lack access to timely and appropriate treatment to meet their needs (Health and Human Services, Office of Adolescent Health). Recognizing the importance of seeking new and innovative approaches to providing comprehensive and accessible services to youth, SCC's BHSD partnered with CYMHW on a new Mental Health Services Act (MHSA) Innovation (INN) project serving to implement an adaption of the original headspace model, known as allcove.[1] The first of its kind in the U.S., the allcove model provides a dedicated youth space or "integrated center" where youth and young adults can receive a variety of services, such as mental health, physical health, substance use, employment, educational services, and family and peer support. After a successful application process, SCC's MHSA INN-13 allcove Project received approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) on August 23, 2018.

Adopting the allcove model in the United States for the first time brings unique financial considerations for implementation and sustainability due to the lack of national healthcare, an obstacle not faced in Australia or Canada. Additionally, allcove Palo Alto offers several services that would not be billable under a national healthcare system. The allcove model also serves as a public mental health prevention and early intervention point of access available to all youth in SCC, which can serve as a state and national model to support youth mental health needs regardless of insurance status.

allcove Service Model in SCC

The intent of allcove in SCC is to increase access to services for all youth, including underserved youth and youth that feel stigmatized by other services that may not be culturally affirming or youth

[1] The Central allcove Team (CaT) developed after this initial partnership was solidified.

focused. allcove is unique in providing a "no wrong door" approach where any youth, regardless of their need or insurance status, can obtain services. There are several core components of the allcove model, some of which include:

- A focus on mild to moderate mental health needs;
- Access to integrated care services (mental health, physical health, substance use, peer support, and education/employment support);
- Services that are accessible, affordable, de-stigmatizing, appealing to youth, and confidential; and
- Prioritization of youth engagement and youth voice in the implementation process through a shared decision-making model that includes brand identity, space design, policies and procedures, evaluation and data, marketing, advocacy, and outreach strategies.

A dozen staff operated SCC's two allcove youth centers in San Jose and Palo Alto, including administrators, care coordinators, mental and physical health care providers, and peer support specialists. The two SCC allcove centers offered a variety of behavioral and physical health, case management, peer, education, and employment services.

Implementation Timeline

Upon receipt of MHSA INN funding in 2018, SCC BHSD began the planning process for implementation of allcove in SCC, with their first program year beginning in fiscal year (FY) 2019-2020. Since allcove in SCC opened, services have been provided on-site and virtually. This hybrid approach ensured that youth were able to access services during the complexities of the COVID-19 global pandemic.

- **FY 1 (FY 2019-2020):** SCC BHSD continued the implementation planning for the allcove model in SCC. BHSD and stakeholders selected and initiated the process for acquiring a site in San Jose and a site in Palo Alto. The team also held planning meetings, designed policies and procedures, hired staff, and collaborated with the evaluation workgroup to develop the evaluation plan. RDA would like to recognize that this work continued even at the start of the COVID-19 pandemic in March 2020.

- **FY 2 (FY 2020-2021):** During COVID-19 restrictions, BHSD implemented a virtual service called Virtual You: Navigating Wellness Online (Virtual You) in the Fall of 2020. BHSD worked with CaT, Alum Rock Counseling Center (ARCC), LPCH at Stanford for psychiatry and psychology services, and Santa Clara Valley Medical Center (VMC) to assist with service support to youth. By the end of FY 20-21the two SCC allcove sites were operational.

- **FY 3 (FY 2021-2022):** Midway through FY21-22, due to circumstances outside of the control of allcove San Jose or BHSD, the allcove San Jose location closed. The response to this closure by BHSD was an excellent example of how innovation programs can pivot and maintain model fidelity. allcove Palo Alto staff were transferred to allcove Palo Alto and youth were

invited to continue receiving services at the Palo Alto location, through telehealth services, and, for those youth receiving clinical and peer services, a temporary space for in-person services was established in San Jose to ensure that youth who could not travel to Palo Alto were fully supported to complete their care. Additionally, during FY 3 allcove Palo Alto met their staffing goals, met all baseline measures on the CaT model Integrity Tool, expanded their service hours to increase accessibility for young people, and offered full scope services. Finally, at the end of FY21-22 the coordination and facilitation of the YAG transitioned from CaT to allcove Palo Alto leadership.

- **FY 4 (FY 2022-2023)**: In FY22-23 allcove Palo Alto providers attended several community events to participate in outreach activities and provide educational opportunities about allcove Palo Alto and the services offered. The types of workshops, classes, and activities that are offered onsite at allcove Palo Alto also expanded during the past fiscal year. allcove Palo Alto leadership and BHSD engaged with partners in sustainability planning, including exploring the possibility of establishing a formal referral source through a new initiative called Children and Youth Behavioral Health Initiative (CYBHI) under the California Department of Health Care Services (DHCS), discussed in greater detail in the Recommendations section.

Evaluation Overview

Evaluation Purpose

The evaluation that RDA and BHSD planned was a process and outcomes evaluation to measure various program elements over time. Over the course of the evaluation, data limitations have restricted RDA's ability to complete an outcomes assessment (*see Data Analysis – Limitations section for more information)*. As a result, the evaluation's focus in the final year has shifted. The purpose of this cumulative evaluation is to:

1. Evaluate the implementation and impact of the allcove SCC project;
2. Support continuous quality program improvement efforts for BHSD and the allcove SCC program; and
3. Comply with MHSA INN regulatory requirements, including annual reports to the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Evaluation Framework

The allcove model is an integrated youth mental health center that welcomes youth and encourages them to access various support services and care. The allcove model is designed with, by, and for youth and reflects local youth's unique perspective and needs. RDA collaborated with BHSD to clearly understand SCC allcove's target population, stakeholders, services, and goals, which directly informed the framework of domains (or areas of inquiry) used to guide the evaluation questions, measures, and activities. The evaluation sought to analyze available qualitative and quantitative findings from data collection across four years (2019-2023) of four evaluation domains, each described below.

- **allcove model**: This domain measures the nature and extent of implementation fidelity to the allcove model's stated and intended model, local community collaboration and awareness of allcove in SCC, as well as input and collaboration regarding allcove in SCC, and youth satisfaction with the program.
- **Public-private financing**: This domain measures financial sources and collaboration of allcove in SCC, including identification of public-private financing models and funding streams, the benefits, challenges, and impact of these models, and how the public-private funding model impacts confidential client continuity of care and informed consent.
- **Access and engagement**: This domain measures client access and engagement with the allcove SCC services, including identification of who allcove SCC serves, access among priority and diverse populations, the nature and extent of services received, facilitators and

barriers to service access, the extent of service appropriateness for meeting existing needs, as well as the cultural sensitivity of allcove SCC services.

- **Client outcomes**: This domain intends to measure a variety of outcomes experienced among allcove SCC clients, including improvement across mental health, physical health, social-emotional wellbeing, and functional wellbeing outcomes, as well as the extent to which such outcomes differ across client demographics, levels of need, and service utilization.

Evaluation Questions

Within this framework of domains, the RDA evaluation team collected data on several evaluation questions spanning all four domains. RDA worked collaboratively with SCC BHSD to develop these evaluation questions, listed in ***Figure 1*** below. In addressing these questions, this report will identify the most effective aspects of allcove in SCC, program aspects for improvement, and recommendations to enhance sustainability. A fuller integrated view of the evaluation domains, questions, measures, and data sources is in Appendix A.

Figure 1. allcove SCC Evaluation Domains and Questions

Domain 1: allcove Model

1. To what extent is the allcove model in SCC being implemented to fidelity? What are successes and challenges in allcove implementation?
2. To what extent are local community context and pressures being addressed by allcove? How are allcove partners collaborating with the local community?
3. To what extent are youth satisfied with the allcove centers?

Domain 2: Public-Private Funding

4. What are the models of public-private financing and funding streams for allcove? What are the benefits and challenges of these models?
5. How does the public-private funding model impact confidential continuity of care and informed consent?

Domain 3: Access and Engagement

6. Who is being served by allcove? What type and how many services are allcove clients receiving? To what extent does the program reach young people from priority populations and reflect the diversity of the community?
7. To what extent are youth being connected to appropriate services that meet their clinical needs and individual goals?
8. To what extent do youth perceive that allcove services are culturally sensitive?

Domain 4: Client Outcomes

9. To what extent does allcove reduce symptoms and improve youth developmental and health outcomes (including mental health, physical health, social-emotional wellbeing, and functional wellbeing)?
10. How do these client outcomes differ based on client demographics, levels of need, and dosage?

Methodology

To address the areas of inquiry, RDA employed a mixed-methods approach for the final cumulative evaluation of allcove in SCC, synthesizing qualitative and quantitative data collected between 2019 and 2023 from program staff, partners, and clients, as well as administrative program data. This methodology supported measuring program progress over time and provided the ability to triangulate and contextualize observations and findings through stakeholder input. The following sections detail (1) the data collection approach and sources used and (2) the data analysis approach for developing findings.

Data Collection

RDA employed a mixed-methods approach to conduct the final evaluation of allcove Palo Alto, combining qualitative data collected from partners, providers, and participants, quantitative administrative data, and project documentation. The final evaluation covers the program period July 1, 2019, through June 30, 2023. Different data sources cover different periods of program implementation, see ***Table 1***. A more detailed overview of the methodology and data sources is in Appendix A.

Qualitative Data Collection

RDA collected a variety of primary and secondary qualitative data sources. RDA conducted focus groups with allcove Palo Alto's service providers, leadership, BHSD, and CaT in 2021 and 2023 (***Table 2***). In 2022, RDA facilitated focus groups with members of the YAG. Secondary sources reviewed included documentation of integrity tools, budget documents, and marketing materials with program descriptions.

Quantitative Data Collection

allcove Palo Alto provided two quantitative data sets to RDA. The first is the Welcome Packet data, which contains client registration information, such as demographic characteristics of clients. Data from the Welcome Packet intentionally captured the elements required by the MHSA and were collected as part of the allcove registration process. Additionally, allcove Palo Alto provided programmatic data, enabling RDA to examine program reach. The second dataset is the intake

and discharge data. This dataset is not reported in the cumulative report, as explained in the limitations section.

RDA collaborated with BHSD to administer and collect several surveys throughout the project (***Table 1***), including surveys to both YAG participants and allcove Palo Alto clients. allcove SCC clients were also asked to fill out an end of visit survey after each service visit.

RDA supported BHSD[2] in electronically collecting anonymous end of visit survey responses through the online survey platform Alchemer. A total of 231 responses were collected between June 2021 and March 2023, including 13 surveys from the San Jose allcove site and 218 from the Palo Alto site. During this timeframe, the allcove SCC sites collected hard copy surveys and electronic copies of the survey from youth. RDA provided BHSD with monthly data updates and exports of survey responses. Beginning in July 2022, BHSD took ownership of data collection and storage. RDA cleaned and reviewed the data to identify key themes and takeaways.

Table 1. Data Collection Methodology and Timeline

Qualitative Data			
Population/Source	**Data Collection**	**Date**	**Number of Participants**
allcove Palo Alto leadership & BHSD	Focus Group	3/2021	2 participants
Central allcove Team	Focus Group	3/2021	4 participants
allcove Palo Alto Providers	Focus Group	3/2021	3 participants
Youth Advisory Group	Focus Group	9/2022	5 participants
allcove Palo Alto Providers	Focus Group	3/2023	9 participants
allcove Palo Alto leadership & BHSD	Focus Group	3/2023	5 participants
Central allcove Team	Focus Group	3/2023	6 participants
Quantitative Data			
Youth Advisory Group	Survey	3/2021	39 Responses
Clients	Survey	9/2022	34 Responses
End of Visit Survey	Survey	6/2021 – 3/2023	231 Responses

[2] allcove SCC is used when end of visit data or Welcome Packet data from both the Palo Alto and San Jose sites are referenced. allcove Palo Alto is used to refer to data specific to the Palo Alto site (i.e., data collected after the San Jose site closed).

Data Analysis

Qualitative Data Analysis

Transcripts from focus groups were systematically reviewed for common themes. The findings presented in this report are derived from the themes that emerged across the focus groups. The findings outlined in this report do not represent every opinion or experience shared by each participant. Rather, they represent the most salient – or commonly noted – opinions and experiences. The thematic analysis aims to elevate priorities captured from participants' shared experiences, understandings, and desires.

Quantitative Data Analysis

The RDA evaluation team began quantitative analysis by organizing and cleaning allcove SCC program record data in Excel. To analyze this data, RDA exported these records into Stata, statistical software, and completed descriptive analyses to understand client demographics, services received, and other relevant client data. RDA requested aggregate and individual-level data from BHSD, which records information on client demographics, service types, service locations, assessment and diagnosis data, and referrals. Throughout March 2023, RDA received this requested data containing information collected from all clients at intake and shared across providers that provide services to these clients. This data enabled RDA to understand the needs, access, engagement, and service utilization of allcove SCC clients.

Limitations

As with most evaluations or research projects, data collection and analysis limitations arose. Highlighted below are two specific methodological limitations that affected the data and analysis.

Self-Report Bias. The evaluation relies on self-report data from surveys, focus groups, and the data reported to allcove Palo Alto during intake. It is important to recognize that the evaluation asked young people to report on their own experiences. When reporting their feelings, it is possible that youth may not have been able to identify their thoughts or feelings in the moment, they may have sought to make a good impression, or they may have been too embarrassed to respond honestly. Although there is no direct evidence of this, given the amount of self-reported data used in the evaluation, it should be noted.

Data Limitations. The process and outcome evaluation were developed with the working group responsible for implementing allcove in SCC. RDA generated the evaluation questions and domains based on the data collected by the minimum dataset created by CaT for allcove SCC. However, the outcome evaluation is more limited than anticipated due to several factors regarding data quality and limited data availability.

The allcove model is a prevention and early intervention (PEI) model meant to be an access point for youth with low to moderate mental health, substance use, or co-occurring needs. The allcove model calls for centers to provide and engage young people in prevention services, screening services, and short-term treatment. This has made categorizing program completion or discontinuance from services difficult for some providers to capture accurately given discharge codes in Electronic Health Records (EHR) systems are based on a more traditional model of mental health services. This has led to questions about the accuracy of the discharge status of youth.

Additionally, the allcove model is designed to be a drop-in center where youth may only attend one session. These youth did formally exit the program, and therefore there is no opportunity to track progress over time or to collect additional data. When developing outcome measures for allcove, see ***Figure 2***, how to measure outcomes for youth that utilize allcove as a drop-in center was not included. To complicate matters further the initial implementation of data collection also included a centralized data system that all providers at each allcove location could enter data into and there could be improved data collection and tracking of youth outcomes. However, during the INN project, this was not completed as DataCove has yet to be piloted.

This limit on the outcome data collected is impactful. Thus, RDA intended to conduct a pre-post analysis to (1) describe outcomes and (2) identify changes in knowledge, attitudes, and skills of youth participants before and after receiving allcove SCC services. Because this data was unavailable, RDA could not complete an outcomes assessment.

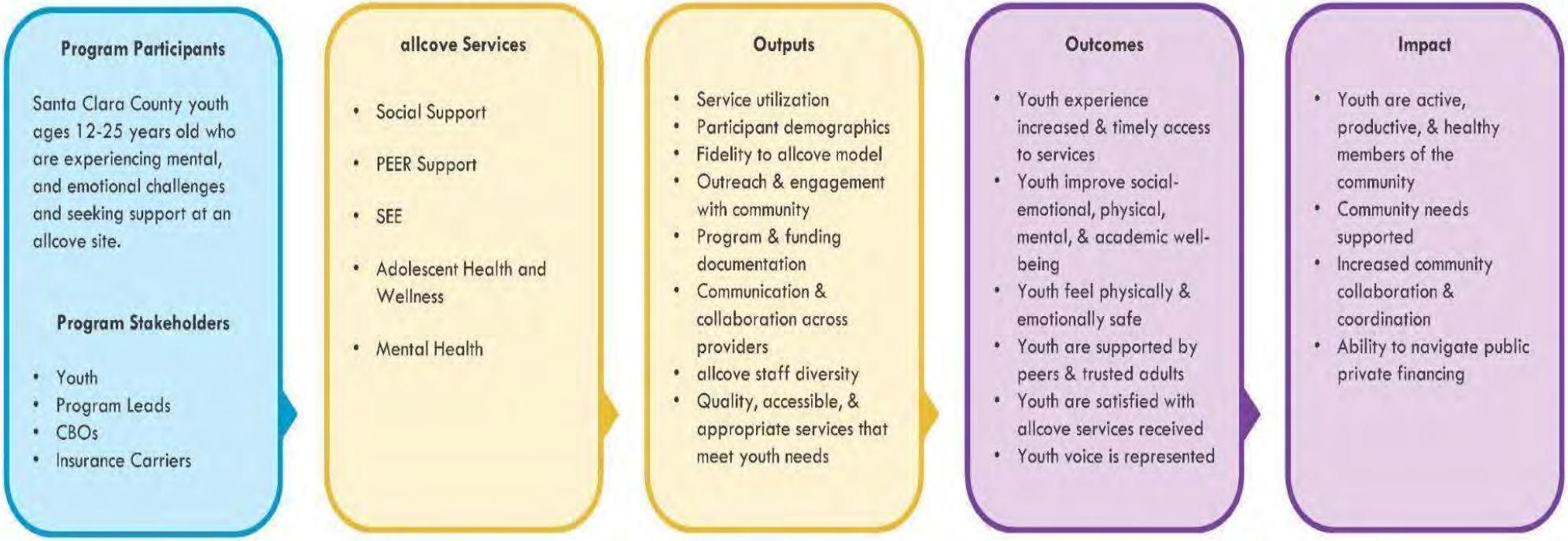
Lastly, qualitative data analysis has its inherent limitations. Researchers coded and analyzed data, and it is impossible to eliminate all variability in how the data is interpreted and understood. The research team met frequently to cross-check definitions and analysis approaches to ameliorate bias to the greatest extent possible.

Figure 2. allcove Logic Model

allcove Integrated Logic Model

A high level look at how and why allcove sites are expected to make lasting change and impact.

Program Context:
allcove is a network of standalone, integrated youth mental health centers that welcome youth and encourage them to access a range of support services and care. The allcove centers are designed with, by, and for youth, and reflecting the unique perspective and needs of local youth.



Findings

Program Reach and Engagement

Overview

County of Santa Clara BHSD and the County's allcove team (which includes partner organizations) have provided young people services under the MHSA Innovation grant since November 2020. As discussed in the previous section, the allcove program was launched in the County during the COVID-19 pandemic when state and local governments instituted public health guidelines restricting public gatherings. After public health restrictions eased and the County could launch the allcove model as intended, allcove SCC providers served hundreds of youths from SCC and beyond. From June 1, 2021, through March 31, 2023, the end date for data collection for the cumulative report, 477 youth were served at both allcove San Jose and allcove Palo Alto.

This section of the report will present key findings related to the youth that engaged in services at both allcove SCC sites, including their demographic characteristics and allcove engagement:

- Youth Enrollment and Engagement
- Youth Profile
- Youth Geographic Profile

allcove in SCC by the Numbers

- Since the start of the allcove initiative in SCC, 477 young people have benefitted from accessing services at the allcove center(s).
- Most young people (82.5%) seeking services from allcove in SCC are interested in mental health services.
- Young people who engaged with allcove services in SCC resided in 75 different zip codes across the Bay Area and Northern California.

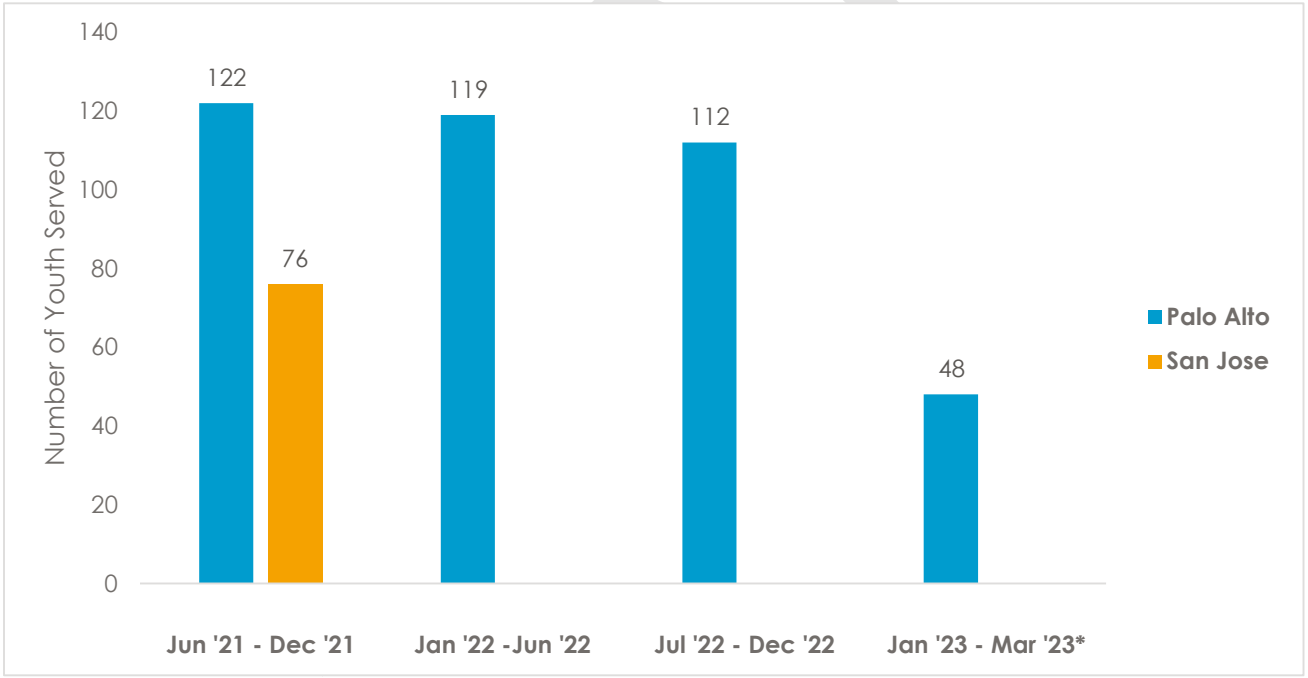
SCC allcove Enrollment and Engagement

Overall, SCC allcove centers served 477 distinct youth, 48% of its original goal of 1,000 distinct youth each year. Several factors should be considered regarding the lower-than-anticipated utilization rate including the impact of COVID-19; the closure of allcove San Jose; an overestimation of the utilization rate based on service offerings called for by the model as expanded on in section one (allcove Model); and challenges to marketing allcove in SCC, addressed in section one (allcove Model).

In June 2021, the County was still in the Orange Tier, meaning that the allcove centers were not fully open due to public health guidelines. Despite these restrictions, there were 46 attendees registered for the opening event in Palo Alto and 40 attendees registered for the opening event in San Jose.

Overall, most youth (84%) received services at the Palo Alto location (n = 401). However, during the six months that allcove San Jose was in operation, 76 youth sought services. In comparison to Palo Alto during the same time period, 120 youth sought services. On an annual basis, allcove SCC served an average of 239 youth per year between FY 21-2022 and FY 22-23.[3] Enrollments across six-month time intervals, with the exception of the last interval which is reflective of the final three months of data collection, can be found in ***Figure 3***.

Figure 3. allcove SCC Enrollments across Six-Month Time Intervals



*Reflects the last three months of the data collection period.

[3] *Note*: Northern and Central California, including the County of Santa of Clara, were impacted by a winter storm season. The County saw higher than average annual rainfall (151%), according to the Santa Clara Valley Water District. These winter storms led to widespread flooding, power outages, impacted public transportation, and impacted the ability the of youth to access allcove Palo Alto, reducing the utilization in the last four months of this reporting period (December 2022 – March, 2023).

allcove Model

Overview

SCC launched the first allcove sites in California and, as such, a component of the evaluation is dedicated to understanding the model and program implementation. There is a need to understand if the model is working as it is intended, reflecting the local community context and needs, and if youth report satisfaction with their allcove experiences. RDA evaluated program implementation, assessed the extent to which services were implemented as planned, and identified implementation successes and challenges. Understanding the success and challenges of the allcove model in SCC informed programmatic improvements. These learnings also supported programmatic growth so the model could be refined, replicated, and rolled out in other counties. A thorough review of program documents and the completion of focus groups with allcove Palo Alto staff, BHSD, and stakeholders has assisted RDA in the development of the following section of the evaluation which explores what was required to initiate and develop the allcove model in SCC over time, including challenges that were addressed and key lessons learned in three domains:

- Fidelity to the Model
- Local Community Contexts and Pressures
- Youth Satisfaction

Summary of Findings

Fidelity to the Model

- The allcove model has been implemented with integrity according to the model Integrity Tool created and completed by CaT.
- Despite several challenges faced early in the implementation of the model, most, if not all, outside the control of the implementation team, the allcove SCC team and BHSD have been able to pivot and develop valuable and needed services for young people.

Local Community Contexts and Pressures

- allcove in SCC continues to expand its community presence by participating in community events and holding information sessions.
- Local high schools and Federally Qualified Health Centers are significant referral sources.
- Young people have expressed overwhelming satisfaction with allcove Palo Alto staff and the center itself and would recommend allcove Palo Alto to a friend.

Fidelity to Model

What are successes and challenges in allcove implementation in SCC? To what extent is the allcove model being implemented to fidelity?

Model Fidelity

During the first six months of implementation, leadership at both allcove Palo Alto and allcove San Jose and YAG had to navigate challenging environmental conditions while making difficult decisions. Both providers and CaT described how allcove Palo Alto and San Jose leadership prioritized youth care and needs while responding swiftly and effectively to the allcove San Jose site closure and quickly transitioning staff. Integrating YAG decisions into program implementation was emphasized as a success of allcove Palo Alto.

allcove Palo Alto leadership, YAG and BHSD were able to creatively leverage the allcove San Jose site closure to adapt the staffing model at allcove Palo Alto to better meet the center's needs and clients' needs, a success celebrated by several focus group participants. The allcove Palo Alto team consolidated program managers at the allcove Palo Alto site and brought on mental health clinicians, psychiatry services, peer support specialists (PSS), and supported education and employment (SEE) specialist which allowed allcove Palo Alto to not only improve current operations but also to expand service delivery to offer weekend hours, thereby increasing the accessibility of allcove services to youth in SCC.

To ensure the model was implemented with integrity, technical assistance (TA) was provided by the CaT. This TA included the CaT team piloting the use of the model Integrity Tool.[4] The purpose of this tool will be to measure an allcove center's alignment to the allcove model. The more indicators that a center meets on the tool, the more evidence there is that youth are receiving high quality, holistic, integrated care in a timely manner. During the TA contract between allcove SCC and CaT, the model Integrity Tool was completed once with allcove Palo Alto in June 2022, one year after the site opened.

> **"With the close of allcove San Jose, there was a quick 're-pivot' of staffing resources to allcove Palo Alto, which was a strength for that center… the opportunity to move staff over to allcove Palo Alto beefed up that staffing profile and provided a solid staffing profile for service delivery."**
> – CaT, March 2023

allcove Palo Alto worked with CaT throughout the TA contract to ensure the center met model fidelity. The Integrity Tool that the center completed with CaT identified opportunities for allcove Palo Alto to leverage so that the investments already made in the model could continue to support the sustainability of the allcove model in SCC. Feedback throughout all seven dimensions of the Integrity Tool indicates that, within one year, allcove Palo Alto achieved or was working on achieving each of the components in the Integrity Tool.

[4] The CaT's model Integrity Tool was in development when allcove Palo Alto was assessed. The assessment allowed the CaT to further refine the tool. When the assessment took place the fidelity objectives were not consistent and SCC allcove met the changing guidelines as recommended by CaT.

allcove model Integrity Tool

Dimension 1: Infrastructure

- This 11-item dimension measures whether an allcove site has capacity to implement and sustain the allcove model.

Dimension 2: Center and Cultural Environnent

- This 7-item dimension evaluates an allcove sites ability to be young people focused and culturally sensitive.

Dimension 3: Access and initiating services

- This 11-item dimension measures the capacity and content of intake and assessment procedures.

Dimension 4: Service delivery and youth response monitoring

- This 13-item dimension measures different components of service delivery in place and how allcove sites are monitoring youth satisfaction and feedback.

Dimension 5: Community networking and integration of services

- This 10-item dimension evaluates how allcove sites network and information share.

Dimension 6: Workforce

- This 11-item dimension determines whether allcove sites are appropriately staffed and that staff are supported.

Dimension 7: Staff training and development

- This 5-item dimension reviews initial and ongoing training for staff and advisory board and youth advisory group members.

Youth Voice

In addition to the support for the implementation of the allcove model in SCC that the Integrity Tool lays a foundation for, youth voice is integrated into decision-making at allcove Palo Alto through the YAG and during service delivery (i.e., between providers and their clients). As a result of the meaningful input from the YAG, there is interest among other SCC stakeholders to increase areas where youth voice and input can be elevated.

The YAG is a diverse group of young people whose involvement developed over time, with representation from across the County. allcove Palo Alto leadership and BHSD shared various examples of decisions that the allcove Palo Alto YAG informed, from hiring decisions to building design. allcove Palo Alto leadership, BHSD, and CaT elevated the importance of hearing from YAG participants from San Jose directly during decisions about the allcove San Jose site, and CaT celebrated the efforts of allcove Palo Alto leadership to continue engaging YAG allcove San Jose participants.

> **"How have we designed programs in the past without this youth input? We are doing things as a center we would not be doing otherwise because of the eyes and energy of YAG. Their eye on the hiring process, I never would have expected that they would be so instrumental in the hiring process. Our team is phenomenal."**
> – allcove Palo Alto leadership and BHSD, March 2023

> **"Another thing that went well was when [BHSD] was talking about whether the allcove San Jose site was going to be closed and how that was going to happen, [BHSD] was interested in keeping the San Jose YAG intact, which was important. We want to uplift that; it was a great success. They understood the need to have San Jose youth represented, that was a great success for model integrity."**
> – CaT, March 2023

Providers highlighted allcove Palo Alto's incorporation of the YAG and the center's ability to engage young people for services as the main attraction that drew them to allcove Palo Alto. Providers share how the interests, topics, and concerns that young express – whether via YAG or during service engagement–are discussed across providers and embedded into service streams. Overall, respondents strongly emphasized that the allcove Palo Alto center design, the welcoming atmosphere for young people, and the quality of staff and their relationships with young people are strongly aligned with allcove model fidelity.

Service Integration and Collaboration

Another key area of model fidelity that is a strength at allcove Palo Alto relates to the service integration and collaboration across providers. Providers, allcove Palo Alto leadership, and BHSD respondents shared how providers leverage their areas of specialization while collaborating, effectively providing a "seamless" experience for young people, regardless of the provider's home agency.

Service delivery is especially enhanced due to on-site integration, allowing for warm handoffs within the same building when needed.

> **"The integrated model is what makes us special. I can see it with reports from parents and youth. It's helpful to collaborate across the PSS who have lived experience with marginalization and the clinical branch."**
> – allcove Palo Alto provider, March 2023

According to providers, allcove Palo Alto grew and expanded policies and procedures over the first 18 months of implementation, which was an essential support to providers. allcove Palo Alto leadership and BHSD value the development of their staff, especially for Peer Support Specialist (PSS) staff who are early in their careers and proactively work to embed ongoing development into their roles. allcove Palo Alto leadership and BHSD have seen the transition of PSS into a future career or postsecondary educational opportunities while maintaining a steady recruitment pipeline and supportive onboarding for new staff. This is similarly seen with YAG members who are attending college and are commonly choosing to major in psychology.

> **"Between the team, we're very open about what we can improve on, and we're a strong team."**
> – allcove Palo Alto provider, March 2023

> **"[For] my daily responsibilities, I know the outline of policies, but I appreciate that when I come up with suggestions for ARCC, the County, or medical… [it feels like you're] able to raise your hand and say something could be better. I'm receiving support and can work to collaborate across the groups on how to enact change."**
> – allcove Palo Alto provider, March 2023

Provider collaboration is a success of allcove Palo Alto largely due to the attention paid during the initial implementation stage of establishing the allcove model in SCC. BHSD and allcove Palo Alto leadership has made collaboration with partners and young people a priority, resulting in improved

> **"I can attest that the team strives toward excellence and is very patient centered. [The team is] very good at advocating for the patients [whether established or new patients]."**
> – allcove Palo Alto provider, March 2023

services youth such as the development of a regularly schedule multidisciplinary team meeting schedule to ensure young people are receiving services in a timely manner, identification of a process for PSS involvement at intake to assist young people in navigating their first experience at allcove. Providers across specializations collaborate to provide input and inform decisions while reflecting on opportunities for growth to strengthen service delivery and practice. Moreover, providers all expressed a shared commitment to delivering high-quality patient-centered care.

Local Community Contexts & Pressures

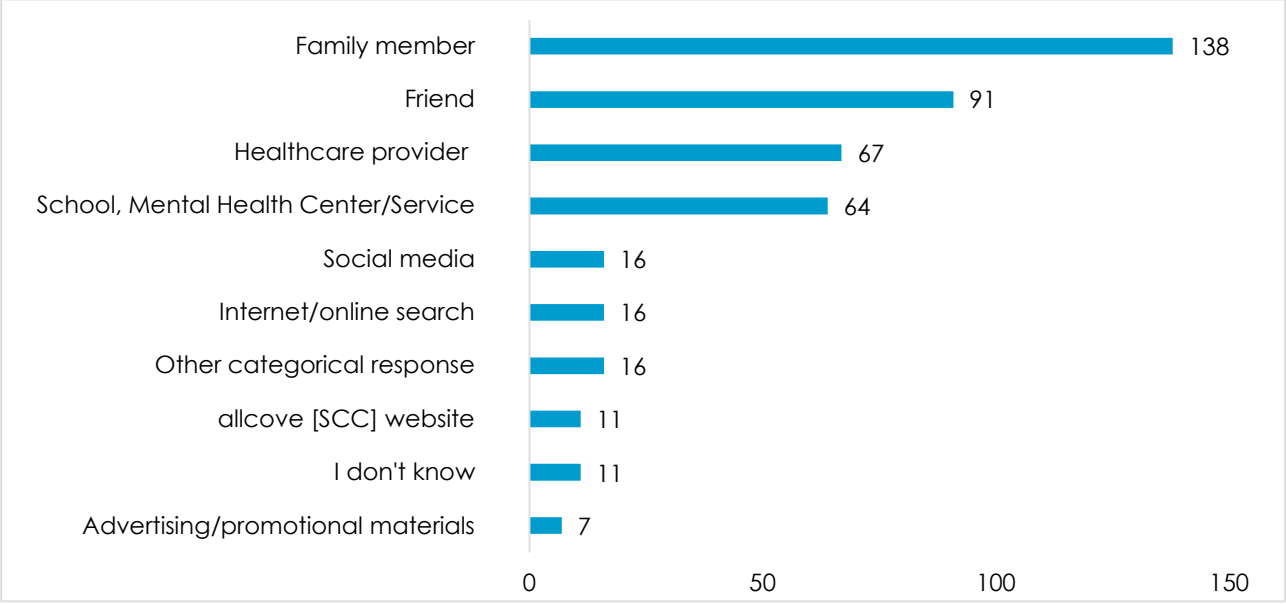
To what extent are local community contexts and pressures being addressed by allcove in SCC? How are SCC allcove partners collaborating with the local community?

The two primary ways allcove in SCC responds to local community context and pressures is through marketing and outreach to promote community awareness of allcove, and secondly, by being responsive to community context through the design and delivery of services and programs.

Community Awareness of SCC allcove

From the Welcome Packet data[5] that all young people complete before receiving services for the first time,[6] it is possible to gain a better understanding of how young people came to know about allcove in SCC (see ***Figure 4***).

Figure 4: Welcome Packet Responses to "How Youth Learned about allcove [in SCC]" (n = 437)



[5] The Welcome Packet is a data collection tool developed to collect demographics, clinical indicators, and to screen youth to identify if they have a need requiring further assessment by a clinician. Welcome Packet data reflects all youth that filled out services from both the allcove Palo Alto site and the six months the allcove San Jose site was in operation.

[6] Returning youth (i.e., youth who received services at an allcove SCC site, completed or ceased receiving those services, and then returned to an allcove SCC site after a certain amount of time) would be asked to complete the Welcome Packet again to ensure the SCC allcove center staff had up to date information on the young person.

Just over half of youth (52%) reported learning about an SCC allcove site through a friend or family member. Less than 10% of young people reported learning about an SCC allcove site through an online resource such as social media, an online search, or the allcove SCC website. In addition to the sources listed in ***Figure 4***, 92 youth specified additional sources of information, many of which overlapped with existing options. Sources include but are not limited to the YAG, a therapist, a wellness fair at school, a mentor, a case worker, and a phone line.

Healthcare providers and school staff/mental healthcare centers are the third and fourth largest referral sources. Providers, allcove Palo Alto leadership, and BHSD indicated in 2023 focus groups that local high schools and Federally Qualified Health Centers are some of the most significant referral sources. Respondents described successful efforts by allcove Palo Alto in conducting targeted outreach to local high schools and colleges, which has been an essential avenue for building community relationships and marketing. For example, as allcove Palo Alto is increasing their outreach, they have received opportunities to interview with news outlets and expand its platform in the community.

"We have a big platform in the community, so we're given opportunities for interviews in schools and with news outlets. It gives us an opportunity to make a big impact in the community."

– allcove Palo Alto leadership and BHSD, March 2023

"Local high schools have been the biggest referrals and youth organizations have also been great. We're looking to connect with middle schools. We've done outreach, partnered with organizations to do outreach events, and now we're constantly getting contacted about that. The connections we've made with the community across the County have been really strong."

– allcove Palo Alto leadership and BHSD, March 2023

Providers expressed that they are aware of other local providers and resources and, as a result, can make referrals to best meet youth needs. The efforts by allcove Palo Alto have developed and sustained community partnerships by networking with other providers' support, increasing incoming and outgoing referrals. Some providers also expressed interest in continuing to build relationships with the community.

"We also have a good awareness of the resources we can offer within allcove [Palo Alto] and of referrals we can make for services [that clients] may need that we don't currently offer."

– allcove Palo Alto provider, March 2023

Community Outreach and Promotion

allcove Palo Alto has convened the Community Consortium of stakeholders to provide input and feedback in designing and delivering services and programs as a mechanism for allcove Palo Alto to be responsive to the community. The Community Consortium is a strategic advisory partnership composed of individuals from nearby school districts, governmental agencies, community health providers, local businesses, and other leaders and groups throughout the SCC community. The Consortium meets quarterly for 75 minutes at the allcove Palo Alto center and is guided by a charter. The Consortium has identified goals that are discussed at each meeting, with objectives identified to be addressed between meetings. Consortium members are embedded in local community organizations, schools, and colleges. As such, these stakeholders also serve an important outreach role to build awareness of allcove Palo Alto throughout the County.

YAG members are eager for allcove Palo Alto to continue increasing outreach and promoting awareness to youth and families in SCC. In doing so, the YAG believe allcove in SCC could expand its impact and serve more young people. This perspective from the YAG indicates that allcove Palo Alto may be addressing the needs of engaged youth eager for the center's reach to expand.

Meeting Community Needs

Providers, allcove Palo Alto leadership, and BHSD also shared examples during the 2023 focus groups of how allcove Palo Alto responds to community needs and interests by tailoring workshops and events based on feedback and assessment of local needs, such as:

- Co-facilitating a social justice art event based on youth interest;
- Hosting a vaping seminar based on stakeholder feedback;
- Hosting parent workshops around pronouns usage;
- Providing education and employment workshops to alleviate the stress of school; and
- Developing resources and referral pathways for youth struggling with eating disorders.

By increasing collaboration and relationships in the community, allcove Palo Alto can decrease stigma around mental health, increase utilization at the center, and be more responsive to local needs. By increasing this collaboration at the state level, allcove Palo Alto is working to expand system capacity and awareness of the allcove model and capacity for engaging youth in decisions related to youth mental health.

Youth Satisfaction

To what extent are youth satisfied with the SCC allcove centers?

Youth satisfaction is a critical component of the allcove model and allcove Palo Alto has been committed to collecting youth feedback from the start. Collecting youth feedback ensures that youth are heard, and their insights are incorporated throughout SCC allcove operations.

Once the SCC allcove centers opened their doors in June 2021, SCC allcove staff began offering an end of visit survey for in-person services. This survey was offered to youth at the end of every visit to an SCC allcove center, so it measured youth satisfaction each time a youth elected to complete the survey.[7] A total of 231 end of visit survey responses were received between June 2021 and March 2023. All surveys were administered in English and 84% of respondents visited the Palo Alto allcove site.[8]

"It was really nice to have a connection with [Staff Name] and I felt respected and listened to."
- Survey Respondent

"Just a great place to vent and receive advice on steps for improvement."
- Survey Respondent

The end of visit surveys show that youth are happy that they came to allcove. For example, 97% of youth responded that they agreed or strongly agreed that they were satisfied with the services they received from the SCC allcove site that they had visited. Additionally, 98% of youth reported that they agreed or strongly agreed that the services they received were of a high quality. Youths' high ratings of services provided may be explained by the welcoming and comfortable environment created by staff and providers. Youth emphasized that they feel listened to and understood by welcoming and friendly staff. Nearly 100% of all young people who completed the end of visit survey agreed or strongly agreed that they felt heard, understood, and respected by staff and 97% reported that they agreed or strongly agreed that staff tried to understand what matters to them. Finally, it is truly an encouraging indicator of how youth feel about the allcove site when 96% of youth agreed or strongly agreed that they would recommend it to a friend.

[7] The end of visit survey is an anonymous survey. As such, there is no way to account for how many youths took the survey at more than one visit and how many youths never completed a survey.
[8] The survey was administered while allcove San Jose was in operation. Therefore, 13 respondents indicated they visited the San Jose allcove site.

These findings are supported in the 2022 Client survey conducted by RDA youth describe staff as nice, enjoyable, and able to make youth feel comfortable. Respondents described feeling supported by allcove Palo Alto staff, including behavioral health clinicians and PSS, and noted that they know where to go with questions. Respondents described the one-on-one mental health support and counseling as helpful and beneficial, acknowledging that they benefit from therapy and enjoy talking to someone one-on-one. Some respondents described the overall atmosphere as welcoming, comfortable, and a place to hang out.

> **"As a current participant, what I enjoy the most about currently receiving services at allcove [Palo Alto] is the welcoming, and sweet energy all the employees have. They're so understanding and help you out the best way they can."**
>
> – 2022 Client Survey Respondent
>
> **"It was the first-time therapy felt like it should, and I actually found help in going."**
>
> – 2022 Client Survey Respondent

Youth emphasized several characteristics that promote accessibility of services, such as adherence to confidentiality, as well as flexible and quick scheduling that allow youth to receive immediate support. A small number of youths expressed the importance of having a place like allcove Palo Alto in their responses to surveys and in the Welcome Packet, stating that without allcove Palo Alto, they would not otherwise be able to access services (see ***Table 2***).

Table 2: Welcome Packet Self-Reported Responses to Question on Seeking Help (N = 477)

Where else youth would have gone for help if not allcove[9]		
Family or friends	247	52%
School counselor or teacher	125	26%
Not sure	148	31%
Would not have gotten help	86	18%
Primary care provider	72	15%
Online support	67	14%
Hospital emergency room	31	6%
Walk-in clinic/urgent care	27	6%
Social services	20	4%
Not reported	17	4%

[9] Counts and percentages do not add up to 477 or 100% because respondents could select more than one option.

Like the youth that completed the 2022 client survey, 2022 YAG focus group respondents also described overall satisfaction with allcove SCC services and the YAG experience. YAG members shared many ways in which allcove Palo Alto staff integrate their voice and opinions into decision making at allcove Palo Alto. Overall, YAG focus group respondents described that, at allcove Palo Alto, youth are empowered to create change and that participation in the YAG was a unique experience.

Staff at allcove Palo Alto have incorporated feedback and ideas from the YAG, including adopting their suggestions on evaluation surveys and intake documents, making decisions on hiring based on YAG feedback on candidates interviewed, implementing structural changes to the YAG (e.g., affinity groups), adding weekend hours and additional engagement opportunities for youth at allcove SCC sites, and incorporating YAG perspectives on the physical space of allcove SCC sites (e.g., logos, colors, shelves, furniture). YAG focus group respondents shared that, in addition to the changes they can see, allcove SCC staff share updates that affirm to participants how their ideas were incorporated into decisions.

Providers shared that they regularly reflect on client satisfaction and feedback surveys to understand more about youth satisfaction, address concerns, and improve service delivery.

Public-Private Financing

Overview

allcove SCC serves all youth, regardless of their insurance status, so it is essential to understand how the partnership between public and private funding entities can support access to services and sustainability of the center for all youth. In similar programs in other countries, such as the headspace model in Australia that inspired the allcove model, access to universal health insurance meant that programs did not have to navigate the complexities of multi-payer insurance systems across both public and private sectors. This domain focuses on the public and private insurance policies that impact allcove SCC services, and the collaboration and communication between allcove Palo Alto, BHSD, service providers, and private insurance entities. It is a goal of the allcove model that youth are not impacted by the complications that arise from the current healthcare landscape in California, but rather, are able to access services and navigate their own care with appropriate informed consent, confidentiality, and continuity of care across services and providers. The following section of the evaluation explores the challenges and key lessons learned by allcove SCC and BHSD. Findings are shared across two domains:

- Policy, Collaboration, and Communication
- Confidential Continuity of Care

Summary of Findings

Policy, Collaboration, and Communication

- The diversification of funding streams from MHSA Innovation funding to a model that is supported primarily through private and public financing will require additional assistance advocacy on behalf of allcove sites in discussions with private insurance providers.

Confidential Continuity of Care

- The continuity of care that allcove Palo Alto has developed and is able to provide to young people is one of the centers strongest features.

Policy, Collaboration, and Communication

What are the models of public-private financing and funding streams for allcove in SCC? What are the benefits and challenges of these models?

Current Funding

As previously described, the allcove model is based on an Australian model of care called headspace, which was developed and implemented within a universal health care system. When the allcove model was brought to California and implemented in SCC, a relationship between public and private health insurers was not in place. Developing and sustaining diverse funding streams has been at the forefront of the implementation of allcove in SCC from the initial proposal of the program.

Currently, allcove Palo Alto is financed through braiding funds from the main source of funding, the MHSA Innovation Grant, and other sources including Medi-Cal, and other County resources. Although BHSD has not developed formal agreements with private insurers as of the writing of this report, they have collected valuable information to assist CaT and MHSOAC in the development of a financial model for allcove centers across the state.

SCC allcove stakeholders described a variety of opportunities that INN funding provided to SCC to launch and implement the allcove model. For example, the early work required for SCC to engage various internal partners – from legal counsel to facilities management – to advance the model and center development. Innovation funding also allowed SCC allcove to invest in the center spaces, from the kitchens to conference rooms to furniture and accessories, which are assets to the center staff and clients. Due to the flexibility of INN funding, staff have been able to adapt their roles to accommodate emerging center needs, such as moving outreach and marketing roles internal to allcove Palo Alto providers. However, this flexibility in funding presents complications because these role accommodations are not reimbursable. Instead, they are additional costs incurred by BHSD.

Once implementation began, INN funding also provided important financing for service provision. Many services under the SEE and PSS service streams, including workshops, would not be able to be billed/reimbursed through private insurance. Overall, allcove Palo Alto leadership could adapt the staffing model at allcove Palo Alto to better meet the center's needs and clients' needs upon the closure of allcove San Jose due to the flexibility of INN funding. This pivot in program implementation was a success celebrated by stakeholders for improving internal operations the new staffing model allowed while also expanding service offerings to reach more youth.

Financial Sustainability

Moving beyond MHSA funding, the discussion of funding and reimbursement for services becomes more complicated. Navigating the California healthcare system, which is a hybrid of multi-payer system, single payer, publicly subsidized private payers, socialized medicine, and self-pay, to establish contracts for reimbursement is an incredibly large feat for a single county's behavioral health

department. This is complicated by several factors including the large number of private insurance providers that youth reported they are covered by (i.e., at least seven different private providers and the Department of Veterans Affairs). The Welcome Packet data displayed in ***Table 3*** illustrates the challenges that SCC allcove is facing. Most clients reported that they had insurance (82%)—either from a private provider (46%) or they indicated they were unsure of their insurance provider (25%). Of note, allcove Palo Alto leadership believe that most youth who were unsure of their insurance status were likely insured through a private provider.

Although nearly half of youth reported having private insurance, several factors could influence their decision to access care with SCC allcove, which is discussed later in the Access and Engagement section of this report.

Although a limited number of youths reported that they were uninsured, leveraging Medi-Cal billing for behavioral health services has been an important component of allcove Palo Alto's financial model. However, the inability to bill private insurance will continue to be a source of concern for the allcove model. Private insurers may already provide the same services that the allcove model requires, such as physical health exams, sexual or reproductive health exams and information, behavioral health treatment and counseling, and mental health treatment. The ability of one allcove center, or one behavioral health department, to negotiate a contract with the

For some youth, they have to repeat their story multiple times because they're changing mental health providers. What is the role of care coordination for that? Is that what they needed? In some cases, we have patients who really love our providers and they want to stay but they can't."

- allcove Palo Alto provider, March 2023

Table 3: Welcome Packet Self-Reported Insurance and Care Needs (N = 477) [10]

Category	Count	Percent
Health insurance status		
Insured	389	82%
Not sure	57	12%
Not insured	30	6%
Not reported	1	<1%
Insurance coverage		
Private	221	46%
Not sure	120	25%
Public	108	23%
Not insured	25	5%
Other	3	1%
Primary care provider		
Yes	302	63%
Unsure	92	19%
No	65	14%
Not reported	18	4%
Accessed mental health care in the last year		
No	263	55%
Yes	162	34%
Unsure	41	9%
Not reported	11	2%

[10] Source: Welcome Packet. Percentages may not add up to 100% due to rounding.

private insurers may be unrealistic without assistance, such as a third party to act as a representative of all allcove centers or a representative of the state-owned model.

SCC allcove stakeholders emphasized that there are several challenges with financing allcove Palo Alto through a billing model, particularly across private insurers and for uninsured youth. For example, respondents expressed concern that establishing a financial model that is based primarily on being able to bill private insurers may result in disparate care based on insurance status, such as limiting services to only youth enrolled in Medi-Cal. This concern regarding the extreme difficulty in establishing billing relationships with private insurers for services that they provide in-house is generated from numerous conversations with partners. Further, considerations must be made regarding service eligibility based on youth insurance status when the allcove Palo Alto center is no longer supported by INN funding. Regardless of why youth sought out services at allcove Palo Alto, if youth with private insurance are unable to have their insurance provider billed for these services, allcove Palo Alto may have to institute a Medi-Cal eligibility requirement for youth seeking specific services.

"The impact is really [significant]. If a patient shows up for care and we're not in their network, they're limited to only the free visits we can offer. When grant funding disappears, we won't have those funds to make those services available in a sustainable way. Even if we provided primary care in a FQHC capacity, if we did co-located services, that still limits the population who can use our services. We don't want to provide disparate care depending on insurance coverage. Same issue on the mental health side. If we're not in their insurance network, we're limited. How do you provide open and welcoming care with sustainable continuity of care?

- allcove Palo Alto provider, March 2023

allcove Palo Alto and BHSD want to maintain their commitment to youth to provide the same quality of service and level of care at an allcove SCC center regardless of a youth's insurance

status. For example, findings from the 2022 YAG focus group respondents highlight the gap allcove SCC fills in services that are accessible to youth. Respondents indicated that seeking services through allcove in SCC is a positive experience, noting that it does not require navigating formal systems like health insurance or the school system. Additionally, services feel more accessible for youth who are undocumented compared to other locations that may offer services to undocumented youth.

Similarly, highlighted among stakeholders was the importance of allcove Palo Alto as a safety-net provider that remains accessible to all youth regardless of insurance status or income. Current demands on the mental health system in the County position allcove Palo Alto as an essential resource for youth needing mental health services, especially those with low to moderate mental health needs, as youth often face waitlists for services at other locations in the County. All 2023 focus group participants expressed enthusiasm for continuing to identify financing mechanisms that meet the needs of youth and enable allcove Palo Alto to provide integrated, youth-centered services.

"A lot of mental health programs have very long waitlists. We're sometimes limited to seeing them for something like eight sessions, and if it takes them a long time to get connected to other services, there can be a gap in care…It can be stressful for mental health providers when they're getting ready to transition a patient but there isn't anywhere to connect them to."

- allcove Palo Alto provider, March 2023

"Looking at opportunities for more centers is something we're excited about and invigorated by. We just need more of the 'how.' We're still figuring out the financial piece."

- allcove Palo Alto leadership and BHSD, March 2023

"We need more staffing, more resources in the community to access mental health services…Ethically, we accept everyone, regardless of insurance, but we don't have enough resources. We're the bridge, we're the safety net for all, so we would need more resources and partnerships to actually help everyone."

- allcove Palo Alto leadership and BHSD, March 2023

Confidential Continuity of Care

How does the public-private funding model impact the confidential continuity of care?

The 2023 focus group respondents indicated that continuity of care is one of the greatest strengths of the allcove model and a testament to allcove Palo Alto's client-first approach. allcove Palo Alto providers discussed being able to make a direct in-person handoff to another provider or clinician for the first time.

Additionally, allcove Palo Alto staff and providers are trained to ensure that all youth are fully informed about the level of confidentiality of care that they can expect when receiving various services at allcove Palo Alto. A common barrier for youth seeking services is confidentiality and fear of stigma, particularly when youth request sexual and reproductive health services;87or behavioral health services. Providers expressed that they want to be able to meet youths' wants and needs for services and recognize the important role of confidentiality.

"For the first time in my career, I can see a patient with a mental health need and take them to see the psychiatrist or mental health clinician in the same building."

– allcove Palo Alto provider, March 2023

However, overall, there are challenges to providing confidential services to youth, given laws that govern minor consent and confidentiality. For example, when billing a private payer, the primary insurance policy holder will see services rendered; the primary policy holder is typically a parent or legal guardian. As a result, providers expressed that youth have been hesitant to access the care they would like to receive. The concern raised by youth is not a direct result of the allcove model, but rather an artifact of the insurance system in California.

"Being able to provide sexual or reproductive health services is also important and being able to do that in a confidential manner. Youth may be having sex but not seeking those services because they're afraid their parents will find out."

– allcove Palo Alto provider, March 2023

Access and Engagement

Overview

A major component of the allcove model is ensuring accessibility for youth for two reasons. One, utilization of the model is crucial for sustainability and access to the allcove centers. Two, being able to successfully link and address youths' needs requires that youth be willing to come to the site and engage in services for the appropriate length of time. Youth engagement depends on high quality, relevant services, and intentional efforts to encourage youth retention and their completion of treatment (or linkage(s) to additional services, if needed). In addition to understanding service utilization, this section reviews how service utilization has impacted allcove in SCC, whether youth appeared to be an appropriate fit for services, and how allcove Palo Alto has developed into a culturally responsive center for young people to seek out services. Findings are shared across three domains:

- Service Utilization
- Appropriate Fit of Services
- Cultural Sensitivity

Summary of Findings

Service Utilization

- The mental health and peer support services are the two most popular service streams offered by allcove Palo Alto.
- Young people have expressed interest in additional support and community groups and the allcove Palo Alto staff have developed several exciting workshops, classes, and community events in response.
- The medical offerings of the center have had a lower than anticipated utilization rate.

Appropriate Fit of Services

- The data indicates that young people seeking services at SCC allcove sites have been able to access the services they have been looking for or referrals to services needed.
- Youth reported services tailored to their needs and access to services they were interested in.
- The intake process has successfully assisted allcove Palo Alto staff in identifying youth in need of further assessment to ensure all youth are getting timely access to, or referrals to, the services needed.

Culturally Sensitive

- Youth feel respected by allcove Palo Alto staff and PSS.
- Several of the services that are offered at the center are offered in multiple languages.

Service Utilization

Who is the youth served by SCC allcove? What type and how many services are SCC allcove clients receiving?

Youth Served by SCC allcove

Table 4 provides a breakdown of youth characteristics for the youth that sought services at an SCC allcove site. The allcove model is designed to provide services to young people between the ages of 12 to 25. Overall, allcove SCC served mostly transition age youth (70%). Nearly three in every four-youth identified as Asian, Pacific Islander, Hispanic/Latino, Multi Racial, Black, American Indian, or Alaska Native (73%). Further, just over half (51%) of all youth self-identified as female and nearly half (49%) of all young people identified as heterosexual. Finally, most youth (94%) identified English as their preferred language.[11] Additional data on participant demographics can be found in Appendix B.

Table 4: SCC allcove Client Characteristics[12]

Category	Count	Percent
Service Location		
Palo Alto	401	84%
San Jose	76	16%
Age Group		
Transition Age Youth (16-25 years old)	336	70%
Children (0-15 years old)	139	29%
Adults (26-59 years old)	1	<1%
Race/Ethnicity		
Asian	154	32%
Hispanic or Latino[13]	112	24%
White	106	22%
More than one race	67	14%
Prefer not to answer[14]	8	2%

[11] A total of 16 youth did not report their gender identity.
[12] Source: Welcome Packet. Percentages may not add up to 100% due to rounding.
[13] The client survey provided different options for respondents to select their ethnicity(ies) or shared culture(s), though the overall rates are like Welcome Packet data. The client survey collected data on the following ethnic/shared culture identifiers: *Central American, Mexican/Chicanx/a/o, Puerto Rican, Another Ethnicity, Prefer Not to Say*.
[14] On the client survey, 32% of the 34 respondents declined to state their race, which is an overall higher proportion of missing data compared to Welcome Packet respondents.

Black or African American	8	2%
American Indian or Alaska Native	4	1%
Gender Identity		
Female	243	51%
Male	157	33%
Other[15]	12	3%

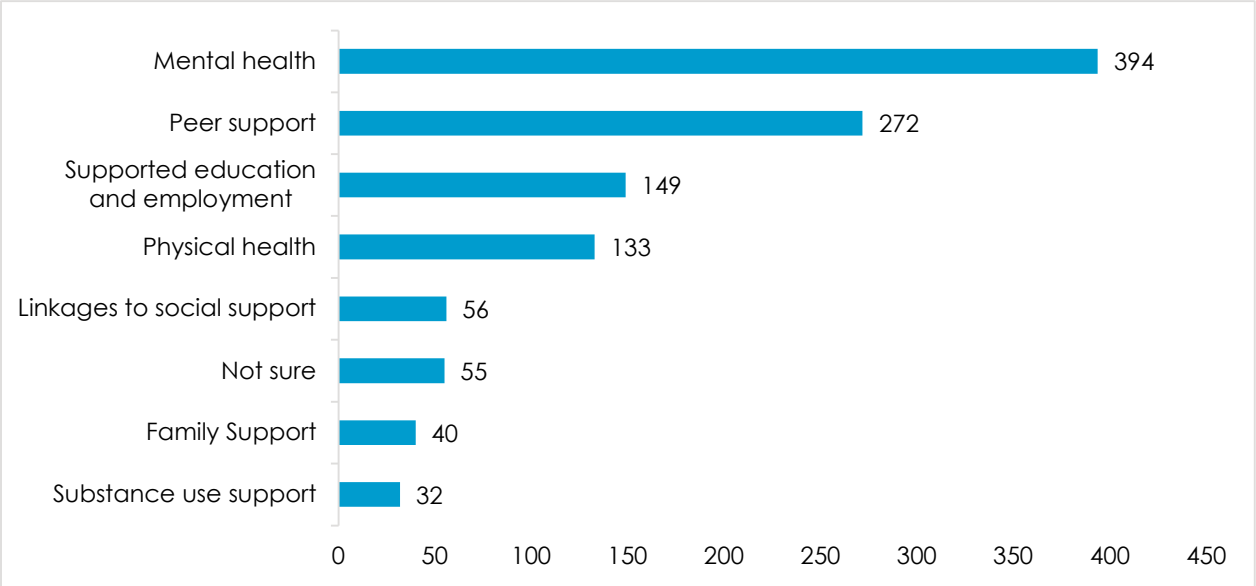
Youth resided in cities in SCC including Campbell, Cupertino, Los Altos, Los Gatos, Milpitas, Mountain View, Santa Clara, Stanford, and Sunnyvale. Additionally, 6% of the 477-youth served by allcove SCC resided in San Mateo County in cities like Menlo Park and Redwood City. Alameda County youth represent 4% of those served by allcove SCC with youth residing in cities including Freemont, Castro Valley, Oakland, Livermore, Newark, and Union City. Finally, youth who received services from allcove SCC and reported residing in San Francisco County, Nevada County, or San Joaquin County represent less than 1% of youth in total. In total 1% (n = 5) of youth self-reported living out of state and 3% (n = 14) of youth served by allcove SCC did not provide information on where they were currently residing.

Services Sought and Received by Youth

The top services sought out by youth, as reported by youth, were mental health services and connections to peer support specialists (PSS). The Welcome Packet data supports this finding (see ***Figure 5***).

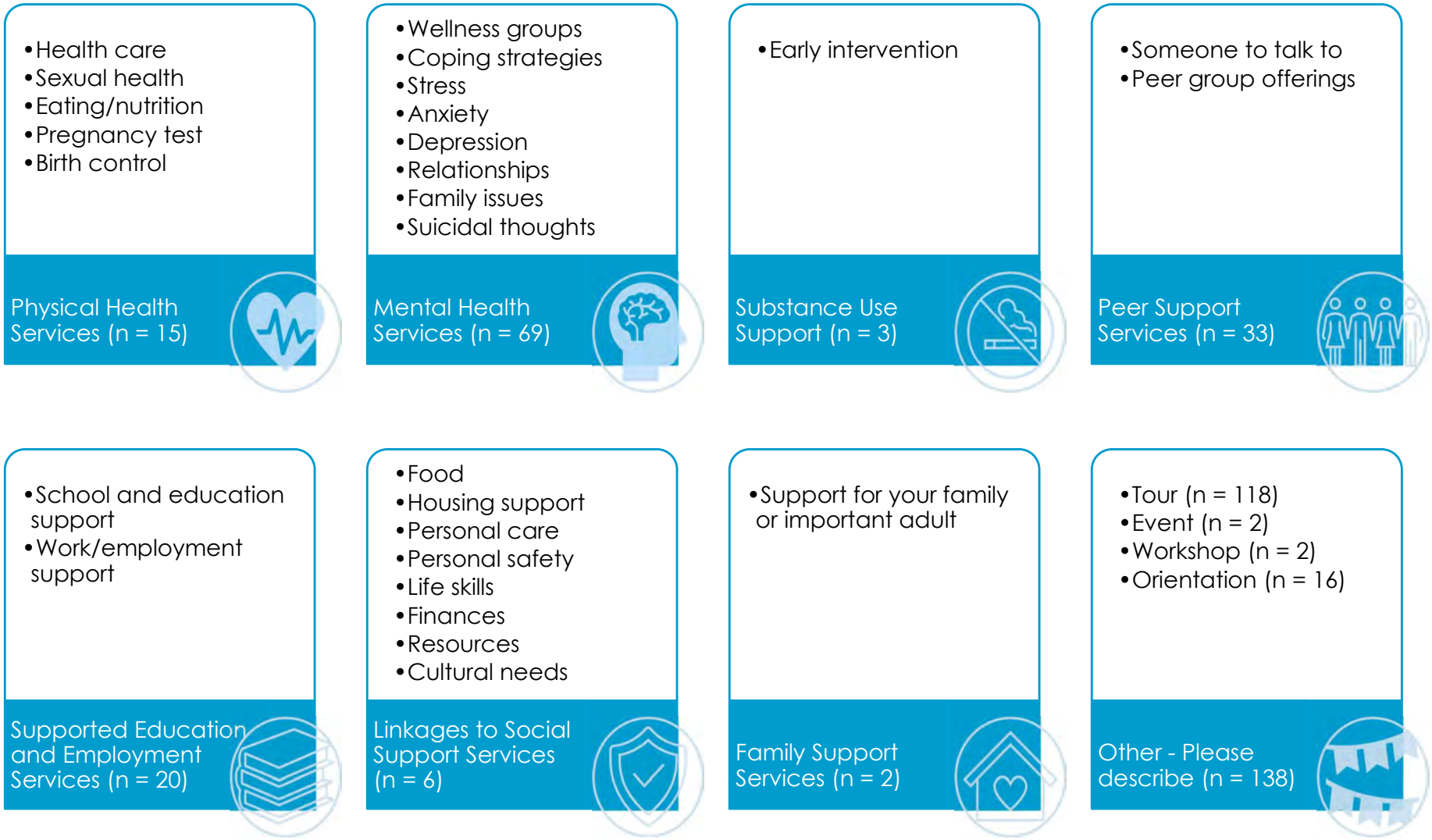
[15] "Other" responses included, among other options, fluid, and non-binary.

Figure 5: Welcome Packet Client Services of Interest



The services that youth are seeking when they first visited an SCC allcove site and what service stream youth actually engaged in at each visit could be quite different based on the assessed need and the discussion with staff that leads to individualized service plan for each youth. The end of visit survey which asks young people, "Which service(s) did you receive at allcove [SCC] today? (Select all that apply)," provides insight into the range of services that youth engage in when they visit SCC allcove sites and the topics they were seeking assistance with (see ***Figure 6***).

Figure 6: allcove SCC Client End of Visit Survey, Services



Example: Continuity of Care Provided to an allcove Palo Alto Youth

Young adult male presents to allcove Palo Alto seeking services.

- Youth welcomed by PSS who have youth fill out Welcome Packet and review it with them.
    - Appointments scheduled for physical health and mental health intake.

Medical Visits with Adolescent Medicine Physician:

- During medical visits, youth state the reason for visit is to screen for sexually transmitted infections (STIs).
    - **Return visits:** Youth returned to clinic on numerous occasions. Youth prescribed pre-exposure prophylaxis against HIV. Treatment continues for various STIs.

Mental Health Visits with Therapist:

- During initial visit with therapist, youth states they are seeking therapy due to mood and anxiety concerns.
- Outcome of therapy sessions:
    - Despite having numerous mental health sessions with therapist with the use of Cognitive Behavioral Therapy (CBT), there is minimal improvement in symptoms.
    - The multidisciplinary team discussed the case resulting in a referral to psychiatry.

Multidisciplinary meeting:

- Symptoms and medical history discussed.
- Concern about high-risk sexual behaviors including concerns about possible exchange of sex for money given numerous infections.

Mental Health Visit with Psychiatrist:

- During visits with psychiatrist, patient discloses episodic changes in mood including times of increased irritability and depressed mood and other times in which youth felt elevated and euphoric.

    - Discloses having racing thoughts and impulsive and risky behaviors including engagement in high-risk sexual behaviors and substance use.
    - Discloses decreased need for sleep.
    - Reports a family history including psychosis, death by suicide, polysubstance use, and anger issues.

Physical Exam:

- Has multiple circular purple skin blemishes on neck in different stages of healing.
- Conclusion of visit:
    - Youth diagnosed with Bipolar Disorder Type II in hypomanic episode.
    - Discussion about medication held with youth who was amenable to starting medication.
    - Need for long-term mental health services discussed with youth.
    - Peer support, medical, and mental health teams worked together to get youth connected to long-term services.

Utilization Rate

During the initial development of the evaluation plan, the evaluation questions created to measure service utilization were framed to assist allcove SCC in understanding the population of young people that visited allcove SCC sites and what services young people engaged in both out of interest and assessed need. As SCC approaches the second anniversary of allcove Palo Alto, the conversation regarding utilization expanded to include a discussion of whether the utilization rate of certain services is justifiable and whether the allcove model can adapt to meet the needs of both young people in SCC and the financial sustainability of allcove Palo Alto.

Overall, the utilization rate is much lower than the projected service rate of 1,000 unique young people per year, per the SCC allcove site. In total, SCC allcove sites had served 477 youth in 22 months. However, as described in previous sections, SCC implemented the allcove model during a global pandemic. Youth were just starting to reintegrate into school and a daily life that was outside of the home which could have impacted youth and family willingness to engage in new medical/health settings. Additionally, the closure of the San Jose site impacted service rates by impacting the number of communities easily served.

In a review of the utilization rate of the various service streams at allcove Palo Alto, the medical/physical health component is severely underutilized. In the first three quarters of FY 22-23, 18 unique young people sought medical services from allcove Palo Alto, and 26 young people overall completed 30 encounters with the medical team. The cost for allcove Palo Alto to operate the medical component of the model including overhead, equipment, contracted providers, and laboratory costs is nearly $760,000.

There are several reasons why medical services are so underutilized. For example, young people may not be seeking out medical services from allcove Palo Alto because the services that are offered are limited in scope and they are limited in scope because allcove Palo Alto is abiding by the allcove model that states any youth ages 12 and up can consent to their health care service. In the state of California this only applies to sexual and reproductive health services. Another reason, as depicted in ***Table 4*** above, is that 63% of the youth that sought services from SCC allcove sites reported having a primary care provider. Additionally, many of the physical health issues that youth have brought to allcove Palo Alto have necessitated a redirection back to their primary care physician (PCP) who would be more appropriate to address their concern.

BHSD and allcove Palo Alto leadership have considered changes to the medical services and suggestions have been offered by allcove stakeholders that would adhere to the allcove model. For example, the allcove model is designed to provide primary care services to young people. In consultation with medical professionals and partners a primary care model would be an extraordinary lift for a facility that is operating based on a prevention and early intervention model. Providing these types of services would require a financial commitment that includes medical staff, additional equipment, and insurance billing infrastructure. Additionally, there are concerns this level of investment in care would not be sustainable because allcove Palo Alto provides medical services

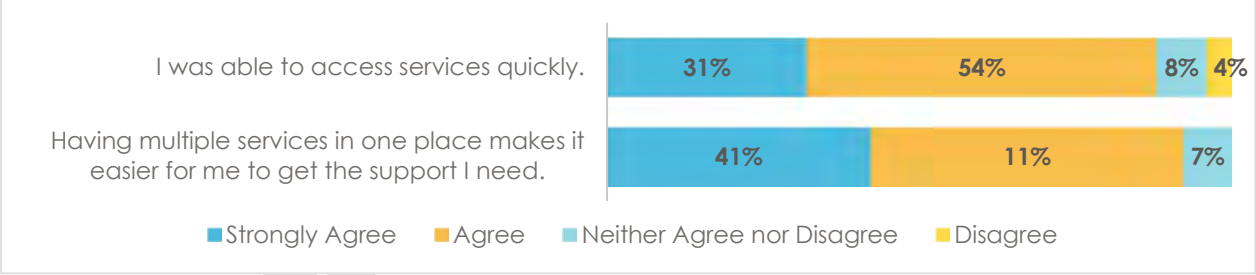
to young people between the ages of 12 and 25 which is usually past the point of when a young person has established a primary care physician, or pediatrician. Additionally, if a youth has a sibling younger than 12 years of age, the younger sibling(s) would not be eligible for medical services at allcove Palo Alto, so their parent, or guardian, would need to take their children to two separate locations for medical services.

Accessibility

Important to understanding utilization is understanding how youth access services. Client survey respondents were asked how they commuted to allcove SCC sites. Youth indicated they used a variety of modes of transportation to access in-person services. Youth most commonly reported being driven by a family member (42%), walking, or riding a bicycle (30%), or driving themselves (14%). Fewer client survey respondents utilized rideshare services (5%), were driven by friends (5%), or took public transportation (2%). The distribution of the various modes of transportation gives insight into how youth are currently accessing services but can also allow for future planning for outreach and potential SCC allcove locations.

A second key component to accessibility is how easy it is for youth to access services once at an SCC allcove site. Youth were unanimous in stating that it is not difficult to access services at allcove Palo Alto. Nearly all youth (92%) responded positively that having multiple services at one SCC allcove site promoted accessibility and, of the 27 youth that responded to the question regarding their level of agreement on how quickly they could access services, 81% were agreeable,[16] as shown in ***Figure 7***. YAG focus group respondents shared that PSS promotes service utilization because they directly connect youth to services (i.e., a warm handoff).

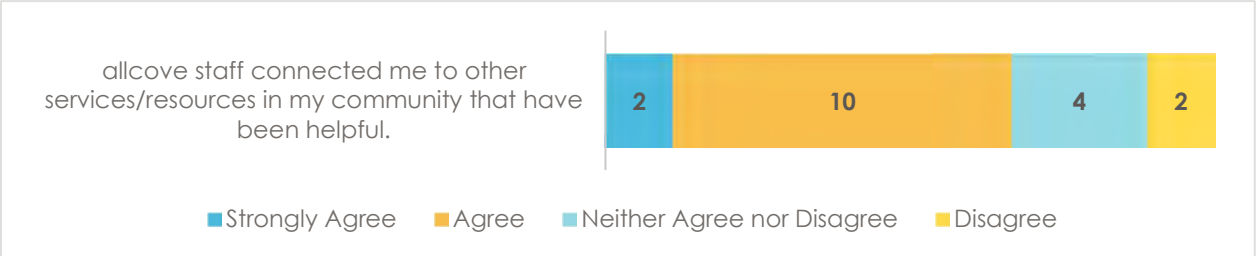
Figure 7: Client Survey Responses on allcove SCC Service Accessibility Questions



A survey of youth also found that 66%[17] were agreeable that allcove Palo Alto staff connect youth to helpful community resources (see ***Figure 8***).

[16] For this question, 2 of 27 respondents indicated "I Don't Remember."
[17] For this question, 6 of 24 respondents selected "Does Not Apply."

Figure 8: Client Survey Responses to allcove SCC's Connections to Helpful Community Resources



Appropriate Fit of Services

To what extent are youth connected to appropriate services that meet their clinical needs and individual goal

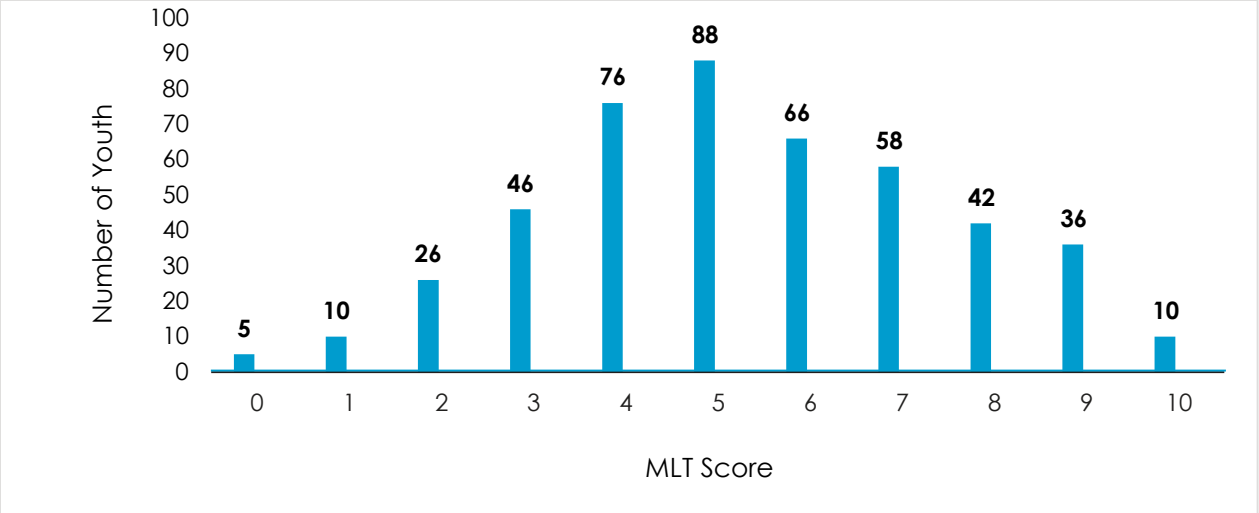
Assessing for Fit

The Welcome Packet asked youth several questions that would allow clinicians to match youth to appropriate services. For example, youth were asked to indicate if they were currently worried that they may hurt themselves or others, with three response options—yes, no, and not sure.[18] Of the 463 responses, 88% (n = 408) of youth indicated they were not worried that they would harm themselves or others while the remaining 12% (n = 55) of youth indicated that this was a worry for them.

Additional instruments used to evaluate youth mental health at intake include five measures assessing youths' general wellbeing, relationships, and coping skills. These measures comprise the MyLifeTracker (MLT) tool which is designed to assess youth mental health and current quality of life.[19] Youth were asked to select a number from zero to 10, with zero indicating "sad" and 10 indicating "happy" to show how they have been feeling over the past week in each area (i.e., general wellbeing, daily activities, relationships, coping). Cumulative MLT scores are calculated by averaging across these five measures, with a higher average score indicating youth feeling as though they have a "high quality" of life. Scores at or below the mean likely indicate intervention is needed. The average score of youth who completed the MLT is 5.44 (see ***Figure 9***).[20]

Figure 9: Welcome Packet Distribution of Responses to MyLifeTracker Tool (n = 463)

[18] BHSD recoded this variable to a binary yes/no variable in which 39 respondents who answered "not sure" were included in the "yes" category.
[19] Kwan, B., et al. (2018). Development and validation of MyLifeTracker: A routine outcome measure for youth mental health. *Psychology Research and Behavior Management, 11*, 67–77.
[20] MLT scores are rounded to the nearest whole number.



Importantly, results from the MLT tool demonstrate that youth with intensive needs—who would benefit from immediate care—are seeking help. Although the allcove model is designed to support youth with mild to moderate needs, it also acts as a hub for all youth seeking services and is available to support higher-need youth through referrals to services. Therefore, allcove SCC is acting, as intended, as an access point for youth in need of immediate referrals to high intensity services. Without allcove SCC, these youth may be placed on waiting lists for services and experience delayed care.

The Welcome Packet also includes both the GAD-2[21] and PHQ-2[22] screening tools to identify youth with probable anxiety and depressive disorders, respectively. The two-item questionnaires inquire about the frequency of how often respondents have been bothered by depression or anxiety over the previous two weeks, with response options including not at all, several days, more than half the days, and nearly every day. Responses are scored, with "not at all" corresponding to zero points and "nearly every day" corresponding to three points. GAD-2 and PHQ-2 cumulative scores ranged from zero to six points, with a score of three or more (on one or both questions) indicating the likely presence of anxiety or depressive disorder.

A total of 467 youth responded to both GAD-2 screening questions for anxiety. Of these respondents, 50% of youth received scores of three or more, indicating the presence of a probable anxiety disorder and the need for additional screening by SCC allcove clinical staff. Similarly, of the 464 respondents who answered both PHQ-2 screening questions for depression, 49% of youth received a score of three or higher, indicating the need for further evaluation for a depressive disorder.

[21] Plummer, F., et al. (2016). Screening for anxiety disorders with the GAD-7 and GAD-2. *General Hospital Psychiatry, 39*, 24-31.

[22] Löwe, B., Kroenke, K., & Gräfe, K. (2005). Detecting and monitoring depression with a two-item questionnaire (PHQ-2). *Journal of Psychosomatic Research, 58*(2), 163-171.

The Welcome Packet includes a two-item tool to screen for early psychosis. Youth were asked to respond "yes" or "no" to questions asking if they can see things others cannot and if they have ever felt that someone was playing with their mind.[23] A cumulative score of zero (i.e., youth responded "no" to both questions) on the screener indicates that psychosis is not present while a score of two (i.e., youth responded "yes" to both questions) indicates the probable presence of an early phase of psychosis. Of the 461 youth that responded to the question "Do you see things that others can't or don't see?" 94% of youth selected "no" and 440 youth responded to the question "Have you ever felt that someone was playing with your mind?" with 89% of youth selecting "no". A total of 16 youth received scores of two on the screener, indicating the likelihood of an early phase of psychosis (see ***Figures 10 and 11***).

Figure 10. Do you see things that other can't or don't see? (n = 461)

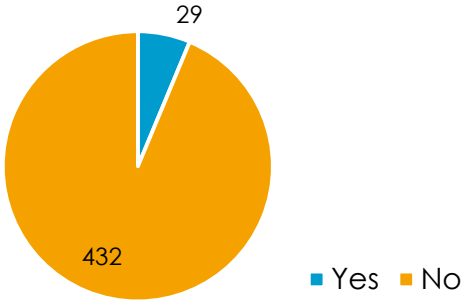
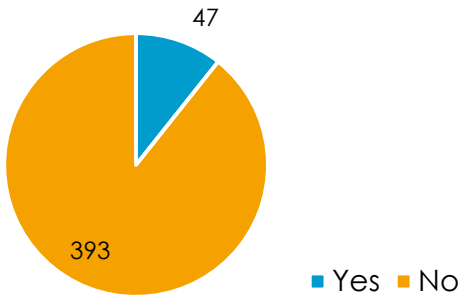


Figure 11. Have you ever felt that someone was playing with your mind? (n = 440)



The CRAFFT+N Questionnaire[24] to screen for risk of substance use disorders is also included in the Welcome Packet. This questionnaire contains four numerical response questions and one "yes" or "no" question. Respondents were asked to estimate how many days over the past 12 months they drank alcohol, used marijuana, used anything else to get high, or used nicotine or tobacco products. If they did not engage in these behaviors, they were instructed to put a zero to indicate "none." Lastly, respondents were to indicate "yes" or "no" to the question "Have you ever ridden in a car driven by someone (including yourself) who was 'high' or had been using alcohol or drugs?"

Respondents who reported having never engaged in these behaviors over the past year were assessed as "at low risk" compared to respondents who had engaged in any of the described behaviors over the past year. Further, respondents who indicated having been in a vehicle with

[23] Phalen, P. L., et al. (2018). Validity of a two-item screen for early psychosis. *Psychiatry Research, 270*, 861–868.

[24] Mitchell SG, Kelly SM, Gryczynski J, Myers CP, O'Grady KE, Kirk AS, & Schwartz RP. (2014). The CRAFFT cut-points and DSM-5 criteria for alcohol and other drugs: A reevaluation and reexamination. *Substance Abuse, 35*(4), 376–80.

an impaired driver were a "riding risk" and should discuss alternatives to riding with impaired drivers.

A total of 302 youth answered zero (i.e., never engaged in substance use over the past month) to the first four questions of the CRAFFT+N Questionnaire. The specific respondent breakdown by question is included in ***Table 5***. Of these 302 youth at "low risk" for substance use disorders, 276 youth further identified that they had not been in a vehicle with an impaired driver.

Table 5: Client Responses to CRAFFT+N Questionnaire

Question *(number of responses)*	**Range of number of days**	**Mean**	**Median[25]**
Drink more than a few sips of beer, wine or any drink containing alcohol *(n = 474)*	0 – 365[26]	8	0
Use any marijuana (weed, oil, or harsh by smoking, vaping, or in food) or "synthetic marijuana" (like "K2," "Spice")? *(n = 475)*	0 – 365	24	0
Use anything else to get high (like other drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? *(n = 476)*	0 - 269	3	0
Use any tobacco or nicotine products (for example, cigarettes, e-cigarettes, hookahs, or smokeless tobacco)? *(n = 477)*	0 - 365	16	0
Question *(number of responses)*	**Yes/No**		
Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs? *(n = 465)*	**Yes** – 62	**No** – 403	

The results from these questions and screeners indicated that youth are overwhelmingly appropriate for the services the allcove Palo Alto center has to offer. For those youth whose responses warranted further assessment, the allcove Palo Alto clinicians are able to assess youth and refer to them a provider who can provide a higher level of care, if needed.

Youth and Staff Perspectives on Appropriate Fit for Service

In addition to the Welcome Packet data, YAG members discussed additional perspectives on how services meet the needs of SCC youth. YAG emphasized that, from their perspective, allcove Palo Alto's focus on "mild to moderate" mental health support is meeting the needs of SCC youth by destigmatizing mental health and creating a place where youth can come to learn about mental health or seek services. They shared that at allcove Palo Alto, there are

[25] Zero days was the most frequent response. Broken down by question, number of respondents who indicated zero days: Q1 (n = 344), Q2 (n = 352), Q3 (n = 448), Q4 (n = 414).

[26] One respondent indicated 730 days. This fell outside of the possible 365-day range, so this response was excluded.

many opportunities for youth to "ease their way" into services through events, like karaoke and board games, or by being present in the allcove Palo Alto center, like doing homework. These events and informal opportunities help youth to get to know staff and feel more comfortable initiating services. Similar to the YAG members, youth reported that services met their needs and that allcove Palo Alto staff were able to tailor services to them.

Provider perspectives on the appropriate fit of services are also an important consideration. Providers shared several ways in which they seek to tailor services to individual youth and best meet their clinical needs and individual goals. First, starting with the Welcome Packet, youth engage with a PSS in a conversation to define their care trajectory, identify the services they are interested in seeking, and provide relevant information so that providers can identify the best-fit clinician or another PSS for each youth. Providers also explained how they work with youth to develop individualized care plans across service streams and providers. Through developing care plans, youth identify what they want to work on with their providers and define success for themselves. Care plans also evolve as youth identify new needs or interests, develop rapport with providers, and share more openly over time. Providers also shared how they use weekly multidisciplinary team meetings to collaborate and ensure all services are tailored appropriately to best support youth. CaT noted a seamless integration across service streams, expressing that youth experience the various providers and services streams as one cohesive allcove center in SCC.

"Our PSS and SEE specialists walk through the Welcome Packet with youth. They assess what brought [the young person] in, what they are looking for, what their goals are. We do the best of our ability, based on staffing and representation, to match the young person to a treatment team and/or with the PSS that most aligns with them. We do that from the moment they walk in."

- allcove Palo Alto provider, March 2023

"I don't like 'goals' as a term. We focus on what difference they want to see now. We structure our first session based on what they want and bring up. Sometimes it's a lot at first, but sometimes they can bring up other stuff later on that we switch to. We put a big emphasis on supporting what youth want."

– allcove Palo Alto provider, March 2023

Additionally, providers shared ways they responded to local needs to adapt services, such as by connecting with and bringing in a community organization to train staff to better meet the needs of youth with emotional disturbances who sought services at allcove Palo Alto.

Finally, providers noted that for youth with high-acuity mental health or substance use needs, allcove's model does not provide in-house services. Instead, providers refer and connect youth to other providers that can better meet their needs. Providers elevated that the team, and especially PSS, effectively help clients navigate systems of care and connect with external providers who may be a more appropriate fit. Further, providers continue to meet for screening, PSS, and medical and drop-in services because youth with high-acuity needs may continue to engage in allcove SCC services, alongside other care supports.

> **"Discharge planning starts from intake. Our team practices that collaboratively with our youth. As soon as we have an intake, we explain our model, which includes that it's short term. We want youth to have the empowerment to seek further help. When we're approaching discharge, we make sure that clients have the resources they need and have the opportunity to ask questions about referrals. We want to make sure they're comfortable with referrals. It's not just one team we connect them with, we want to make sure the totality of the care we give is continued on discharge. We ask if they are able to contact the referrals or want other options."**
>
> - allcove Palo Alto provider, March 2023

The allcove model is a prevention and early intervention model, which means that it seeks to serve individuals with mild to moderate needs, as compared to high acuity needs. This can create challenges for youth who do not fit within allcove Palo Alto's target population but also experience challenges receiving care elsewhere. For this reason, providers explained how they are responsive to the model's focus and shared information about the model with youth upon intake as well as discharge.

Cultural Sensitivity

To what extent do youth perceive that allcove center services are culturally sensitive?

How youth perceive the cultural sensitivity of SCC allcove staff and the ability of SCC allcove staff to respond to their diverse backgrounds, cultures, and lived realities is important to understand, both to be able to engage with youth in authentic and meaningful ways as well as

to be able to understand cultural differences in care. Across focus groups and surveys, youth emphasized that allcove Palo Alto staff demonstrate values of cultural sensitivity and diversity based on the lived experiences and identities of staff, how programs and services are designed and delivered, and how allcove Palo Alto accommodates a variety of accessibility needs for youth.

allcove Palo Alto leadership and BHSD agreed with youth in that they value staff diversity and their varied backgrounds. Providers agreed that their experiences and identities are valued by allcove Palo Alto leadership and that they are encouraged to voice their perspectives on service delivery and quality through the lens of their own experiences and knowledge. Youth described an aspect of their role as client advocacy rooted in their lived experience.

> **"Largely, the perspective is people are experts in their own lives and cultures. When we have people of those marginalized groups, we're careful that those voices are prioritized. People who work with specific cultures bring that in, are not hasty to diagnose things that could be culturally specific."**
>
> – allcove Palo Alto provider, March 2023

The diversity among the allcove Palo Alto providers and staff allows them to better tailor their service delivery to be culturally responsive to youth. For example, PSS at allcove Palo Alto may share with youth details regarding their own identities or experiences with mental illness and mental health to destigmatize these experiences and better support youth navigating similar

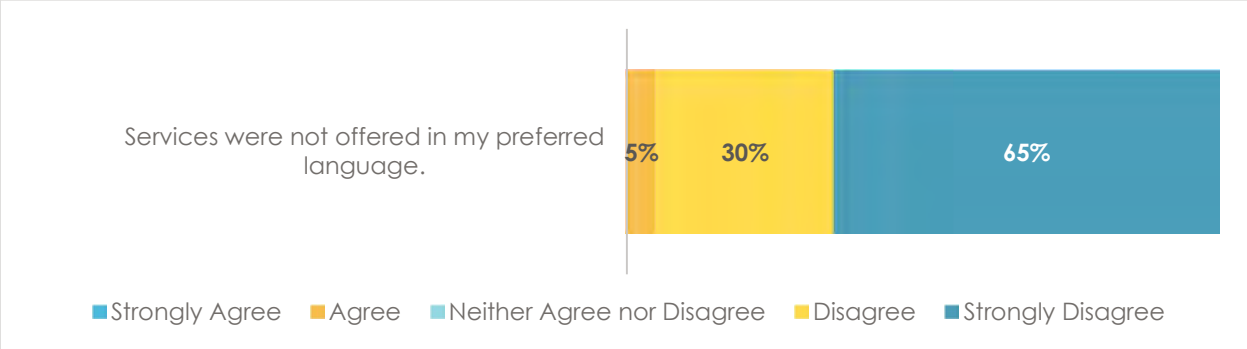
> **"We share our own lived experiences, but in subtle ways, like just holding the space for youth to have discussions about that. [We focus on] empowering them to feel this is a space where they can comfortably share with us. We promote non-judgment. Everyone is welcome. I feel like we try to honor that in our space."**
>
> - allcove Palo Alto provider, March 2023

> **"I think this is a big strength of allcove [Palo Alto]. For conversations and topics that young people bring up, we have a team that's very open to talking about it, it's really embedded into service streams. People come here [to work] because of our lived experience. We show up every day ready to talk, be uncomfortable, and be curious. Ourselves showing up as ourselves: we promote that engagement and reduce stigma in how we show up for young people."**
>
> – allcove Palo Alto provider, March 2023

experiences. They emphasized that such openness allows them to listen with non-judgment and create a welcoming environment for youth.

As described in the Service Utilization section above, youth come from diverse backgrounds and communities. Youth seeking services from allcove Palo Alto could potentially need services available to them in a different language. For example, 20% of youth surveyed reported that Spanish was their preferred language. A few youths reported preferred languages such as Hebrew, Czech, and Mandarin. The majority of young people (95%) reported that services were offered in their preferred language (see ***Figure 12***).

Figure 12: Client Survey Distribution of Responses to allcove Palo Alto Cultural Sensitivity Questions



Additionally, allcove Palo Alto providers shared that they are able to provide services in English, Spanish, Vietnamese, and Tagalog. When there is a need for services to be provided in a language outside of these four, providers shared how they are responsive to serving those needs by accessing County resources. Providers and allcove Palo Alto leadership emphasized that language diversity supports youth across all allcove model service streams, including clinical services, mental health services, and SEE workshops.

Client Outcomes

Overview

The intent of the final domain of the evaluation was to center on client outcomes, or the impacts that SCC allcove has on those who utilize services. Client outcomes related to mental health, physical health, social-emotional wellbeing, and functional well-being are important to understand the extent to which the site and its integrated service approach is effective. However, one of the lessons learned during this INN program was that the more traditional parameters used to measure outcomes are not applicable to PEI programs. This discovery has led to very fruitful discussions on how to improve outcome measures moving forward. Therefore, the outcome analysis provided is predominantly qualitative in nature. Findings are shared across four domains:

- Mental Health
- Physical Health
- Social- Emotional Wellbeing
- Functional Wellbeing

Summary of findings from the subdomains

Mental Health

- Mental health services are the most sought service stream at allcove Palo Alto.
- The center has prioritized creating a space that is created for and centered around making young people welcome and safe.
- Youth can engage in mental health services at the pace and level that feels appropriate to them.
- Youth have expressed their interest in wanting more sessions with their counselors and the mental health staff at allcove Palo Alto.

Physical Health

- allcove Palo Alto staff are interested in making changes to the medical/physical health component to better meet the needs of the community and address the low utilization rate of the medical services offered.

Social-Emotional Wellbeing

- allcove Palo Alto staff and clients have reported seeing benefits in their confidence in social settings, developing skills in how to express their emotions in a healthy way, and how to communicate with family.

Functional Wellbeing

- A strength of the allcove model is how it is individualized to each youth. allcove Palo Alto staff recounted how youth had achieved several life goals including getting their driver's license or applying for and getting into college.
- Other youth came to allcove Palo Alto unable to concentrate on their wellbeing because their basic needs were not being met and staff were able to connect them to social services in the community to help find them stability.

Mental Health

To what extent does allcove Palo Alto improve youth developmental outcomes?

Providers, allcove Palo Alto leadership, and BHSD emphasized the strengths of allcove Palo Alto's service delivery and integrated model in creating a welcoming and accessible space for youth to receive support for their mental health. Providers emphasized that mental health outcomes are supported when youth can access the space regardless of their insurance status or income.

> **"That's the greatest value we offer to the community: we're a place youth can go, get their questions answered, and get connected to the services they need. Other systems can be tough to get into or require referrals and have waitlists. But ours is designed to be welcoming, open, and fast for all ages, all groups. It's a starting place."**
>
> – allcove Palo Alto provider, March 2023
>
> **"In terms of [a] youth-friendly and inviting space that encourages youth to get support for their mental health, I think we've got a great program."**
>
> - allcove Palo Alto leadership and BHSD, March 2023

Providers emphasized that allcove Palo Alto allows youth to engage in mental health services at the pace and level that feels appropriate to them. For example, youth can participate in movie nights and game nights, and spend time in the center if they are uncomfortable with seeking mental health services, which has created the opportunity for youth to ask questions and, over time, become more comfortable with engaging in more formal mental health services.

Physical Health

To what extent does allcove Palo Alto improve youth developmental outcomes?

allcove Palo Alto has established two primary methods for actively improving youth developmental outcomes. First, providers at allcove Palo Alto provide care coordination to all youth around physical health. This allows providers to identify, consult, and refer young people to their PCP, or another specialty based on the need of the youth. For example, a young person

may visit allcove Palo Alto and request a medical appointment for a sports injury that has resulted in concussion systems. The allcove team, knowing that the clinic is not the most appropriate provider for this youth can connect him, or link him, to a PCP to get a neurology referral.

Additionally, during focus groups with providers they emphasized that sexual and reproductive health services are important as many young people that are having sex, have concerns around confidentiality with their parents or guardians and, as a result, may be uncomfortable seeking sexual and reproductive education and health services. Finally, providers at allcove Palo Alto have developed health education workshops that will be available beginning in August 2023, to serve as an entry point to the center's medical services.

"I would love to see more education and comfortability [sic] with sexual health and wellness since we advertise it. I only have seen comfort on the medical team. With PSS education and background, I want to better implement with young people in that aspect of life."

- allcove Palo Alto provider March 2023

Social-Emotional Wellbeing

To what extent does allcove Palo Alto improve youth developmental outcomes?

Youth shared insightful examples of the types of social-emotional skills gained from allcove Palo Alto services. According to 2022 YAG focus group respondents, allcove Palo Alto staff provided training to YAG participants that equipped them to support their peers, such as by developing their skills around empathy and receiving and expressing emotions.

Providers shared similar examples of youth meeting their social-emotional goals, such as increasing confidence and comfort in social settings and growing peer relationships. According to providers, these social-emotional outcomes are, in part, a result of having youth-led goals and youth engagement in care plans.

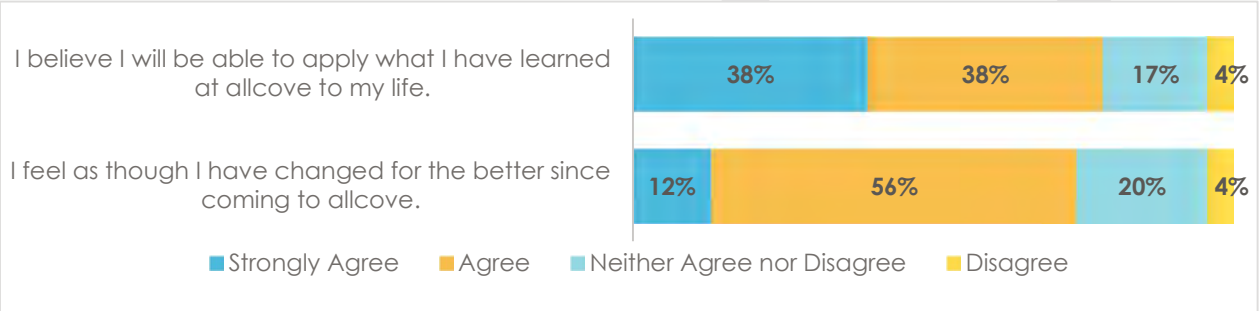
Currently, allcove Palo Alto occasionally provides family-focused workshops or makes referrals to family-focused local organizations. Additionally, family therapy, when clinically and developmentally appropriate, is provided.

Functional Wellbeing

To what extent does allcove Palo Alto improve youth developmental outcomes?

Youth have indicated that allcove Palo Alto services are contributing to positive outcomes in their lives. For instance, 75% of survey respondents indicated that allcove Palo Alto services offer transferable lessons and skills that they utilize in their lives (see ***Figure 13***).[27] Additionally, 68% of youth answered agreeably that they "have changed for the better since coming to allcove [Palo Alto]."[28]

Figure 13: allcove Palo Alto Client Survey Distribution of Responses to Personal Outcomes Questions



Providers shared that youth set their own goals for functional well-being and, therefore, the services and outcomes may look different for each youth. Some youths have set personal goals like getting a driver's license, school success, or improving personal and social relationships. Measuring progress towards goals is done through consistent engagement in services over time.

> **"Our clients more so measure progress than we do, because for me, markers of progress are youth staying consistently engaged, youth feeling fulfilled with sessions."**
>
> - allcove Palo Alto provider, March 2023

Providers also define youths' ability to navigate their own medical and mental health care more effectively and independently as an important functional outcome. To this end, the allcove model provides scaffolded support to youth learning to access and manage services across multiple providers.

[27] For this survey question, 1 of 24 respondents indicated "Does Not Apply."
[28] For this survey question, 2 of 25 respondents indicated "Does Not Apply."

Conclusion & Recommendations

Summary

The implementation of the allcove model in Santa Clara County required innovative and collaborative approaches between BHSD and their partners. The implementation process, which included work group meetings with partners and youth, promoted the creation of an iterative process of addressing challenges and refining services throughout the first two years of program operations. This process has also allowed for strengthened collaboration in service provision to clients.

In addition to engaging in a thoughtful implementation process that allowed for the refinement of services as the program moved from initial implementation to full implementation, a structure was established within the SCC allcove centers to ensure that service providers and site administrators were able to make refinements to improve overall service delivery and provide person-centered care to youth. Providers at the SCC allcove sites engaged in multidisciplinary team meetings that improved communication to meet the needs of clients. Overall, the allcove Palo Alto site has had a significant impact on the lives of young people. Clients shared how they accessed services, engaged in multiple service streams, saw improvements to their mental health and confidence, had access to positive support, received medical services, and received tutoring or assistance with college applications.

The cross-system care that allcove centers provide youth is an ambitious model and SCC has established relationships and cross-sector collaboration to set a foundation for improving the medical and behavioral health outcomes for youth in Santa Clara County. allcove Palo Alto has increased the service provisions available to youth in SCC, which may pave the way for more systems impact across the County.

Recommendations

This closing section provides recommendations for SCC allcove practices for long-term sustainability of the allcove model in the County. Additionally, there are several recommendations for the state to consider regarding the allcove model itself, given that this is the first report on successes and lessons learned from the full implementation of the allcove model.

Based on the challenges, solutions, and impacts experienced throughout implementation of the allcove model in SCC, there are opportunities to continue improving and refining partnerships and administration to carry on lessons and successes in the future. The following recommendations identify areas to improve service delivery, assist with sustainability planning, and bolster current initiatives.

SCC allcove

SCC allcove Model Fidelity: There is a delicate balance in maintaining model fidelity while considering service adaptability and responsiveness. The level of investment made by BHSD in meeting model fidelity is noteworthy. Partners expressed concern that the resources required for allcove Palo Alto to continue monitoring and meeting adherence require significant staff time and resourcing, such as maintaining branding, marketing, and documentation. This level of resourcing poses a challenge to the sustainability and flexibility of the center.

- BSHD and allcove Palo Alto should ensure that data-driven decisions are driving adaptations to the model, in collaboration with providers and YAG members.

- BHSD should consider challenges that are making data collection difficult, such as separate data systems that limit information sharing.

Financial Sustainability: To ensure long-term sustainability of the allcove model in SCC there must be a diversification of the funding streams.

- BHSD should continue to pursue becoming a designated school wellness center as a contracted provider through the new initiative from the Department of Health Care Service (DHCS) Children and Youth Behavioral Health Initiative (CYBHI). This would allow allcove Palo Alto to provide mental health services to school age children within two miles of the center's location and receive reimbursement through the CYBHI program.

- BHSD and SCC allcove should investigate the possibility of additional community partnerships that could engage in fundraising opportunities on behalf of the SCC allcove site. These partnerships could include referral partners, community outreach

and youth organizations that share common goals or mission statements and have the ability to host fundraising events.

- BHSD should utilize their recent community survey to understand gaps in community services, as well as the strengths and assets in the community. This would help to inform discussions about how to provide services to the community that are needed and still meet the allcove model.

Access and Engagement: One key area that impacts both the engagement and financial sustainability areas is increasing awareness of allcove Palo Alto, and any subsequent allcove sites in SCC.

- BHSD and allcove Palo Alto leadership should collaborate with the local community to get feedback on marketing and outreach materials to make them more responsive.

- allcove Palo Alto and BHSD may also consider consulting with the Public Information Office on marketing and promotion possibilities that are available and allowable within the County's purview, while adhering to the allcove branding/marketing guidelines.

- allcove Palo leadership should work with BHSD and the CaT to make modifications to the allcove Palo Alto website to be more accessible to youth and to clearly describe the variety of services offered at allcove Palo Alto. Engage YAG and youth to assist with website updates to ensure descriptions are written for youth.

- allcove Palo Alto leadership could consider incorporating more youth voice and testimonials on the website and in promotional materials.

- BHSD and allcove Palo Alto leadership should continue to pursue greater involvement from the Community Consortium by ensuring that regular quarterly meetings are taking place, they are consulting on matters related to strategic planning and fundraising.

Youth Outcomes: A lesson learned during the implementation of the allcove model is understanding and adjusting how to measure youth outcomes for a primary and early intervention model like allcove. There are operational changes that can be made to make tracking youth outcomes for SCC allcove providers and staff easier.

- BHSD and allcove Palo Alto leadership should consider the adoption of a new set of outcomes measures that are aligned with a prevention and early intervention model.

Statewide allcove Model Considerations

There are three areas of recommendations for the state to consider about the allcove model and data reporting requirements as part of the MHSA Innovation funding.

First, the adaptability of the model to meet the needs of the community it has been implemented in. Effective implementation allows for adaptations to a model to suit the population served. A concern raised in SCC about the allcove model that will need further attention is the medical component. Specifically, concerns have been raised that there is not enough demand or need of medical services by youth in SCC to support the financial sustainability of allcove Palo Alto.

- Consider holding information gathering sessions with allcove sites across California about the medical/physical health component. These conversations should focus on challenges and successes in implementation, responsiveness to youth needs, and financial sustainability.

- During the information gathering sessions, collect feedback on sites about the adaptations they have made to the medical components of their programs and what drove those decisions.

- In collaboration with the CaT, determine if there are different medical service streams that allcove sites could implement with fidelity to the allcove model.

Second, there is concern with the public and private financing model that has been identified as the main source of revenue for allcove sites. Given that the allcove model in California does not exist in a universal healthcare system, but rather, has required individual County's to attempt to negotiate contracts with large private insurance providers there are concerns about equity in contracting and capacity issues for BHSD and the County to complete the negotiation process with multiple insurance providers.

- With multiple allcove sites in operation there may be an opportunity for the sites to enter into negotiations as a collective. This could be facilitated by the state.

- Additional statewide funding opportunities could be identified to assist in the long-term sustainability of allcove sites.

There are currently data collection and reporting requirements that necessitate the collection of sex assigned at birth, which is reported as a binary variable (i.e., male or female). However,

allcove Palo Alto leadership and providers recognize the inherent inaccuracy of this variable and the harm it can cause when asked of clients who are not able to respond to this question.

- Consider updating data collection instruments to reflect measures that are representative of all young people and their identities.

Acknowledgements

The Santa Clara County Behavioral Health and Services Department wishes to thank all those who contributed to this project, including but not limited to: members of the YAG for their continued input and participation in implementing the allcove model and in the evaluation, in addition to allcove Palo Alto, Alum Rock Counseling Center, Santa Clara Valley Medical Center, Lucile Salter Packard Children's Hospital, and the Central allcove Team and all the providers and staff from these partners that participated in focus groups. Finally, appreciation is expressed to all the young people that participated in surveys to share their own insight and perspectives about the services they received and personal impacts of engaging with allcove Palo Alto. Your support has been invaluable throughout the evaluation process.

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Appendix A. Evaluation Domains, Questions, Measures, and Data Sources

Table 1. Evaluation Domains, Outcome Measures, and Data Sources

Evaluation Domain		Outputs and Outcome Measures	Data Sources
allcove Model	*Evaluation Question #1: To what extent is the allcove model being implemented to fidelity? What are successes and challenges in allcove implementation?*		
	Fidelity to Model	• Documentation of the allcove project implementation • Reasons for changes to program • allcove implementation successes & challenges	• Focus Groups with providers • Program Documents • Background/Observation
	Evaluation Question #2: To what extent are local community context and pressures being addressed by allcove? How are allcove partners collaborating with the local community?		
	Local Community Context & Pressures	• Community awareness of allcove • Community context and input on allcove services and design	• Community Benchmarks • Focus Groups • Program Documents • Background/Observation
	Evaluation Question #3: To what extent are youth satisfied with the allcove centers?		
	Youth Satisfaction	• Youth/consumer satisfaction overall and by population • Youth voice within allcove • Clarity and transparency of services	• Youth Survey(s) • Focus with providers
Public-Private Financing	*Evaluation Question #4: What are the models of public-private financing and funding streams for allcove? What are the benefits and challenges of these models?*		
	Policy, Collaboration, & Communication	• Funding streams • Collaboration and communication (changes, successes, challenges) • Impact of policies and disparate funding sources on services provided	• Provider Focus Group • Program Documents
	Evaluation Question #5: How does the public-private funding model impact confidential continuity of care?		

Evaluation Domain		Outputs and Outcome Measures	Data Sources
	Confidential Continuity of Care	• Client consent and confidentiality • Continuity across service providers • Ease of services and payments	• Youth Survey(s) • Focus Groups with providers
Access and Engagement	*Evaluation Question #6: Who is being served by* allcove*? What type and how many services are* allcove *consumers receiving?*		
	Service Utilization	• Youth served and demographics (also, compared to community) • Reasons for service, types, and frequency of services • Length of time from request to treatment • Obstacles to and facilitators of access	• Program Records • Youth Survey(s) • Focus Groups with providers
	Evaluation Question #7: To what extent are youth being connected to appropriate services that meet their clinical needs and individual goals?		
	Appropriate Fit of Services	• Services tailored to youth clinical needs • Services tailored to youth interests	• Program Records • Youth Survey(s)
	Evaluation Question #8: To what extent do youth perceive that allcove *services are culturally sensitive?*		
	Culturally Sensitivity	• Provider respect for youth • Culturally appropriate and accessible services	• Youth Survey(s) • Focus Groups with providers
Client Outcomes	*Evaluation Question #9: To what extent does* allcove *improve youth developmental outcomes (including mental health, physical health, social-emotional wellbeing, and functional wellbeing)? How do these impacts differ based on client demographics, levels of need, and dosage?*		
	Mental Health	• Psychological distress • Coping skills to manage symptoms • Awareness of mental health resources and services outside of allcove • Follow through on linkages/referrals to other services	• Program Records • Youth Survey(s) • Focus Groups with providers Program Documents
	Physical Health	• Knowledge of how to manage physical health and pre-existing medical diagnoses • Physical ability for activities, that youth are interested in	

Evaluation Domain	Outputs and Outcome Measures	Data Sources
Social-Emotional Wellbeing	• Connection and support from peers and adults (both at and outside of allcove) • Youth wellbeing and quality of life	
Functional Wellbeing	• Job search and interview skills • Educational outcomes • Basic needs	

Table 2. Data Collection Plan

Data Sources	Collected By	Timing
allcove Records	BHSD, ARCC, Stanford, SCVMC	Collected July 2022 & February 2023
Youth Post-Visit Survey	BHSD, ARCC, Stanford, SCVMC	By consumer, after each visit or training
allcove Staff/Provider Focus Groups	RDA	Fall 2022
Community Benchmarks	RDA	Spring 2023
allcove Program Documents	allcove Partners and Stakeholders	Collected continuously
Background Materials & Observation	allcove Partners and Stakeholders, RDA	Collected continuously
Interviews/Focus Groups/Surveys	RDA	YAG Focus Group and General Youth Survey – Fall 2022 BHSD, Stanford, and Partners – Spring 2023

Appendix B. Client Characteristics

Appendix B: SCC allcove Client Characteristics[29]

Category	Count	Percent
Preferred Language		
English	447	94%
Spanish	7	2%
Farsi	4	1%
Vietnamese	1	<1%
Armenian	1	<1%
Catalan	1	<1%
Russian	1	<1%
Korean	1	<1%
Prefer not to answer	1	<1%
Interpretation Services Needed		
No	357	75%
Yes	4	1%
Unsure	3	1%
Sexual Orientation		
Heterosexual or straight	234	49%
Bisexual	75	16%
Prefer not to answer	41	9%
Gay or lesbian	34	7%
Questioning or unsure of sexual orientation	31	7%
Queer	26	6%
Other[30]	20	4%
Veteran Status		
No	409	86%
Prefer not to answer	3	1%
Impairment or Disability[31]		
Mental health condition	210	44%
None	159	33%
Difficulty seeing	57	12%
Other[32]	17	4%
Chronic health condition	10	2%
Difficulty hearing	10	2%
Neurological impairment	8	2%

[29] Source: Welcome Packet. Percentages may not add up to 100% due to rounding.
[30] Other responses included but were not limited to asexual, demisexual, pansexual, and polysexual.
[31] Counts and percentages do not add up to 477 or 100% because respondents could select more than one option.
[32] Other responses included but were not limited to attention deficit hyperactivity disorder (ADHD), asthma, autism, bipolar disorder, irritable bowel syndrome (IBS), and post-traumatic stress disorder (PTSD).

CIBHS
CALIFORNIA INSTITUTE for BEHAVIORAL HEALTH SOLUTIONS

SANTA CLARA INDEPENDENT LIVING EMPOWERMENT PROJECT (ILEP)

Evaluation Report

June 2023

1760 CREEKSIDE OAKS DRIVE, SUITE 175 • SACRAMENTO, CA 95833 P 916.556.3480 • CIBHS.ORG

INTRODUCTION

The County of Santa Clara Behavioral Health Services Department is implementing the Independent Living Empowerment Project (ILEP) in partnership with the Community Health Improvement Partners (CHIP). ILEP is funded through Mental Health Services Act (MHSA) Innovation funds, and the California Institute for Behavioral Health Solutions (CIBHS) has been contracted to evaluate the program's success. The County wishes to understand and enhance the extent to which ILEP improves tenant experiences and outcomes as well as staff/owner skills and relationships with clients, in addition to increasing the County's overall capacity of Independent Living homes. This is the second ILEP evaluation report, which describes the project ramp-up, enrollment of initial members, and baseline evaluation data through June 2023.

SUMMARY OF ACTIVITIES

This section documents the key activities and milestones accomplished thus far through ILEP. ILEP officially kicked off in April 2022. The evaluation and implementation kicked off simultaneously, and the project established biweekly meetings between the County, CHIP, and CIBHS beginning in the second week of April.

Program Ramp-Up

Activities Described in Previous Evaluation Report

From April through October 2022, CHIP launched the ILEP in Santa Clara County. CHIP and Santa Clara County established and launched a process for enrolling Independent Living Operators, as well as begun hosting Operator trainings in the County. The program aims to enroll 30 Independent Living homes in Santa Clara County within 2 years of the program launch. During the project's first six months, the project incorporated peer representation into the planning process, launched the ILEP website[1], began recruiting Operators and evaluating potential homes, and enrolled it's first Operator as a Member of the project.

Activities Occurring During the Current Evaluation Period

Key milestones accomplished between November 2022 and June 2023 include:

- November 2022
    - Enrolled second member home

[1] ILA Santa Clara County - ILA Santa Clara County - Independent Living Association - ILA California

    - Received applications for 4 additional homes from 3 Operators
- December 2022
    - Enrolled third member home
    - Two applications for 3 additional homes remain in progress
- January 2023
    - Presented evaluation details at Work Team meeting
    - Completed 11 pre-Peer Review Assessment Team (PRAT) visits
    - Two new potential applicants identified
    - Built partnerships with Project Sentinel and HAERT (Happiness, (self) Awareness and Emotional Resilience Training)
    - Presented about ILEP at Grace Community Center event
    - Began responding to needs identified in community regarding quality of independent living homes not currently involved with ILEP
- February 2023
    - Project Sentinel presentation at Work Team meeting
    - Updated Work Team meeting schedule to have quarterly in person meetings with monthly virtual meetings in between in person meetings
    - Introduced HAERT to Santa Clara County ILEP team
- March 2023
    - HAERT presentation at Work Team meeting
    - Participated in Community Living Coalition meetings at Northside Community Center
    - Continued working with County to build strategy to support quality of independent living homes not currently involved with ILEP
    - Attended and gave public comment at Executive Meeting regarding quality of independent living homes not currently involved with ILEP
- April 2023
    - Enrolled fourth member home
    - Six applications for 6 additional homes in progress
    - Presented at NAMI monthly meeting
    - Presented to Behavioral Health Board
    - Reviewed list of homes currently housing people being served by County Behavioral Health to ensure CHIP reaches out to discuss membership in ILEP
    - Visited 5 homes from list provided by NAMI
    - Attended Project Sentinel Fair Housing Symposium
    - Continued working with County to build strategy to support quality of independent living homes not currently involved with ILEP
- May 2023
    - Enrolled fifth member home
    - Seven applications for 7 additional homes in progress
    - Held first unannounced visit for existing member home
    - Meet & Greet with Senior Adults Legal Assistance (SALA)

    - Attended West Valley Community Services Resource Fair
    - Participated in Zephyr/Grace Wellness Center Mental Health Awareness Month activities
    - Met with Faith in the Valley
    - Visited homes from list of homes currently housing people being served by County Behavioral Health
    - Attended City of Palo Alto Affordable Housing Resource Fair
    - Continued working with County to build strategy to support quality of independent living homes not currently involved with ILEP
- June 2023
    - Enrolled sixth member home
    - Conducted 3 PRATs, 5 pre-PRATs, and 2 unannounced visits
    - Received and followed up on three grievances, two for existing member homes and one for a non-member home
    - Attended Recovery Café and presented on program for Housing Access class
    - Presented at Catholic Charities staff meeting
    - Participated in City of San Jose Rent Stabilization Program
    - Met with contractor for home repairs to brainstorm incentives to support members
    - Continued outreach to independent living homes in the County
    - Held prePRAT at Lewis House, an independent living home from the County's master lease program for Assisted Outpatient Treatment and Assertive Community Treatment programs

In the coming months, CHIP will continue outreach activities to identify potential Operators and support them through the approval process. CHIP will continue to work with the County to identify opportunities to improve the quality of existing independent living homes throughout the County, and to increase the availability of independent living homes for individuals being served through County Behavioral Health.

Trainings

From November 2022 through June 2023, a number of trainings were offered to potential Operators and community members in Santa Clara County, as well as to CHIP and County staff. The table below describes the trainings held and participants from Santa Clara.

Training	Description	Dates Held	Attendance
Introduction to Independent Living Operations	Provides an overview of how to operate a high-quality independent living home	• 11/4/2022 • 3/7/2023 • 3/10/2023 • 4/7/2023 • 5/12/2023 • 6/23/2023	• 2 Operators • Momentum Team • Unknown • 1 Operator (Member) • 3 Potential Operators • 1 Operator

Training	Description	Dates Held	Attendance
PRAT Member Training	Helps attendees understand the PRAT process	• 11/9/2022	• 1 Community Member
Tenant Screening Training	Helps Operators screen potential tenants to identify their needs in an independent living home	• 11/10/2022	• 3 Operators
PET Screening Training	Reviews HUD rules and regulations regarding emotional support animals and allowed types of pets	• 11/2022	• 1 Operator
Budgeting Training	Helps Operators build budgeting skills to manage independent living homes	• 12/13/2022	• Unknown
Mental Health First Aid (hosted by Santa Clara County)	Helps Operators learn how to recognize and respond to signs of mental illness and substance use disorders	• 3/13/2023	• 2 CHIP team members
HAERT Training	Helps reduce burnout, improve mental health and wellness for operators and tenants	• 10 week pilot for CHIP team	• CHIP team
Disability Rights Training (partnership with Disability Rights California)	Clarifies tenant and landlord rights and responsibilities	• 3/16/2023	• Unknown
Pest Prevention Training	Provides guidance on pest prevention in independent living homes	• 4/21/2023	• 7 Santa Clara attendees, 2 ILEP members
Emotional CPR Training (hosted by Santa Clara County)	Follow up to MHFA training	• 5/2023	• CHIP team

Overall Quality of Independent Living Homes in Santa Clara County

In early 2023, the Santa Clara County Behavioral Health Board received an inquiry about quality standards and living standards at four specific independent living homes in the County. Though these homes were not ILEP members, Santa Clara Behavioral Health engaged the ILEP team to help respond to the inquiry and develop processes to monitor the quality of independent living homes in the County that are not currently participating in the ILEP. In the following months, CHIP collaborated with Santa Clara County Behavioral Health to clarify ILEP's scope and identify opportunities to leverage ILEP processes to improve quality of independent living homes throughout Santa Clara County. Conversations remain ongoing and may result in updates to CHIP's contract with the County when it is renewed.

Evaluation and Data Collection Design

From November 2022 through June 2023, CIBHS, Santa Clara County, and CHIP continued to refine the evaluation approach and identify sources of data to measure key evaluation objectives. The table below documents the ILEP evaluation elements, specific measures, and data sources, which has been updated to reflect decisions on how to collect the data elements that were still pending at the time of the previous evaluation report. Details on updates to data sources can be found below the table.

Evaluation Element	Element Type	Specific Measures	Data Source
Tenant receipt of self-advocacy training	Process	# of tenant self-advocacy courses	CHIP Descriptive Data
		# of tenant self-advocacy course attendees	
		Tenant self-advocacy course registration rates	
Tenant receipt of tenant rights education	Process	# of tenant rights courses	CHIP Descriptive Data
		# of tenant rights course attendees	
		Tenant rights course registration rates	
Tenant participation in independent research councils	Process	Extent of peer input and participation in project implementation	Focus Groups/ Interviews/ Surveys
Staff/owner participation in client culture activities	Process	# of staff/owners participating in activities	Monthly Evaluation Check-Ins
	Process	# of MHFA courses	CHIP Descriptive Data
		# of MHFA course attendees	

Evaluation Element	Element Type	Specific Measures	Data Source
Staff/owner participation in Mental Health First Aid (MHFA) activities		MHFA course Registration Rates	
Incorporation of steering committee, clients, and supportive community members in creation of a policy advocacy/education agenda to raise awareness about independent living facilities	Process	Participation of steering committee, clients, and supportive community members in Work Team/Steering Committee meetings	Observational Data/Monthly Evaluation Check-Ins
Reduced tenant hospitalizations	Outcome	# of tenant hospitalizations	CIBHS Tenant Survey
Improved mental health and prevention of mental health decline	Outcome	# of tenants reporting stable or improved mental health	CIBHS Tenant Survey
Increased wellness and recovery	Outcome	# of tenants reporting increased wellness/recovery	CIBHS Tenant Survey
Reduced justice involvement	Outcome	# of tenant arrests/incarcerations	CIBHS Tenant Survey
Improved housing stability and prevention of homelessness	Outcome	Length of time in home	Operator Move-Out Survey
		Exits to homelessness	
Reduced tenant complaints	Outcome	# of grievances	CHIP Descriptive Data
		Tenant rating of process for handling complaints	CHIP Tenant Satisfaction Survey
Increased tenant satisfaction	Outcome	Tenant self-reported satisfaction with their home	CHIP Tenant Satisfaction Survey
Increased tenant engagement in activities	Outcome	# of tenants participating in activities	CIBHS Tenant Survey
Improved staff and tenant relations	Outcome	Staff perception of relationship with tenants	CHIP Operator Survey/Focus Groups, Interviews

Evaluation Element	Element Type	Specific Measures	Data Source
		Tenant perception of relationship with staff and/or other tenants	CHIP Tenant Satisfaction Survey
Increased staff/owner knowledge and understanding of client culture and how to support tenants with mental illness	Outcome	Operator and Tenant perception of understanding of client culture and support for mental health needs	CHIP Operator Survey/CIBHS Tenant Survey
		Tenant perception of staff understanding and respect for their mental health needs	CHIP Tenant Satisfaction Survey
Increased number and percentage of quality independent living members	Impact	# of ILA/RRA Homes (by region, month/year, population, pet-friendly, wheelchair-accessibility, meal provision)	CHIP Descriptive Data/Operator Move Out Survey
		# of ILA/RRA Operators (by region, month/year)	
		# of ILA/RRA Beds (by region, month/year, population, pet-friendly, wheelchair-accessibility, meal provision)	
		# of ILA/RRA Home Applicants (by region)	
		# of ILA/RRA Bed Applicants (by region)	
		# of ILA Tenants/Beds Occupied	
		PRAT Pass/Fail Rates	
Reduced stigma faced by tenants of independent living facilities	Impact	Tenant perception of stigma	CIBHS Tenant Survey
Longitudinal analysis of expenditures, processes, outcomes, and impacts	Sustainability	Changes in measures above, plus expenditure data	Multiple, as defined above

Observational Data/Monthly Evaluation Check-Ins

Each month, the CHIP team reports on applications for memberships, PRAT visits completed and outcomes of those visits, trainings held and training participants, and outreach activities conducted. These items are recorded and tracked for evaluation purposes. CHIP and Santa Clara County also report on Steering Committee and Work Team meetings during these check-ins, and CIBHS attends meetings when appropriate to share updates on the evaluation and observe participation in the meetings.

CHIP Operator Survey

CHIP collects Operator Surveys during PRAT visits to understand Operators' experiences. The CHIP Operator Survey has been adapted to incorporate additional questions to facilitate evaluating ILEP goals. The full CHIP Operator Survey is available in Appendix A. CHIP Operator Survey data was not available for this report but will be included in future evaluation reports.

CIBHS Tenant Survey

To capture data not included in the CHIP Tenant Satisfaction Survey, CIBHS collaborated with the County and CHIP to develop an additional Tenant Survey. This survey was adapted to incorporate additional items based on updated evaluation planning. The full CIBHS Tenant Survey is available in Appendix B.

BASELINE EVALUATION DATA

ILEP Membership and Homes Enrolled

Through June 2023, ILEP has enrolled 6 member homes, operated by 4 different Operators. Those homes contain a total of 57 beds. CIBHS interviewed 3 ILEP Operators in May 2023 to understand their experiences with the project thus far. Across the board, Operators reported a positive experience working with the CHIP team to become ILEP members. They especially appreciated the constructive approach taken by the CHIP team to address any issues identified in their home, including connecting them to resources to fix any problems found. They felt that joining ILEP promoted accountability for themselves and their tenants, without feeling punitive or regulatory. Operators felt like CHIP team members were trustworthy, cared about them, and supported their success with running their homes. At this time, Operators did not provide significant suggestions for improvement in the membership process but felt that ILEP was a welcome and needed addition to Santa Clara County.

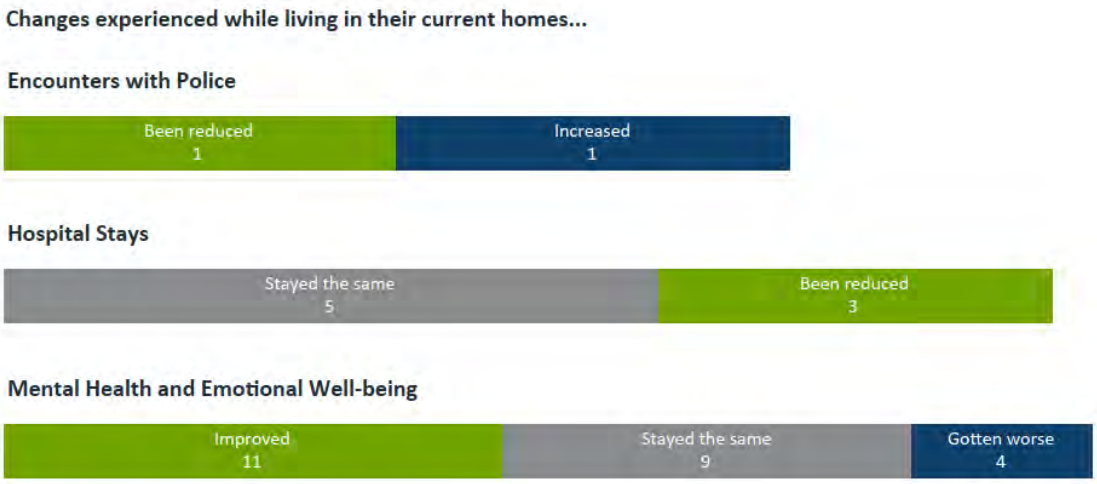
Tenant Experiences

In May 2023, 24 tenants completed the CIBHS Tenant Survey. Tenants had resided in their homes for a range of times prior to completing the survey, ranging from less than one month to over three years. There were no reported move-outs from ILEP member homes during this evaluation period.

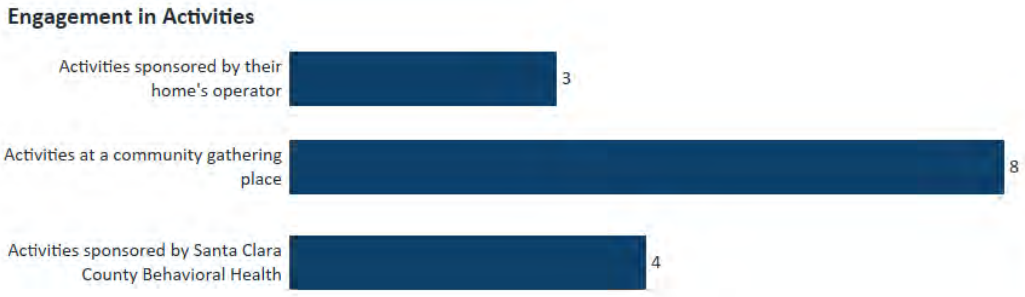
In the year prior to moving into their homes, some tenants experienced homelessness, arrest, and overnight hospitalization.

Over the past six months, however, tenants' encounters with police and hospital stays have stabilized[2], while many experienced improved emotional health and well-being.

[2] Individuals with no encounters with police or hospital stays in the past year responded "Not Applicable" to these items.



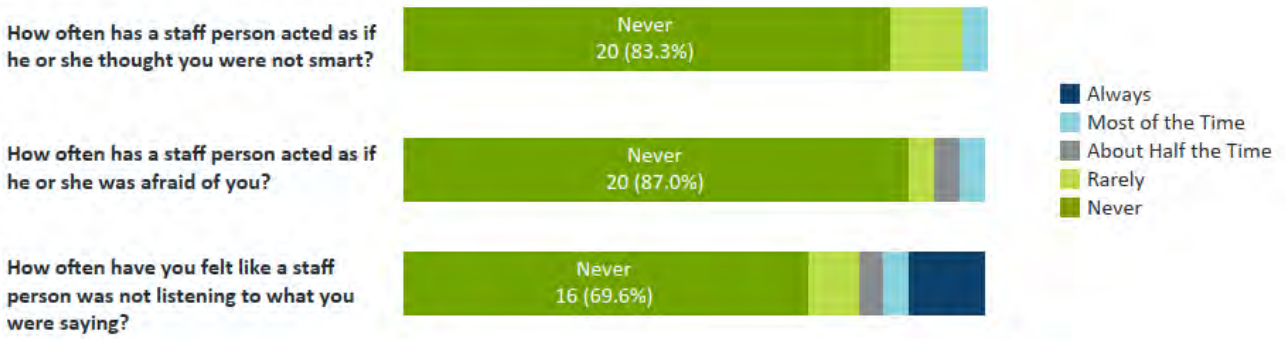
In the last six months, tenants reported engaging in activities hosted by their home's operator; community gathering places like community centers; houses of worship, or schools; and Santa Clara County Behavioral Health.



To understand whether tenants in ILEP member homes experience reduced stigma, tenants were asked a series of questions about their experiences in their homes. First, tenants were asked to rate the frequency with which staff engaged in the following stigmatizing behaviors:

- Acting as if they thought the tenant was not smart;
- Acting as if they were afraid of the tenant; and
- Not listening to what the tenant was saying.

The majority of tenants reported that they never experienced these behaviors, though tenants were more likely to feel like a staff person was not listening to them.



Tenants were also asked to rate their agreement with a series of statements, from strongly disagree to strongly agree. Responses were weighted from 1 (strongly disagree) to 5 (strongly agree) and averaged to generate an overall response score.

Overall, respondents felt they were generally able to live positive and meaningful lives in their homes, and that staff believed in them and supported their mental health needs. Tenants' ratings were slightly lower when asked whether they would still live in their current home if they had other choices, which likely reflects the lack of available high-quality and affordable independent living homes in the area.

This baseline data shows promising results for creating positive experiences and outcomes for ILEP tenants. Future reports will document changes in these measures over time, as homes remain in the ILEP and additional member homes are brought on board.

Role of Peers and Tenants in ILEP Planning and Administration

ILEP strives to incorporate peer and tenant voice in all aspects of project planning and administration. To that end, peers have been involved in Work Team meetings, the evaluation work group, and are part of the CHIP team leading the project. Additionally, one Operator is a family member of an individual with mental health challenges and previously worked with NAMI. All of the Operators interviewed described the ways in which they work with their tenants to understand their needs and expressed a strong desire to operate high quality independent living homes.

RECOMMENDATIONS AND CONCLUSIONS

At this stage of the ILEP project period, the project team has enrolled its first member homes in Santa Clara County, and continues to conduct outreach efforts to add homes. Preliminary data from the first ILEP Operators and Tenants demonstrates positive outcomes for both groups. As the program moves forward with recruiting additional Operators and member homes, the team should continue their extensive outreach efforts to existing independent living Operators in the County, and especially those serving individuals served by Santa Clara County Behavioral Health. Additionally, ILEP should work with ILEP Operators to prioritize moving in Tenants served by Santa Clara County Behavioral Health when vacancies occur. ILEP should leverage the attention generated by recent inquiries to the Behavioral Health Board, as well as the positive preliminary data from ILEP member homes, to promote membership in ILEP. Overall, ILEP continues to make progress towards its goals and shows promising preliminary outcomes for Operators and Tenants.

APPENDIX A. CHIP OPERATOR SURVEY

INSTRUCTIONS: The ILA/RRA Team would like to know more about your experiences as an ILA/RRA member. Please complete the following survey to your best ability. This survey will be kept anonymous.

PART 1: General Information

1. Please select which association you are a part of below:
   Please circle the answer below.
   San Diego ILA Alameda ILA Fresno ILA Santa Clara ILA
2. Please indicate the nature of today's visit:
   Please circle the answer below.
   Initial PRAT visit Annual PRAT visit Other_____

PART 2: ILA/RRA Membership

Please indicate if you agree or disagree with the statements listed below:

Please check the box.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
3. ILA/RRA staff have been helpful since I have been in contact with them.					
4. ILA/RRA staff have been attentive since I have been in contact with them.					
5. ILA/RRA staff have been knowledgeable since I have been in contact with them.					
6. I have been treated with respect since I have been in contact with the ILA/RRA Staff.					
7. I have been served in a timely manner since I have been in contact with the ILA/RRA Staff.					
8. The PRAT provided me with information to help with the quality of my home.					

9. Does having an annual PRAT add value to running your home?
   Please circle the answer below.
   Yes No
10. If the PRAT DOES add value to running your home, please explain how below.
    If the PRAT DOES NOT add value to running your home, please describe how value can be added.

PART 3: ILA/RRA Membership

11. Please select your level of satisfaction with the ILA/RRA.
    Please check the appropriate box.

Very dissatisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Very satisfied

12. Please explain why you chose the following:

PART 4: ILA/RRA Membership

13. What could improve your experience in the ILA/RRA?

14. Please provide any additional feedback in the space provided below:

PART 5: Additional Items added for ILEP

Please indicate if you agree or disagree with the statements listed below:

Please check the box.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
15. Tenants come to me when they need help solving a problem with their home.					
16. I am able to work together with tenants to address potential violations of house rules and policies.					
17. Tenants treat me with dignity, consideration, and respect.					
18. I understand tenants' mental health needs.					
19. I am able to support tenants to meet their mental health needs.					
20. Tenants and I agree that their mental health is important.					

APPENDIX B. CIBHS TENANT SURVEY

As part of the Santa Clara County Independent Living Empowerment Project (ILEP), the County has asked the California Institute for Behavioral Health Solutions (CIBHS) to help track how people living in Independent Living communities feel about the support they receive and their lives and wellness overall. This survey is confidential and will not affect your ability to continue living in your current home. Please skip any questions you prefer not to answer. Any information you share will only be used to understand and improve tenants' experiences in the future. CIBHS and Santa Clara County may share averaged responses but will not share any individual information.

1. How long have you lived in your current home?
   o Less than 1 month o 1-6 months o 7-12 months
   o 1-2 years o 2-3 years o 3+ years
2. In the year before you moved into your current home, were you, at any time…
   a. Homeless? o Yes o No
   b. Arrested? o Yes o No
   c. Hospitalized overnight? o Yes o No
3. [Since you moved into your current home/Over the last six months[3]], have your encounters with the police*…
   *By "encounters with the police" we mean being arrested, calling 911 to resolve an issue in your home, being hassled by the police while in the community, or being taken by police to a shelter or crisis program.
   o Been reduced o Stayed the same
   o Increased o Not applicable (I had no police encounters this year)
4. [Since you moved into your current home/Over the last six months[3]], have your hospital stays*…
   *By "hospital stays" we mean needing to spend one or more nights in a hospital to address your physical or mental health needs.
   o Been reduced o Stayed the same
   o Increased o Not applicable (I had no hospital stays this year)
5. [Since you moved into your current home/Over the last six months[3]], has your mental health and emotional well-being…
   o Improved o Stayed the same o Gotten worse

[3] The specific wording of these questions differ based on how long the individual has lived in their current home.

6. During the last 6 months, have you participated in any of the following types of activities (you may choose more than one)?
   o Activities sponsored by your home's operator
   o Activities at another gathering place, like a community center, house of worship, or school
   o Activities sponsored by Santa Clara County Behavioral Health, like mental health awareness events or counseling
   o Other (Please specify)
7. During the past 6 months…
   a. How often has a staff person acted as if he or she thought you were not smart?
      o Never o Rarely o About Half the Time
      o Most of the Time o Always
   b. How often has a staff person acted as if he or she was afraid of you?
      o Never o Rarely o About Half the Time
      o Most of the Time o Always
   c. How often have you felt like a staff person was not listening to what you were saying?
      o Never o Rarely o About Half the Time
      o Most of the Time o Always
8. For each of the items below, please mark whether you strongly disagree, disagree, are neutral, agree, or strongly agree.
   a. In general, I am able to live life the way I want to.
      o Strongly Disagree o Disagree o Neutral
      o Agree o Strongly Agree
   b. I can have a good, fulfilling life while living in my current home.
      o Strongly Disagree o Disagree o Neutral
      o Agree o Strongly Agree
   c. I have people I can count on.
      o Strongly Disagree o Disagree o Neutral
      o Agree o Strongly Agree
   d. If I had other choices, I would still live here.
      o Strongly Disagree o Disagree o Neutral
      o Agree o Strongly Agree
   e. Staff here believe I can grow, change and recover.
      o Strongly Disagree o Disagree o Neutral
      o Agree o Strongly Agree
   f. Staff here and I agree that my mental health needs are important.
      o Strongly Disagree o Disagree o Neutral
      o Agree o Strongly Agree

Thank you for completing this survey. By clicking “submit” you will share your responses with CIBHS. If you have any questions about this survey or how your responses will be used, please contact Samantha Spangler at samantha@behavioral-health-data.com.

TRUSTED RESPONSE URGENT SUPPORT TEAM

Analysis and report prepared by Dignity Best Practices

Quarterly Summary | April 1 to June 30, 2023

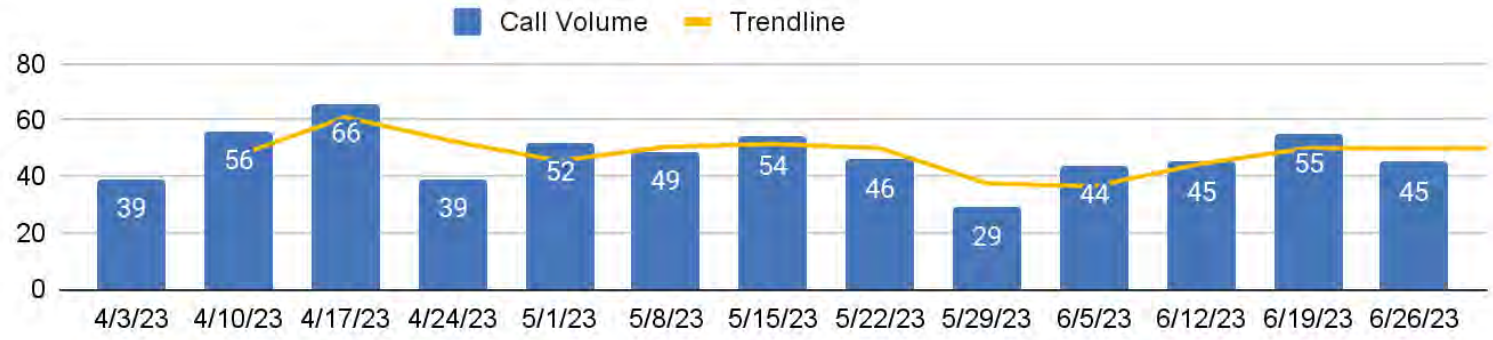
626 calls-for-service	2% escalated to law enforcement *of all calls received*	29% stabilized over phone *of all calls received*	47% field units dispatched *of all calls received*	62% stabilized in community *of dispatched field units*

Highlights

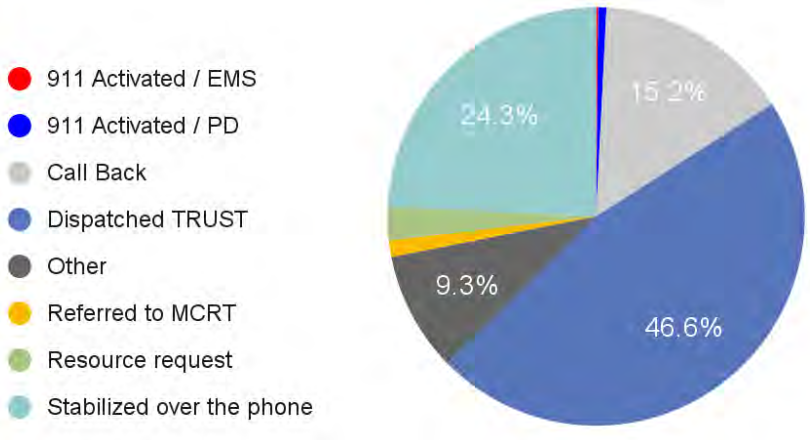
TRUST monthly call volume has been trending up since program launch in November 2022. Compared to the prior quarter, TRUST maintained the same rate of field dispatch (47%) and law enforcement involvement (2%). TRUST experienced a moderate increase of cases stabilized over the phone, 5% higher than the prior reporting period. Data quality and analysis during this time period may be impacted due to data collection challenges.

TRUST Call Center Activity (Total: 626)

Weekly Calls Received



Calls Received by Disposition



NOTE: 988 call takers conduct the initial screening prior to transferring to the TRUST Call Center. Occasionally, calls are transferred to TRUST that do not meet eligibility criteria. As such, the category "Other" has been used to label calls that did not meet criteria for service, including wrong numbers, out of county requests, non-emergency crime reports or complaints, and services declined. TRUST call takers had to activate 911 5 times (0.8%) between April and June 2023, directing 1 calls-for-service (0.16%) to EMS and 4 calls-for-service (0.64%) to police (PD).

A Closer Look: Call Backs

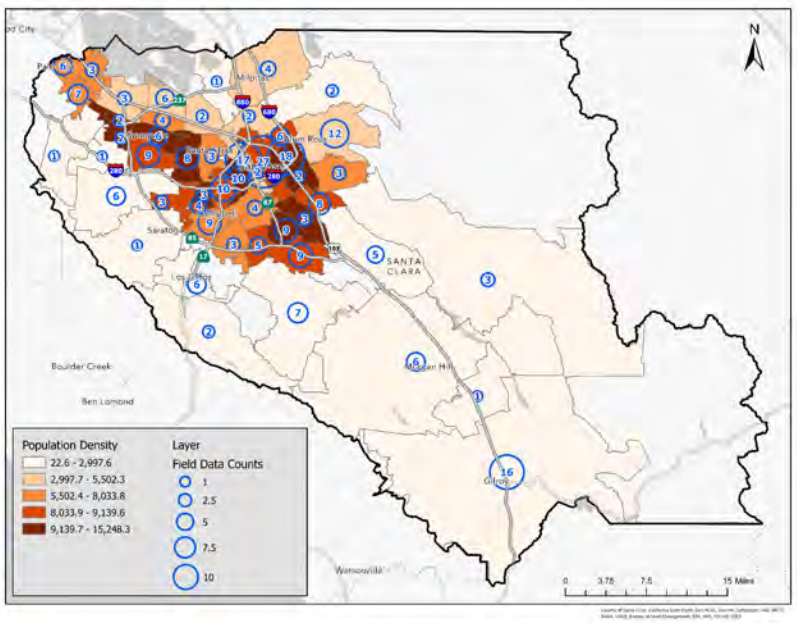
The "Call Back" disposition, or service outcome, indicates that a TRUST call taker initiated the call. In Q4, call takers documented 95 dispositions as "Call Backs":

- ➔ **Care coordination (47%)**
- ➔ **Failed transfers, dropped calls (23%)**
- ➔ **Unknown (29%)**

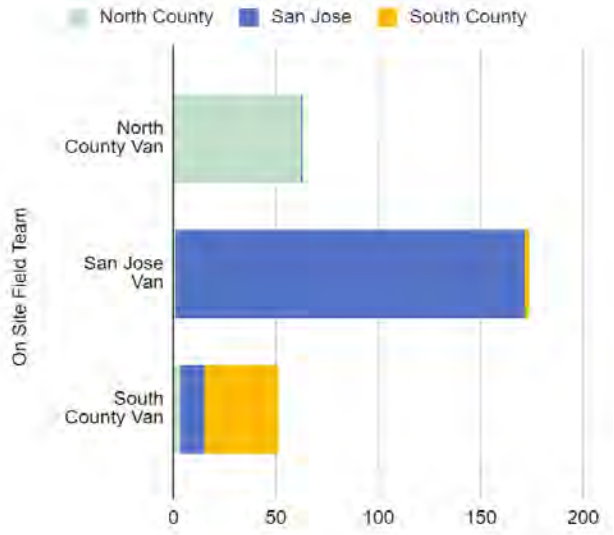
The breakdown of "Call Backs" reveals the variable nature of this call disposition, as well as important insights to TRUST Call Center workflow. Santa Clara BHSD, TRUST providers, and evaluators are working to better capture this critical component of TRUST service activity. Changes will be reflected in FY24 quarterly summary reports.

TRUST Field Team Activity (Total: 294)

Dispatched Units by Zip Code

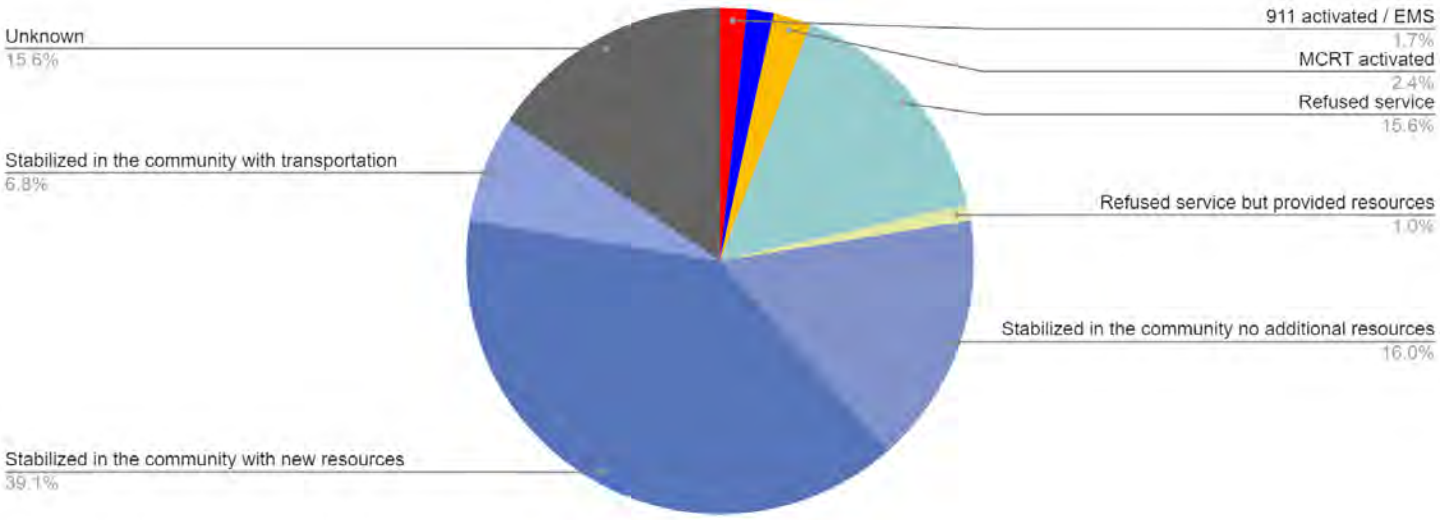


Dispatched Units by Team & Territory



NOTE: This chart reflects 290 out of the 294 dispatched units due to some missing information. Compared to the prior quarter, there is greater alignment between the service territory and the dispatched team.

Dispatched Field Units by Service Outcome



NOTES: A significant number of calls (15%) in this report are missing service outcome information due to delays and other complications in dataset production; These cases, labeled "Unknown" by the evaluators, may mischaracterize trends in service outcomes. Additionally police presence is not always initiated by TRUST. Some instances where MCRT, EMS, or PD were activated ultimately had a resolution in the field. During this period, some TRUST field teams did not have the ability to conduct 5150 assessments for involuntary hospitalization; as such, some MCRT units were activated to provide this service assessment.

Notable Impacts to Service Provision

There were no documented stoppages in TRUST services between April 1 and June 30, 2023. TRUST providers are continuing to refine assessment tools and documentation processes, and working to fully staff call center and field teams. During this quarter, technological challenges and resource barriers led to delays in producing datasets for evaluation. Consequently, the operational outputs and related trends represented in this report may be inaccurate or incomplete.

Vivo Vietnamese Voluntary Foundation

PEI Stigma & Discrimination Reduction Program

Prevention & early intervention (PEI) 1-Year Evaluation Report Data: FY2023 (July 1, 2022 – June 30, 2023)

Submitted by Community Connections Psychological Associates, Inc.
Brandon Hoeflein, Ph.D., and Joyce Chu, Ph.D.

1. Program Description

Initially proposed to serve the Vietnamese community in the County of Santa Clara, and expanded to include the African American/Ancestry community following an evidence-based needs assessment, the parent Innovation 16 grant seeks to increase knowledge of mental health and access to mental health services in those communities. The parent project seeks to destigmatizing mental health services in the context of their culture, focusing on prevention community outreach/education, and provision of co-located professional mental health treatment services to children, adults, and families. Following is a program description of VIVO Vietnamese Voluntary Foundation's INN 16 program.

VIVO provided the proposed services at the George Shirakawa Community Center of San Jose as the main location to serve the Vietnamese American Community. Designated as the Vietnamese American Cultural Center (VACC) by the City of San Jose, this community center has been operated by the city for the Vietnamese American Community to come and conduct its support group, cultural and social activities, from small groups of 10 or 20 community members to larger groups of hundreds community members, in-doors and outdoors.

Located inside the center, for this mental health program, VIVO operated out of this VACC center to address the stigma and/or trauma by mental health clients in the Vietnamese American community, and by stressing "Prevention and Early Intervention":

i. To recruit clients for the community at large via various channels.
ii. To admit and in-take clients based on individual needs.
iii. To assess, classify clients' mental health statuses and make plans for their rehab. The duration of the plan may last for days, weeks or month depending on their needs with proper monitor for effective results.
iv. To integrate clients into other existing services offered by VIVO, such as ESL classes, Computer Classes, Exercise, Social Gathering, etc.
v. To integrate into other services offered for free by other Vietnamese Interest Groups, such as Dancing, Karaoke, Exercises, Faith Circle, Support Groups etc.

Note that, as nature of the VACC, all services were offered for free by all interest groups, or for small fees to cover the cost of materials and supplies. Besides the services offered at the VACC, VIVO partnered with other religious, faith based groups or special social groups:

i. To introduce clients to the service by local temples and faith groups for further healing.
ii. To follow-up with clients to monitor their progress.

2. Program Indicators

VIVO's program addresses **suicide prevention** and prevention of **prolonged suffering** through two main targets or mechanisms:

i. **Increased Access to Services:** VIVO's Family Harmony program facilitates service access via hiring of a referrals case manager. They also disseminate knowledge of County resources at every workshop event.
ii. **Decrease Stigma:** VIVO's Family Harmony workshops function on a rotating list of topics intentionally chosen based on high stigma and the need to address intergenerational stigma. Their program decreases stigma by holding community discussions on these topics, sharing these discussions on radio broadcasts, and submitting 2-page write-ups in local magazines/newspapers often accessed by the Vietnamese community.

3. Program Goals, Objectives & Outcomes

VIVO aimed to meet the original stated goals of the Innovation Program, listed below. It is important to note, however, that original participant target numbers were initial guesstimates that were aspirational in nature. These target numbers may require future revision and flexibility as the Innovation Program learns about population size, need, and the program design needed to adequately outreach and serve the needs of the Vietnamese community.

i. Securing partnerships for locating mental health services in community facilities, faith-based organizations, cultural centers, and/or other entities.
ii. An estimated four hundred eighty (480) families will be served through parent cafes each year.
iii. An estimated five hundred (500) families will be served through healing circles each year.
iv. An estimated four hundred (400) clients who attend community outreach events will visit tables with materials for VIVO annually.
v. An estimated 20% of families engaged through VIVO will receive referrals to other community-based organizations for additional services.
vi. Develop an anti-stigma outreach campaign through the mail targeting the Vietnamese communities.
vii. Develop an anti-stigma outreach campaign through social media targeting the Vietnamese communities.

4. Clients Served & Annual Cost per Client Data

Refer to Innovation Cover page.

5. Evaluation Activities

SPECIFIC PEI STRATEGIES

VIVO addresses both PEI strategies of Access and Linkage and Improving Timely Access to Services for Underserved Populations, and does so by directly addressing mental health stigma:

- **Access and Linkage** and **Improving Timely Access to Services for Underserved Populations:** VIVO's Family Harmony program facilitates service access via hiring of a referrals case manager. They also disseminate knowledge of County resources at every workshop event.
- **Decrease Stigma**: VIVO's Family Harmony workshops function on a rotating list of topics intentionally chosen based on high stigma and the need to address intergenerational stigma. Their program decreases stigma by holding community discussions on these topics, sharing these discussions on radio broadcasts, and submitting 2-page write-ups in local magazines/newspapers often accessed by the Vietnamese community.

DETAILED INFORMATION ABOUT THE EVALUATION PLAN AND OUTCOMES (IN NARRATIVE FORM)

Overall Description of Evaluation Plan

The evaluation plan for the VIVO Innovations Program consisted of a mixed methods design spanning formative (initial and ongoing), process, and summative evaluative capacities. Evaluation activities allow the project to meet all quarterly and annual reporting requirements. Data and narrative reports are reported by VIVO on a quarterly basis, to BHSD and the program evaluation team. The program evaluators analyze the data and provide an annual report about ongoing progress. This plan for evaluation reporting allows for tracking of project goals.

Program evaluation for these projects occurred in several steps:

1. Collaborative development of an evaluation-specific logic model and evaluation plan for VIVO
2. Execution of formative and summative evaluation processes
3. Ongoing and final reporting.

Collaborative Development of Evaluation and Measurement Plan and Logic Model

Consistent with the tenets of Community Based Participatory Research, the evaluation team and VIVO engaged in an iterative developmental process to create the evaluation plan. The process involved conducting a series of meetings between CCPA with VIVO, with the consultation of the MHSA team from Santa Clara County's BHSD. The collaborative team created following logic model and measurement plan. These plans are consistent with the goals and scope of the grant, but modified to fit the unique cultural needs of the targeted cultural stakeholder committees.

Germane to the evaluation plan, is the measurement and identification of the cultural adaptation-specific elements of the outreach and programmatic activities. This understanding of the impact of cultural and spiritual nuances, beliefs, practices and norms on program planning, delivery, and outcomes for each of the target communities, are essential to the core goals of the grant.

Logic Model for VIVO's INN 16 MHSA Project

Problem Statement	Program Goal(s):
"The County's Vietnamese [community has] faced historical and contemporary traumas that result in … trouble trusting authority and government agencies… [which] often results in delaying or avoiding accessing treatment."	"...to increase knowledge of an access to mental health services among Vietnamese communities by destigmatizing mental health services in the context of their culture."

Resources	Activities	Outputs	Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes
• SCC Behavioral Health Services Department • 40+ of Vietnamese community building • Physical space at VASC • Language Skills • Community Trust • Intergenerational Staff Approach • MHSA Innovation Funds	• Community Outreach Events • Family Cafes • Healing Circles • Referrals (warm hand-offs) • Broadcast Media (e.g., radio)	• Securing partnerships for locating MH services • 480 families served through Family Cafes annually • 500 families served through Healing Circles annually • 400 clients reached at community outreach events • 20% of clients referred for additional services • Anti-stigma outreach campaign	• Identification of key cultural lessons and programs components used to engage the Vietnamese community, increase knowledge of and access to mental health services • Increased knowledge of participants & their families • Access to Resources (e.g., handouts) • Increased Awareness of VIVO • Increased Awareness of BHSD services	• Establishment of a cohesive culturally innovative model to increase knowledge of and access to mental health services among Vietnamese communities • Decreased mental health stigma within the Vietnamese community • More referrals to mental health and substance use services	• Sustainable plan for continuation of the culturally innovative model to increase knowledge of and access to mental health services among Vietnamese communities • Specific recommendations for Vietnamese community / family programming • Increased comfort discussing mental health and social topics (e.g., LGBTQ+ issues, BLM)

Process Evaluation: Using Data to Monitor Implementation

The project's ongoing formative evaluation process will take place quarterly during the first two years with three main aims: (1) to assess whether integration of culturally-informed organizational and service delivery processes is consistent with project objectives; (2) to inform remediation of challenge areas as they arise; and (3) to evaluate implementation of those changes and inform any necessary iteration. Data will be collected through interviews/questionnaires with staff, program reports, and other relevant program administration and marketing documentation.

Gap / Strengths / Innovations Analysis and Timely Changes to Care Plans. Data will be analyzed to identify challenges and barriers from the original plan as they arise, the potential impact of these challenges, proposed course of action in response to these challenges, and learning lessons from these challenges with regards to cultural adaptations and innovations. Through this evaluation process, strategies for making innovative adaptations to serve the needs of the community will be formulated and implemented. A summary of cultural lessons learned will be detailed in annual reports.

Quarterly Process Evaluation Protocol

1. What has gone well so far?
2. What are been ongoing challenges?
3. What goals and/or solutions will you pursue in the next phase of this project?
4. Please describe the key cultural elements of your outreach and programmatic activities.
    a. What are the specific cultural and spiritual nuances, beliefs, practices, and norms specific to the African American/ African Ancestry communities that you've found need to be incorporated into the planning, delivery, and outcomes of mental health services?
    b. What have you found to be effective ways for the African American/ African Ancestry faith-based and medical communities to welcome and integrate mental health clients into their community?
5. What types of partnerships have you secured for pathways to mental health services? Any faith-based or medical communities?

Have you integrated any specific evidence-based practices and community-defined strategies of trauma-informed care into your efforts?

Summative Evaluation: Utilizing Qualitative and Quantitative Data to Evaluate Effectiveness

Goals of the summative evaluation are to establish outcomes for project for quarterly and annual reporting activities. Data will be analyzed to assess progress on project goals with regards to identified outcome variables. Flexibility and innovation is required in the evaluation approach, with attempts made to determine the most effective way to capture outcome data via quantitative and qualitative methods.

Y1 Update on Evaluation Plan Development and Activities:

During Y1, VIVO has established the Family Harmony program to carry out the Innovations Grant. From August through December 2022, VIVO staff met with external program evaluators to establish a culturally-appropriate evaluation plan for the Vietnamese community.

VIVO implemented an internal data collection system to include a post-event survey. VIVO collaborated with the program evaluation team to bolster the post-event survey with three additional items meant to help measure the full spectrum of domains outlined in the Innovations grant. See "Participant Satisfaction & Feedback" below for additional information on the specific items as well as the results.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years		
16 -25 years		
26- 59 years	261	42.9%
60+ years	319	52.4%
Prefer not to answer		
Unknown	29	4.8%
Unduplicated Total	609	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native		
Asian	609	100%
Black or African American		
Native Hawaiian or Other Pacific Islander		
White/ Caucasian		
Other		
More than one race		
Prefer not to answer		

Unknown		
Unduplicated Total		

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		
Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino		
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		

Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		
Prefer not to answer		
Unknown		
Unduplicated Total	609	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	200	32.8%
Female	407	66.8%
Prefer not to answer		
Unknown	2	0.3%
Unduplicated Total	609	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	200	32.8%
Female	407	66.8%

Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	2	0.3%
Unduplicated Total	609	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight	609	100%
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown		
Unduplicated Total		

	FY 2023	
Primary Language	**# Served**	**% of Served**

English		
Spanish		
Vietnamese		
Chinese		
Tagalog		
Farsi		
Other – Vietnamese	609	100%
Prefer not to answer		
Unknown		
Unduplicated Total		

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military	609	100%
Prefer not to answer		
Unknown		
Unduplicated Total	609	100%

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		

Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability		
No Disability		
Prefer not to answer		
Unknown	609	100%
Unduplicated Total		

*Participants may choose more than one option for Disability.

7. Group Services Delivered

FY 2023		
Unduplicated N =		
Number of Groups	Attendance	Average Attendance per Group
56	608	10.5

8. Detailed Outcomes

CULTURAL LESSONS LEARNED FROM YEAR ONE (Y1) INNOVATIONS

1. **Recruitment is most effective when it draws in Vietnamese individuals based on their social services needs and addresses trauma-related social topics.** VIVO staff have been most successful in increasing attendance by marketing events/topics that are of direct practical utility to the Vietnamese community. The language used in marketing is, at times, strategically parallel to traditional behavioral health terminology, which seems to be a key cultural consideration (see "Workshop Topics" table below).
2. **Intergenerational approaches to care are key.** VIVO Family Harmony staff have developed an entire program of workshops intended to heal acculturation-related intergenerational divides in a uniquely nuanced culturally-congruent manner.
3. **It takes more time to address the mental health attitudes of Vietnamese individuals than mental health knowledge or skills.** Per VIVO Family Harmony staff, as well as participant self-report measures, Family Harmony programming has increased Vietnamese community knowledge and skills related to mental health. However, staff report that attitude/stigma remain a continued goal.
4. **BHSD referrals are best facilitated in 1:1 interaction by a known agency (a trust agent).** VIVO Family Harmony staff have found that the best way to connect Vietnamese individuals to BHSD services

is to first build relationships through prevention/education/case management, and then to initiate referrals in a private 1:1 setting.

5. **Recruitment requires culturally-driven, individualized outreach messages.** For each topic, VIVO Family Harmony staff send individualized text messages to each family in their database. These messages carefully crafted from a cultural lens to portray values of respect and hospitality while also creating a warm welcome. VIVO staff report that these messages are seemingly straightforward but are culturally-attuned in very fine detail.
6. **Workshops are effective when Vietnamese facilitators model stigma-busting by disclosing their own personal history with the workshop topic.** Notably, Vietnamese participants seem to respond best to topics when the group leader initiates self-disclosure and brings a "human element" to the community processing.
7. **In order to bridge the intergenerational divide fueled by historical harms, it is important to address the concerns of each generation separately (e.g., 1st generation, 2nd generation, 1 ½ generation).** VIVO staff have intentionally spent the first year focused on 1st generation Vietnamese folx (e.g., primarily acculturation-related social topics and social service needs) with exploratory efforts at addressing the needs of younger generations (e.g., Vietnamese language classes). Family Harmony staff have learned that these parallel approaches are critical based on the unique needs of the different generations within Santa Clara County's Vietnamese community.
8. **Adults require a different approach than older adults.** This difference was hypothesized as being due to the fact that younger generations are currently raising young children and working full-time. The initial innovative attempts to reach younger adults and middle-aged adults have been stymied even when collaborating with other Vietnamese-specific agencies; younger adults and middle-aged adults are a high priority for additional innovation in Y2.
9. **Vietnamese individuals are hesitant to use the BHSD Access Line.** Family Harmony staff have found that community members are hesitant to call a line staffed by unknown professionals, and would instead prefer a direct, agency-to-agency warm handoff. Without that option currently, VIVO has innovated by hiring an additional case manager to facilitate referrals.

PROGRESS TOWARDS PROGRAM GOALS & OBJECTIVES

a) Securing Partnerships for Locating Mental Health Services in Community Facilities, Faith-Based Organizations, Cultural Centers, and/or Other Entities.

Behavioral Health Partnerships.

During Y1, VIVO's Family Harmony program aimed to identify a community agency that provides culturally-appropriate behavioral care specific to Vietnamese individuals. They identified Mekong as their ideal community collaborator and have taken multiple steps over the past year to establish and build a professional relationship.

One of the barriers to external referrals has been the hesitation for Vietnamese individuals to receive services by another agency. In addition, VIVO has noted the hesitation of the Vietnamese community to utilize the BHSD Access Line ("[Vietnamese] clients would prefer personal contact or a personal referral, [rather] than a number that will lead them to anywhere." As such, VIVO has adopted a dual case management strategy in which they offer social services at their facility (e.g., English language classes, citizenship classes) and are working to facilitate BHSD Access Line referrals, both of which are being implemented via the hiring of a case manager specifically to manage referrals (both internal and external).

Religious/Spiritual Settings.

During Year One, VIVO Family Harmony staff have brainstormed multiple religious/spiritual faith centers as potential partnerships to develop in Y2 of the grant. Specifically, they plan to coordinate with local churches, temples, and parishes by inviting their staff to co-host workshops at VIVO.

b) Parent Cafes & c) Healing Circles

During Y1, Vivo's Family harmony staff have conducted 56 workshops (integrated Parent Cafes and Healing Circles). These events are centered around acculturation/assimilation/social service topics that combine:

- psychoeducation about a topic of interest to the Vietnamese community
- community-building via shared home-cooked, culturally-congruent meals
- discussion of intergenerational differences on the topic and methods of addressing those intergenerational divides (Parent Cafés)
- shared community discussions guided by scaffolding communication skills related to intergenerational trauma and historical harms (Healing Circles)

The initial set of 15 topics were derived via an intergenerational process in which VIVO staff paired with Vietnamese college students and brainstormed topics which have traditionally caused intergenerational rifts and been difficult for the community to address. The topics generally fall into the following categories:

- substance use and mental health (e.g., Domestic Violence/Abuse, Gambling Addiction)
- controversial social topics (e.g., LGBTQ+ topics, interracial marriage, politics, divorce)
- practical social services (e.g., Caring for Elderly Parents)

The college students then created sets of PowerPoint slides that could be translated and presented to the 1st generation Vietnamese individuals. Those slides were then translated and adapted by VIVO staff to best facilitate community conversation.

Over the year, VIVO staff have consistently asked community members for additional topic suggestions and have added workshops on housing information, tuberculosis, and English as a Second Language (ESL).

Considering that the Innovations grant is highly focused on methods of engaging/recruiting/accessing the Santa Clara County Vietnamese community, it is worth noting that community participation varied by topic, serving as an indicator of which events are most motivating for the Vietnamese community. An analysis of attendance numbers indicates that the Vietnamese community is most interested in the following topics:

- Computer Skills
- Political Discussion & Election
- Housing Information

Date	Workshop Topics	Total Attendees
7/29/2022	Alcohol/Drug Abuse	30
8/14/2022	War & Sorrow [Vietnam War Trauma]	13
8/17/2022	War & Sorrow [Vietnam War Trauma]	4
8/21/2022	LGBTQ+	12
8/24/2022	LGBTQ+	2
8/26/2022	Alcohol/Drug Abuse	20
8/28/2022	Alcohol/Drug Abuse	8
9/4/2022	Gambling Addiction	22
9/11/2022	Gambling Addiction	8
9/25/2022	Tiger Parents	9
9/30/2022	Caring for Elderly Parents	23
	Quarter 1 Total:	**151 (119)**

10/12/2022	Caring for Elderly Parents	19
10/16/2022	Interracial Marriage	6
10/19/2022	Interracial Marriage	3
10/23/2022	Economy, Finance, and Debt	10
10/26/2022	Political Discussion & Election	3
10/28/2022	Political Discussion & Election	38
10/30/2022	Political Discussion & Election	68
11/2/2022	Political Discussion	3
11/5/2022	Political Discussion	10
11/6/2022	Divorce & Impacts	7
11/12/2022	Parents' Pressure on Children	7
11/20/2022	Parents' Pressure on Children	8
12/3/2022	Bullying in Schools	8
12/4/2022	Medicare Guidelines*	6
12/10/2022	"Forgetful Parents" [Parents Not Fulfilling Duties to Children]	13
12/11/2022	Funeral Services*	5
	Quarter 2 Totals	**214 (124)**
1/7/2023	"Stress & How to Deal with It" [Economy, Finances, and Loss]	9
1/8/2023	"Stress & How to Deal with It" [Economy, Finances, and Loss]	9
1/14/2023	"Economic Pressure" [Economy, Finance, and Loss]	6
1/15/2023	"Economic Pressure" [Economy, Finance, and Loss]	6
1/28/2023	Gun Control & Safety	9
1/29/2023	Gun Control & Safety	16
2/4/2023	"Teaching Children to be Good" [Parents Not Fulfilling Duties to Children]	9
2/5/2023	"Teaching Children to be Good" [Parents Not Fulfilling Duties to Children]	25
2/11/2023	"Close Relationships Between Parents & Children" [Parents Not Fulfilling Duties to Children]	9
2/12/2023	"Close Relationships Between Parents & Children" [Parents Not Fulfilling Duties to Children]	9
2/19/2023	Funeral Preparation*	11
2/24/2023	"Anti-Asian" [Anti-AAPI Racial Discrimination]	46
2/26/2023	"How to get a Happy Family" [Parents Not Fulfilling Duties to Children]	11
3/4/2023	"How to Help Children Be Successful" [Parents Not Fulfilling Duties to Children]	8
3/5/2023	"Orienting Life for Elderly in the Future" [Caring for Elderly Parents]	33
3/11/2023	Domestic Violence and Abuse	14
3/12/2023	Domestic Violence and Abuse	10
3/18/2023	Housing Information*	48
3/19/2023	Housing Information*	16
3/24/2023	Housing Information*	49
	Quarter 3 Totals	**353 (148)**
4/2/2023	Housing Information*	57
4/16/2023	Computer Class*	69
4/21/2023	Breast Cancer*	52
5/7/2023	Teaching Children*	9

5/13/2023	Teaching Children*	11
5/21/2023	Teaching Children*	18
5/26/2023	Interracial Marriage	51
6/11/2023	King Road Improvement Plan*	23
6/23/2023	Tuberculosis*	37
Quarter 4 Totals		**327 (216)**
Y1 Healing Circle / Parent Café Totals		**1,045 (607)**

Note: As a critical cultural adaptation, some of the advertised event titles do not directly match the content of the discussion; in such cases, the advertised title is listed in parentheses with the accurate title in brackets

Note: An asterisk (*) indicates a topic that was not originally planned but was added based on community needs and community member feedback.

d) Community Tabling Events.

During Y1, VIVO Family Harmony staff have conducted six (6) community tabling events, yielding direct contact with 570 community members. As seen below, these community tabling events were largely conducted at Vietnamese community cultural events. Of note, at each event, VIVO staff kept a running list of attendees along with their phone numbers, which is the primary method that they used to expand their list of VIVO participants who receive text invitations to Family Harmony workshops.

Date	Event/Location	Total Direct Interactions
8/27/2022	Community Day (VACC)	100
9/9/2022	Lantern Festival Day (Milpitas City Hall)	62
9/16/2022	Moonfest Festival (VACC)	315
Quarter 1 Total:		**477**
10/29/2022	Halloween Festival at (VACC)	31
Quarter 2 Totals		**31**
1/29-1/30/2023	Tet Festival (Viet Museum)	37
Quarter 3 Totals		**37**
4/30/2023	Black April (San Jose City Hall)	25
Quarter 4 Totals		**25**
Y1 Community Outreach Totals		**570**

e) Referrals for Additional Services/Resources.

VIVO provided referrals to two main groups of individuals. First, referrals were provided to Family Harmony participants. In order to facilitate referrals to additional services/resources, VIVO has crafted a list of 40 agencies/services that are of unique interest to the Vietnamese community. This list is discussed at each event to increase Vietnamese individuals' awareness of resources. In addition, the feedback form for each event asks if the individual would like assistance accessing any of these resources, or any other resources. Second, referrals were provided to individuals who called VIVO after hearing/reading one of their anti-stigma campaigns (e.g., radio interviews, flyers). Specifically, at all of the anti-stigma outreach campaigns (radio programs, newspaper/magazine articles), VIVO has included their contact information and encourages Vietnamese individuals to call for help accessing resources. In order to provide individualized assistance with resource access, VIVO Family Harmony hired a half-time referral case manager, who facilitates referral requests from both sources.

During Y1, of the 609 individuals who attended a Family Harmony event, 412 of them (67.6%) requested help accessing additional resources; of these, 336 (81.2%) were referred for one resource/service, and 76 (18.4%) were referred for two resources/services. In total, VIVO facilitated 488 referrals for 412 individuals. See below for a chart detailing the number of referrals per quarter in Y1.

VIVO Family Harmony: Y1 Referrals, by Quarter	
Q1 (7.1.22-9.30.22)	139
Q2 10.1.22-12.31.22)	172
Q3 (1.1.23-3.30.23)	124
Q4 (4.1.23-56.30.23)	53
Total	488

Of these 488 referrals, the top request was for citizenship resources/classes (62.3%), followed by housing resources (14.3%). For full results, see chart below.

VIVO Family Harmony: Y1 Referrals, by Agency/Services	
VIVO: Citizenship Resources	304
VIVO: Housing Resources	70
VIVO: Government Benefits	36
VIVO: Smart Phone Resources	26
VIVO: ESL Resources	24
VIVO: Computer Resources	16
VIVO: Health/Exercise/Yoga Benefits	12
Total	**488**

f) Anti-Stigma Outreach Campaign.

Radio. During Y1, VIVO has contracted with a local radio station commonly used by the Vietnamese community. They have arranged for weekly air time in which a staff member (Mr. Tam) revisits the main speaking points from that week's Family Harmony workshop. It is estimated that each week's radio address reaches an audience of over 40,000. Moving into Y2, VIVO Family Harmony has signed a one-year extension of the contract and will continue holding 15-minute radio segments every week.

Local Newspaper/Magazines. In addition, a Family Harmony staff member has been tasked with creating a 2-page summary of talking points from the week's Family Harmony workshop, which is being published in local magazines/newspapers utilized by the Santa Clara County Vietnamese community.

Paper Flyers. Moreover, VIVO started a neighborhood flyer program in April.

VIVO's Family Harmony Program Workshop Attendance					
	Q1 (7/1/22-9/30/22)	**Q2** (10/1/22-12/31/22)	**Q3** (1/1/23-3/30/23)	**Q4** (4/1/23-6/30/23)	**Y1 TOTALS**
g) Reach 480 individuals via Family Cafe events, unduplicated consumers	119	124	148	216	**607**

h)	Reach 500 individuals via Healing Circle events, unduplicated consumers	119	124	148	216	**607**
i)	Reach 400 individuals via community outreach (tabling events)	477	31	37	25	**570**
j)	Refer 20% of clients to additional services	139	172	124	53	**67.9% (N = 412)**

PARTICIPANT SATISFACTION & FEEDBACK

At the onset of the Innovations grant, VIVO had independently implemented an internal survey feedback form for use after every workshop. Using a five-point Likert scale (1 = Lowest, 5 = Highest), the original five prompts were:

1. "I improve[d] my knowledge in attending this class, workshop, or helping session."
2. "I am satisfied in attending this class, workshop, or helping session."
3. "I [would] recommend this class, session, workshop or helping session to others."
4. "The staff or teacher has been helpful in providing these services."
5. "The site and/or classroom provide for necessary comforts and cleanliness."

After collaboration with the program evaluation team, VIVO added an additional three questions. Using a five-point Likert scale (1 = Not Agree, 5 = Yes, Strongly Agree), the additional three prompts were:

A. "I think it is important for this topic to be discussed in the Vietnamese community."
B. "We addressed a topic not usually discussed in the Vietnamese community."
C. "I became more aware of the need to get help or support for issues that are usually silent."

Full data are listed below by event, including averages for each of the eight (8) survey items, as well as an overall satisfaction average. In summary, VIVO Family Harmony participants were very satisfied with every workshop conducted within Y1 (overall satisfaction averages ranged from 3.8 to 5, on a scale of 1-5). Of the 56 workshops conducted over the year, 45 of them (80%) had an overall satisfaction average of 4.5 or higher. The highest-rated event in Q1 was War & Sorrow (4.9). The highest-rated event in Q2 was Political Discussion (4.9). The highest-rated event in Q3 was Funeral Preparation (5). The highest-rated workshop in Q4 was tied between Teaching Children (5) and King Road Improvement Plan (5). There were three event topics with an overall satisfaction average of 5, listed below:

- Funeral Preparation
- King Road Improvement Plan
- Teaching Children

In addition, the overall satisfaction averages increased over the course of Y1, such that every event in Q3 and Q4 had an overall satisfaction average of 4.5 or higher.

In sum, these community data suggest that VIVO Family Harmony has established a very strong methodology for recruiting and engaging the Vietnamese community in high-caliber, culturally-appropriate anti-stigma services, and has consistently improved the quality of their events across Y1.

VIVO Family Harmony Workshops: Post-Event Survey Results

Date	Workshop Topics	Knowledge	Satisfaction	Would Recommend	Satisfaction With Leader	Physical Location	Important	Stigma Topic	Help-Seeking Attitude	Sum Average
Quarter 1 Events										
7/29/2022	Alcohol/Drug Abuse	4.6	4.6	4.6	4.6	4.4	-	-	-	**4.5**
8/14/2022	War & Sorrow	4.6	4.8	4.8	4.7	4.6	-	-	-	**4.7**
8/17/2022	War & Sorrow	4.3	5.0	5.0	5.0	5.0	-	-	-	**4.9**
8/21/2022	LGBTQ+	4.3	4.3	4.3	4.3	4.1	-	-	-	**4.2**
8/24/2022	LGBTQ+	4.5	4.5	4.5	4.5	4.5	-	-	-	**4.5**
8/26/2022	Alcohol/Drug Abuse	4.8	4.6	4.9	4.7	4.8	-	-	-	**4.7**
8/28/2022	Alcohol/Drug Abuse	4.7	4.4	4.8	4.9	4.7	-	-	-	**4.7**
9/4/2022	Gambling Addiction	4.8	5.0	5.0	5.0	5.0	4.8	4.4	4.7	**4.8**
9/11/2022	Gambling Addiction	-	-	-	-	-	-	-	-	**-**
9/25/2022	Tiger Parents	4.3	4.1	4.1	4.3	4.2	-	-	-	**4.2**
9/30/2022	Caring for Elderly Parents	4.6	4.7	4.6	4.6	4.6	-	-	-	**4.6**
Quarter 2 Events										
10/12/2022	Caring for the Elders	4.4	4.4	4.4	4.5	4.4	-	-	-	**4.4**
10/16/2022	Interracial Marriage	-	-	-	-	-	4.3	3.8	4.3	**4.2**
10/19/2022	Interracial Marriage	-	-	-	-	-	4.0	3.7	4.0	**3.9**
10/23/2022	Economy, Finance, and Debt	-	-	-	-	-	4.3	4.0	4.4	**4.2**
10/26/2022	Political Discussion & Election	-	-	-	-	-	4.0	3.7	3.7	**3.8**
10/28/2022	Political Discussion & Election	4.7	4.7	4.6	4.7	4.6	-	-	-	**4.7**
10/30/2022	Political Discussion & Election	4.8	4.9	4.9	4.7	4.8	4.5	4.5	4.7	**4.8**
11/2/2022	Political Discussion	-	-	-	-	-	4.7	5.0	5.0	**4.9**
11/5/2022	Political Discussion	-	-	-	-	-	5.0	4.6	4.6	**4.7**
11/6/2022	Divorce & Impacts	-	-	-	-	-	4.4	4.4	3.7	**4.2**
11/12/2022	Parents' Pressure on Children	-	-	-	-	-	4.7	4.6	5.0	**4.8**

11/20/2022	Parents' Pressure on Children	-	-	-	-	-	4.0	4.0	4.3	**4.1**
12/3/2022	Bullying in Schools	4.6	4.4	5.0	4.4	4.9	5.0	4.3	4.5	**4.6**
12/4/2022	Medicare Guidelines	4.4	4.6	4.6	4.2	4.0	4.8	4.0	4.2	**4.4**
12/10/2022	Forgetful Parents	4.6	4.7	4.2	4.6	4.8	4.6	4.6	4.8	**4.6**
12/11/2022	Funeral Services	4.4	4.6	4.8	4.4	4.2	4.6	4.4	4.6	**4.5**
Quarter 3 Events										
1/7/2023	Stress & How to Deal with It	4.8	4.6	4.8	4.8	4.9	4.1	3.7	4.2	**4.5**
1/8/2023	Stress & How to Deal with It	4.8	4.5	4.8	5.0	4.9	4.3	3.8	4.4	**4.5**
1/14/2023	Economic Pressure	5.0	4.7	5.0	5.0	5.0	4.5	4.7	4.8	**4.8**
1/15/2023	Economic Pressure	5.0	5.0	4.7	4.8	5.0	4.7	4.8	5.0	**4.9**
1/28/2023	Gun Control & Safety	4.5	4.6	4.6	4.5	4.5	4.5	4.3	4.4	**4.5**
1/29/2023	Gun Control & Safety	4.7	4.4	4.7	4.7	4.8				**4.7**
2/4/2023	Teaching Children to be Good	4.9	5.0	5.0	5.0	4.9	3.9	4.3	4.0	**4.6**
2/5/2023	Teaching Children to be Good	4.5	4.7	4.7	4.6	4.6	4.6	4.3	4.9	**4.6**
2/11/2023	Close Relationships Between Parents & Children	4.8	4.8	4.7	4.8	4.9	-	-	-	**4.8**
2/12/2023	Close Relationships Between Parents & Children	4.7	4.8	4.7	4.8	4.8	4.7	4.7	4.7	**4.7**
2/19/2023	Funeral Preparation	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	**5**
2/24/2023	Anti-Asian	4.8	4.8	4.8	4.8	4.9	4.9	4.8	4.8	**4.8**
2/26/2023	How to get a Happy Family	4.6	4.7	4.8	4.7	4.5	4.8	4.5	4.5	**4.6**
3/4/2023	How to Help Children Be Successful	4.8	4.6	4.3	4.4	4.9	4.6	4.4	4.3	**4.5**
3/5/2023	Orienting Life for Elderly in the Future	4.6	4.7	4.8	4.9	4.9	4.9	4.8	4.8	**4.8**
3/11/2023	Domestic Violence and Abuse	4.7	4.7	4.7	4.9	4.9	4.6	4.5	4.6	**4.7**
3/12/2023	Domestic Violence and Abuse	4.8	4.6	4.5	4.4	4.3	4.5	4.3	4.4	**4.5**
3/18/2023	Housing	4.9	4.9	4.9	4.9	5.0	4.9	4.8	4.9	**4.9**
3/19/2023	Housing Information	4.7	4.7	4.5	4.5	4.5	4.6	4.5	4.6	**4.6**
3/24/2023	Housing Information	5.0	5.0	4.0	4.0	5.0	4.6	4.6	4.7	**4.6**
Quarter 4 Events										
4/2/2023	Housing Information	-	-	-	-	-	4.9	4.9	4.9	**4.9**
4/16/2023	Computer Class	4.5	4.8	4.8	4.8	4.7	4.8	4.8	4.8	**4.8**

4/21/2023	Breast Cancer	4.6	4.7	4.7	4.8	4.8	4.8	4.7	4.8	**4.7**
5/7/2023	Teaching Children	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	**5**
5/13/2023	Teaching Children	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	**5**
5/21/2023	Teaching Children	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	**5**
5/26/2023	Interracial Marriage	4.9	4.9	4.9	4.9	4.9	4.8	4.8	4.8	**4.9**
6/11/2023	King Road Improvement Plan	5.0	5.0	5.0	5.0	5.0	5.0	4.9	4.8	**5**
6/23/2023	Tuberculosis	4.5	4.6	4.6	4.5	4.6	4.6	4.6	4.6	**4.6**

9. Evaluation Summary

During Y1, VIVO has established the Family Harmony program to carry out the Innovations Grant. Their efforts have yielded the following 9 cultural lessons:

i. Recruitment is most effective when it draws in Vietnamese individuals based on their social services needs and addresses trauma-related social topics.
ii. Intergenerational approaches to care are key.
iii. It takes more time to address the mental health attitudes of Vietnamese individuals than mental health knowledge or skills.
iv. BHSD referrals are best facilitated in 1:1 interaction by a known agency (a trust agent).
v. Recruitment requires culturally-driven, individualized outreach messages.
vi. Workshops are effective when Vietnamese facilitators model stigma-busting by disclosing their own personal history with the workshop topic.
vii. In order to bridge the intergenerational divide fueled by historical harms, it is important to address the concerns of each generation separately (e.g., 1st generation, 2nd generation, 1 ½ generation).
viii. Adults require a different approach than older adults.
ix. Vietnamese individuals are hesitant to use the BHSD Access Line.

(a) Over Y1, they have established partnerships with religious/spiritual settings as well as behavioral health organizations.

(b) and (c) During Y1, VIVO has conducted 56 workshops integrating Parent Cafés and Healing Circles serving a total of 608 individuals, with participant feedback indicating very strong satisfaction with services.

(d) During Y1, VIVO has participated in six (6) community tabling events, reaching a total of 570 community members.

(e) During Y1, VIVO has completed warm-handoff referrals for 412 participants.

(f) and (g) During Y1, VIVO has employed a strong anti-stigma outreach campaign including a weekly radio address reaching 40,000 individuals and local newspaper/magazine articles disseminating content from the workshop events.

VIVO has not only made notable strides in reaching and serving Vietnamese individuals, but they have made notable innovations and discoveries about key elements needed to outreach, educate, decrease stigma, and address service connection disparities for the historically underserved Vietnamese community.

UJIMA Adult and Family Services

PEI Stigma & Discrimination Reduction

Prevention & early intervention (PEI) 1-Year Evaluation Report Data: FY2023 (July 1, 2022 – June 30, 2023)

Submitted by Community Connections Psychological Associates, Inc.
Brandon Hoeflein, Ph.D., and Joyce Chu, Ph.D.

1. Program Description

❖ Overview

Initially proposed to serve the Vietnamese community in the County of Santa Clara and expanded to include the African American/Ancestry community following an evidence-based needs assessment, the parent Innovation 16 grant seeks to increase knowledge of mental health and access to mental health services in those communities. The parent project seeks to destigmatizing mental health services in the context of their culture, focusing on prevention community outreach/education, and provision of co-located professional mental health treatment services to children, adults, and families. Following is a program description of Ujima and its Ubuntu Wellness Center services:

❖ Ujima: Program Operations

i. The PEI Stigma and Discrimination Reduction Program at Ujima Adult and Family Services - via their Ubuntu Wellness Center - focuses on prevention and community outreach/education, establishing partnerships to co-locate Ujima/Ubuntu and its services to be provided to children, adults, and families. Ujima provides mental health prevention services for youth and children and psychoeducation targeting parents and grandparents on child/brain development, mental health conditions and services, and improving help-seeking behaviors.

ii. Ujima and its Ubuntu Wellness Center integrates mental health services into the gathering environments of the target populations by securing partnerships with community facilities, faith-based organizations, cultural centers, and other entities where people may be comfortable and receptive to hearing about available mental health services.

❖ Description of Ujima/Ubuntu's Services

i. Ujima includes community outreach, including recruitment of community members that are uniquely qualified and effective at reaching the target population, door to door outreach, and outreach at faith-based gatherings and medical clinics, and utilization of other unconventional community liaisons.

ii. Ujima also includes outreach to African American focused fraternities and clubs at local Santa Clara County universities and community colleges. Additional ideas for innovative and effective communities for outreach opportunities will be continually added.

iii. Ujima works with proposed physician and faith-based leader strategic planning committees, comprised of a diverse group of faith-based and physician community leaders and other advisory groups to develop outreach and promotion strategies/plans.

iv. Ujima seeks to develop new ethnic-cultural sensitivity trainings (e.g., develop a new curriculum addressing the unique needs and challenges faced by multi-ethnic individuals, such as half African American - half White, and half African American-half Asian individuals).

v. Ujima conducts parent cafes, healing circles, and workshops with the aim to be able to link and refer clients to existing cultural affirming mental health services as needed within the County Behavioral Health Services Mental Health Plan (MHP) Network.

2. Program Indicators

Ujima's Ubuntu Wellness Center addresses **suicide prevention** and prevention of **prolonged suffering** through two main targets or mechanisms:

i. Increased Access to Services: Ujima's Ubuntu Wellness Center facilitates service access via increasing African/Black community knowledge of BHSD/SCC/community resources available to them. They provide a number of those services in-house or have strong connections to African/Black-centered services agencies, which facilitates access to culturally appropriate care.
ii. Decrease Stigma: Ujima's Ubuntu Wellness Center facilitates decreased stigma by pairing community building events alongside mental health and substance use education and resource facilitation.

3. Program Goals, Objectives & Outcomes

Ujima and its Ubuntu Wellness Center aimed to meet the original stated goals of the Innovation Program, listed below. It is important to note, however, that original participant target numbers were initial guesstimates that were aspirational in nature. These target numbers may require future revision and flexibility as the Innovation Program learns about population size, need, and the program design needed to adequately outreach and serve the needs of the African Ancestry community.

i. Securing partnerships for locating mental health services in community facilities, faith-based organizations, cultural centers, and/or other entities.
ii. An estimated four hundred eighty (480) families will be served through parent cafes each year.
iii. An estimated five hundred (500) families will be served through healing circles each year.
iv. An estimated four hundred (400) clients who attend community outreach events will visit tables with materials for Ujima annually.
v. An estimated 20% of families engaged through Ujima's Program will receive referrals to other community-based organizations for additional services.
vi. Develop an anti-stigma outreach campaign through the mail targeting the African American/ African Ancestry communities.
vii. Develop an anti-stigma outreach campaign through social media targeting the African American/ African Ancestry communities.

4. Clients Served & Annual Cost per Client Data

Please refer to Innovation Cover page

5. Evaluation Activities

❖ SPECIFIC PEI STRATEGIES

Ujima addresses both PEI strategies of Access and Linkage and Improving Timely Access to Services for Underserved Populations, and does so by directly addressing mental health stigma:

i. Access and Linkage and Improving Timely Access to Services for Underserved Populations: Ujima's Ubuntu Wellness Center facilitates service access via increasing African/Black community knowledge of BHSD/SCC/community resources available to them. They provide a number of those services in-house or have strong connections to African/Black-centered services agencies, which facilitates access to culturally-appropriate care.

ii. Decrease Stigma: Ujima's Ubuntu Wellness Center facilitates decreased stigma by pairing community building events alongside mental health and substance use education and resource facilitation.

❖ Overall Description of Evaluation Plan

The evaluation plan for the Ujima Innovations Program consisted of a mixed methods design spanning formative (initial and ongoing), process, and summative evaluative capacities. Evaluation activities allow the project to meet all quarterly and annual reporting requirements. Data and narrative reports are reported by Ujima on a quarterly basis, to BHSD and the program evaluation team. The program evaluators analyze the data and provide an annual report about ongoing progress. This plan for evaluation reporting allows for tracking of project goals.

Program evaluation for these projects occurred in several steps:

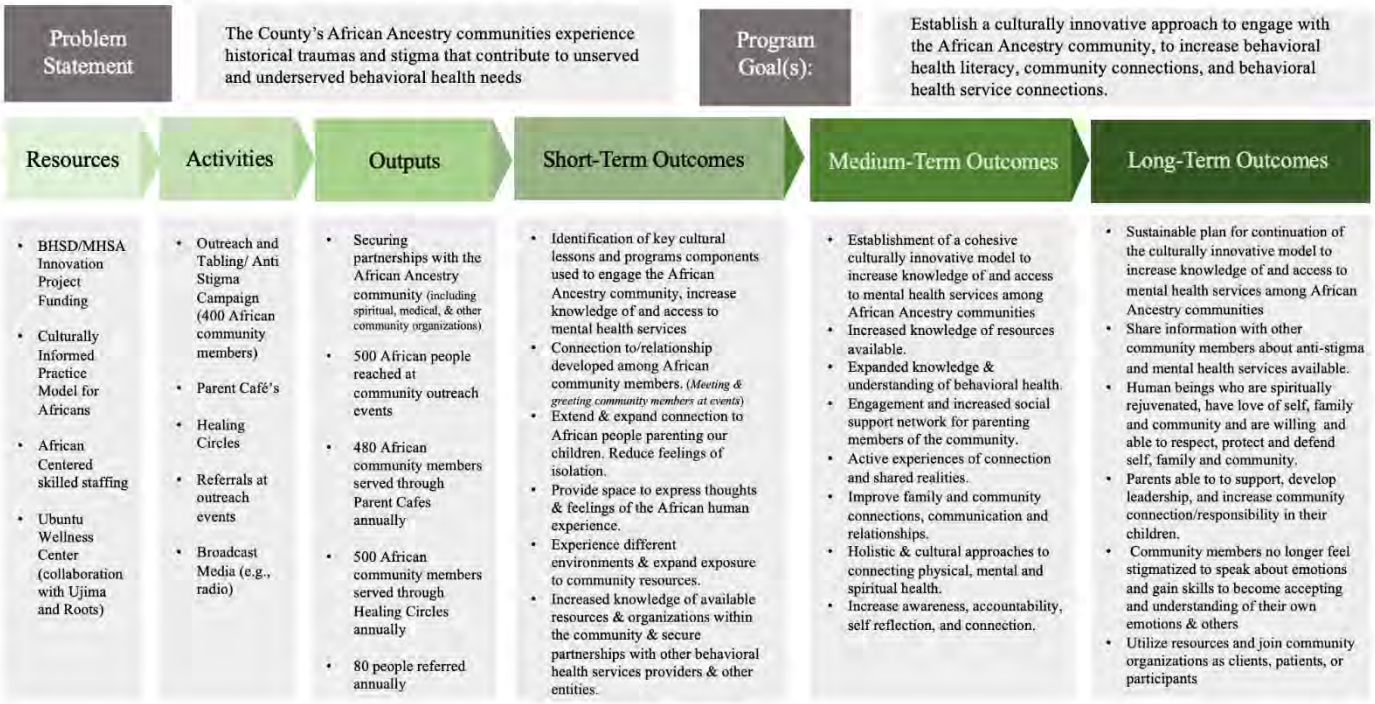
i. Collaborative development of an evaluation-specific logic model and evaluation plan for Ujima
ii. Execution of formative and summative evaluation processes
iii. Ongoing and final reporting.

❖ Collaborative Development of Evaluation and Measurement Plan and Logic Model

Consistent with the tenets of Community Based Participatory Research, the evaluation team and Ujima engaged in an iterative developmental process to create the evaluation plan. The process involved conducting a series of meetings between CCPA with Ujima, with the consultation of the MHSA team from Santa Clara County's BHSD. The collaborative team created following logic model and measurement plan. These plans are consistent with the goals and scope of the grant, but modified to fit the unique cultural needs of the targeted cultural stakeholder committees.

Germane to the evaluation plan, is the measurement and identification of the cultural adaptation-specific elements of the outreach and programmatic activities. This understanding of the impact of cultural and spiritual nuances, beliefs, practices and norms on program planning, delivery, and outcomes for each of the target communities, are essential to the core goals of the grant.

Logic Model for Ujima's INN 16 MHSA Project



❖ Process Evaluation: Using Data to Monitor Implementation

The project's ongoing formative evaluation process will take place quarterly during the first two years with three main aims: (1) to assess whether integration of culturally-informed organizational and service delivery processes is consistent with project objectives; (2) to inform remediation of challenge areas as they arise; and (3) to evaluate implementation of those changes and inform any necessary iteration. Data will be collected through interviews/questionnaires with staff, program reports, and other relevant program administration and marketing documentation.

Gap / Strengths / Innovations Analysis and Timely Changes to Care Plans. Data will be analyzed to identify challenges and barriers from the original plan as they arise, the potential impact of these challenges, proposed course of action in response to these challenges, and learning lessons from these challenges with regards to cultural adaptations and innovations. Through this evaluation process, strategies for making innovative adaptations to serve the needs of the community will be formulated and implemented. A summary of cultural lessons learned will be detailed in annual reports.

❖ Quarterly Process Evaluation Protocol

i. What has gone well so far?
ii. What are been ongoing challenges?
iii. What goals and/or solutions will you pursue in the next phase of this project?
iv. Please describe the key cultural elements of your outreach and programmatic activities.
    a. What are the specific cultural and spiritual nuances, beliefs, practices, and norms specific to the African American/ African Ancestry communities that you've found need to be incorporated into the planning, delivery, and outcomes of mental health services?
    b. What have you found to be effective ways for the African American/ African Ancestry faith-based and medical communities to welcome and integrate mental health clients into their community?
v. What types of partnerships have you secured for pathways to mental health services? Any faith-based or medical communities?

vi. *Have you integrated any specific evidence-based practices and community-defined strategies of trauma-informed care into your efforts?*

❖ Summative Evaluation: Utilizing Qualitative and Quantitative Data to Evaluate Effectiveness

Goals of the summative evaluation are to establish outcomes for project for quarterly and annual reporting activities. Data will be analyzed to assess progress on project goals with regards to identified outcome variables. Because of the historical trauma and mistrust of researchers and health providers within the African Ancestry community, flexibility and innovation is required in the evaluation approach, with attempts made to determine the most effective way to capture outcome data via quantitative and qualitative methods.

❖ Y1 Update on Evaluation Plan Development and Activities:

During Y1, Ujima has established the Ubuntu Wellness Center to carry out the Innovations Grant. From August through December 2022, Ubuntu Wellness staff met with external program evaluators to establish a culturally-appropriate evaluation plan for the African/Black community.

Quantitative analyses were thoroughly discussed as a method of data collection. Ujima staff described a long history of attempting survey-based assessments with African/Black peoples and explained that qualitative methodology tends to be most effective. However, Ujima staff were incredibly open to innovating new methods of survey data collection. Over the course of Y1, the following methods were attempted:

i. Placing giant papers on the wall after each event with responses (Agree, Neural, Disagree) and asking participants to respond to about two short prompts (e.g., “How well dd this event fit your needs as an African/Black person?”). Participants were given a small post-it note and asked to place the post-it note beneath the response they most agreed with.
    a. Results: This methodology was effective for a few weeks, at which participants simply stopped engaging. This outcome is likely due to a perception of repeated prompting.

ii. Placing giant papers on the wall after each event with a prompt that is consistent with Ujima dialoguing (e.g., "In just a few words, what did your spirit say to you after this event?" "What touched you during this event?” “How did this event fit for you as an African/Black person?").
    a. Results: Similarly, this methodology yielded participant engagement for a period of a few weeks, before participants stopped engaging. This outcome is likely due to a perception of repeated prompting.

It is worth noting that these innovative data collection attempts were ceased for the reasons that Ujima mentioned at the beginning of the process: that African/Black people are storytellers and relational in all that they do, so impersonal surveys/data collection are culturally incongruent. Moving forward, it was decided to evaluate participant satisfaction and outcomes via qualitative methodology (e.g., interviews).

At the end of Y1, a set of qualitative interviews were conducted with community consumers of Ujima’s Ubuntu Wellness Center programming. See “Participant Satisfaction & Feedback” for more information.

6. Demographic Data

	FY 2023	
Age Group	**# Served**	**% of Served**
0 – 15 years	20	4.1%
16 -25 years	91	18.6%

26- 59 years	70	14.3%
60+ years	6	1.2%
Prefer not to answer		
Unknown	294	60.2%
Unduplicated Total	488	100%

	FY 2023	
Race	**# Served**	**% of Served**
American Indian or Alaska Native		
Asian		
Black or African American	488	100%
Native Hawaiian or Other Pacific Islander		
White/ Caucasian		
Other		
More than one race		
Prefer not to answer		
Unknown		
Unduplicated Total		

	FY 2023	
Ethnicity	**# Served**	**% of Served**
Hispanic or Latino:		
Caribbean		
Central American		

Mexican/ Mexican-American/ Chicano		
Puerto Rican		
South American		
Hispanic/ Latino (undefined)		
Other Hispanic/ Latino		
Hispanic or Latino Subtotal		
Non-Hispanic or Non-Latino as follows:		
African		
Asian Indian/ South Asian		
Cambodian		
Chinese		
Eastern European		
European		
Filipino		
Japanese		
Korean		
Middle Eastern		
Vietnamese		
Non-Hispanic/ Non-Latino (undefined)		
Other Non-Hispanic/ Non-Latino		
Non-Hispanic or Non-Latino Subtotal		
More than one ethnicity		

Prefer not to answer		
Unknown	488	100%
Unduplicated Total	488	100%

	FY 2023	
Gender (Assigned at Birth)	**# Served**	**% of Served**
Male	63	12.9%
Female	75	15.4%
Prefer not to answer		
Unknown	350	71.7%
Unduplicated Total	488	100%

	FY 2023	
Gender (Current)	**# Served**	**% of Served**
Male	63	12.9%
Female	75	15.4%
Transgender (Male to Female)		
Transgender (Female to Male)		
Transgender (Undefined)		
Genderqueer		
Questioning or Unsure		
Another gender identity		
Prefer not to answer		
Unknown	350	71.7%

Unduplicated Total	488	100%

	FY 2023	
Sexual Orientation	**# Served**	**% of Served**
Gay or Lesbian		
Heterosexual/ Straight		
Bisexual		
Questioning/ Unsure		
Queer		
Another sexual orientation		
Prefer not to answer		
Unknown	488	100%
Unduplicated Total		

	FY 2023	
Primary Language	**# Served**	**% of Served**
English	488	100%
Spanish		
Vietnamese		
Chinese		
Tagalog		
Farsi		
Other		
Prefer not to answer		

Unknown		
Unduplicated Total		

	FY 2023	
Military Status	**# Served**	**% of Served**
Active Military		
Veteran		
Served in Military		
Family of Military		
No Military		
Prefer not to answer		
Unknown	488	100%
Unduplicated Total		

	FY 2023	
Disability*	**# Served**	**% of Served**
Difficulty seeing		
Difficulty hearing or speaking		
Other communication disability		
Cognitive		
Physical/ Mobility		
Chronic Health Condition		
Other non-communication disability		
No Disability		
Prefer not to answer		

Unknown	488	100%
Unduplicated Total		

*Participants may choose more than one option for Disability.

7. Group Services Delivered

FY 2023		
Unduplicated N = 488		
Number of Groups	Attendance	Average Attendance per Group
104	930	9

8. Detailed Outcomes

❖ CULTURAL LESSONS LEARNED FROM YEAR ONE (Y1) INNOVATIONS

1. **Community building is a psychological/spiritual intervention for African/Black people.** It is clear upon speaking with community members that the very act of together-ness in African/Black-exclusive spaces increases their psychological/spiritual well-being.
2. **Referrals for African/Black people are best conducted via empowerment and "planting the contemplation seed."** Specifically, it seems best that referrals are self-initiated and arise organically out of relationship with trusted African/Black providers. Over the past year, Ubuntu Wellness Staff have facilitated proper County referrals by building relationships, providing information about resources, and facilitating requests as prompted by the participants.
3. **African/Black-exclusive spaces are critical.** Both Ubuntu Wellness staff and participants note the importance of having spaces/events that are exclusive to African/Black people.
4. **Intergenerational approaches to care are key.** Ubuntu Wellness staff and participants consistently agree that behavioral/spiritual health interventions must be oriented to the collective nature of African/Black peoples, including events in which all generations can attend.
5. **African/Black outreach is most effective when conducted via relations with the African/Black network.** Some of Ubuntu's most successful events have occurred via collaborations between the Ubuntu Wellness Center staff and other African/Black organizations/individuals, such as "Black Girls Surf." An additional source of effective outreach event planning has included direct feedback from Ubuntu participants ("keeping our ears to the ground").
6. **Networking with relevant community partners requires the investment of time.** Over the last year, Ubuntu Wellness staff have identified three (3) ideal candidate African/Black churches for collaborations, but it has taken time (up to a year, in one instance) to fully develop those collaborative relationships to the point that actionable collaboration can take place.
7. **There are unique challenges in recruiting African/Black men for wellness events.** Both Ubuntu Wellness staff and participants noted the difficulties recruiting men. Staff have reported learning that the attendance rates of men increase during events involving music (e.g., beat-making, African drumming) and physical activity (e.g., boxing).
8. **Support groups alone are not an effective outreach technique for African/Black people.** Results from this year suggest that effective outreach requires interesting, culturally-relevant events, which are most effective when conducted in collaboration with other African/Black event sponsors who can tap into their own social networks for recruitment.

It is important to note that the above "Cultural Lessons" map directly onto the cultural knowledge of Ujima staff, matching and confirming Ujima's place / mission as a cutting-edge source of cultural expertise in behavioral health service delivery for African/Black people.

❖ PROGRESS TOWARDS PROGRAM GOALS & OBJECTIVES

Securing Partnerships for Locating Mental Health Services in Community Facilities, Faith-Based Organizations, Cultural Centers, and/or Other Entities.

i. Medical Settings

During Y1, Ujima's Ubuntu Wellness Center has sustained their pre-existing partnership with Roots, the African/Black-focused health/medical center with which they share a facility. Within the next year of the grant (Year 2), they plan to consider expanding their network of medical setting partners, largely in terms of community tabling events and marketing Ujima/Roots.

ii. Religious/Spiritual Settings

During Y1, Ujima's Ubuntu Wellness Center has identified three target African churches in Santa Clara County as potential collaborators:

- *Bible Christian Way*. Over Y1 of the grant, Ujima staff have established a working relationship with Bible Christian Way and have successfully conducted multiple healing circle events there, including at their youth summer program.
- *Maranotha Christian Center*. Over Y1 of the grant, Ujima staff have established a working relationship with Maranotha Christian Center. Over the next year of the grant (Year 2), they plan to deepen this connection with the goal of actionable collaboration.
- *Emmanuel African Church.* Over Y1 of the grant, Ujima has identified Emmanuel African Church as the third target for faith-based collaboration. While there have been multiple communication efforts, this church is undergoing a series of internal changes, which are expected to ameliorate over the next year. Once the organization has moved through its current change process, Ujima plans to further develop the collaboration into actionable collaborations (e.g., shared events).

iii. College Settings

During Y1, Ujima's Ubuntu Wellness Center has expanded the aims of the Innovations Grant by establishing relationships with Santa Clara County's colleges/universities in an effort to target transitional-aged youth (TAY), specifically college students.

- *Santa Clara University (SCU)*. Within Y1, Ujima's Ubuntu Wellness Staff have established a relationship with SCU's National Society for Black engineers and their African Student Association, yielding two healing circles out in the community. Of note, these outreach events facilitated TAY African/Black students attending Ubuntu Wellness events such as the beat-making event and the surfing event.
- *San Jose State University's (SJSU) Nigerian Club*. Within Y1, Ujima's Ubuntu Wellness Staff have established a relationship with SJSU's Nigerian club and plan to conduct healing circles there during the next academic year.

iv. Parent Cafes

During Y1, Ujima Ubuntu Wellness staff have conducted 29 parent cafés, titled Sawabona Circles. These events have served as discussion opportunities for African/Black parents (non-gendered) to support each other in the uniqueness of parenting in Santa Clara County while African/Black. Broadly, Ujima has noted consistent troubles increasing the reach of the Sawabona Circles, although noting strong satisfaction from those who attend. Moving into Y2, Ujima's Ubuntu Wellness Center staff are focused on further innovating these events in a manner that will best serve the community; based on ongoing innovative brainstorming, potential solutions include events focused on events specific to African/Black youth and/or young African/Black men.

Date	Event/Location	Total Attendees (Unduplicated Attendees)
7/26/2022	Sawabona Circle	6 (6)
	Quarter 1 Total:	**6 (6)**
10/4/2022	Sawabona Circle	6 (2)
10/11/2022	Sawabona Circle	4 (0)
10/18/2022	Sawabona Circle	5 (1)
10/29/2022	Sawabona Circle	5 (2)
11/1/2022	Sawabona Circle	3 (1)
11/8/2022	Sawabona Circle	5 (1)
11/15/2022	Sawabona Circle	8 (4)
11/26/2022	Sawabona Circle	2 (0)
12/6/2022	Sawabona Circle	5 (2)
12/13/2022	Sawabona Circle	2 (0)
12/20/2022	Sawabona Circle	3 (1)
	Quarter 2 Totals	**48 (14)**
1/3/2023	Sawabona Circle	2 (0)
1/10/2023	Sawabona Circle	10 (3)
1/17/2023	Sawabona Circle	3 (0)
1/28/2023	Sawabona Circle	7 (2)
2/7/2023	Sawabona Circle	7 (5)
2/14/2023	Sawabona Circle	4 (0)
2/21/2023	Sawabona Circle	4 (1)
2/25/2023	Sawabona Circle	4 (0)
3/14/2023	Sawabona Circle	6 (2)
3/25/2023	Sawabona Circle	2 (0)
	Quarter 3 Totals	**49 (13)**
4/11/2023	Sawabona Circle	11 (1)
4/29/2023	Sawabona Circle	3 (0)
5/9/2023	Sawabona Circle	4 (1)
5/27/2023	Sawabona Circle	3 (0)
6/13/2023	Sawabona Circle	0 (0)
	Quarter 4 Totals	**21 (2)**
Y1 Parent Café Totals		**124 (35)**

v. Healing Circle Events

During Y1, Ujima Ubuntu Wellness staff have held 75 different healing circle events. The primary innovation here is the way in which Ubuntu staff are using attractive community-building events (e.g., surfing, yoga) as invitations

for participants to “come through the door,” and then ending each of those events with a Healing Circle intervention aimed at addressing historical harms and reducing stigma. Using this approach, community members are not coming for a “mental health intervention” or “to get support.” Instead, community members are coming for a shared cultural experience, which then lays the foundation for them to more fully engage in the historical harms intervention.

Date	Event Description	Total Attendees (Unduplicated Attendees)
7/6/2022	Sistah Sistah	2 (2)
7/8/2022	Peaces of a Dream	3 (3)
7/22/2022	Peaces of a Dream	4 (0)
8/3/2022	Sistah Sistah	2 (0)
8/3/2022	Mental Health Workshop	31 (31)
8/10/2022	West African Dance	7 (7)
8/17/2022	West African Dance	17 (15)
8/24/2022	West African Dance	5 (0)
8/26/2022	Peaces of a Dream	3 (0)
8/31/2022	West African Dance	5 (0)
9/4/2022	West African Dance	6 (0)
9/14/2022	West African Dance	9 (3)
9/21/2022	Drumming Workshop	15 (13)
9/28/2022	West African Dance	7 (0)
	Quarter 1 Total:	**116 (74)**
10/5/2022	West African Dance	7 (0)
10/12/2022	West African Dance	10 (0)
10/14/2022	Peaces of a Dream	3 (0)
10/19/2022	Drumming Workshop	12 (2)
10/26/2022	West African Dance	15 (5)
10/28/2022	Peaces of a Dream	3 (0)
10/28/2022	Drumming Workshop	24 (24)
10/29/2022	Growing the Garden	5 (1)
11/2/2022	Drumming Workshop	8 (1)
11/2/2022	Menlo Park High School: BSU	17 (17)
11/4/2022	Sunnyvale High School BSU	10 (10)
11/9/2022	West African Dance	5 (0)
11/10/2022	Defining Disapora	18 (18)
11/16/2022	Drumming Workshop	7 (2)
11/17/2022	Black Wealth Maters	10 (5)
11/19/2022	Youth Game Day	11 (11)
11/20/2022	Black Panther Movie Night	45 (45)
11/30/2022	West African Dance	10 (5)
12/7/2022	Drumming Workshop	7 (2)
12/7/2022	Sistah Sistah	5 (3)
12/8/2022	Peaces of a Dream	3 (0)
12/14/2022	West African Dance	6 (0)
12/21/2022	Drumming Workshop	5 (0)

12/28/2022	Kwanza Dinner	45 (30)
	Quarter 2 Totals	**291 (181)**
1/4/2023	Sistah Sistah	2 (0)
1/11/2023	Soul Yoga	10 (0)
1/18/2023	Soul Yoga	5 (2)
1/19/2023	Paint & Chat	9 (2)
1/25/2023	Soul Yoga	8 (2)
2/1/2023	Soul Yoga	10 (2)
2/8/2023	Soul Yoga	8 (1)
2/15/2023	Soul Yoga	18 (15)
2/15/2023	African Dance & Drum	19 (18)
2/22/2023	Soul Yoga	8 (0)
2/28/2023	Cook & Chat	14 (5)
3/1/2023	Soul Yoga	12 (1)
3/2/2023	Drumming Circles	20 (19)
3/9/2023	Drumming Circles	13 (7)
3/10/2023	Wellness Workshops	28 (28)
3/15/2023	Financial Workshop	5 (0)
3/16/2023	Drumming Circles	6 (0)
3/22/2023	Poetraying Ourselves	13 (8)
3/23/2023	Drumming Circles	6 (0)
3/29/2023	Poetraying Ourselves	11 (2)
	Quarter 3 Totals	**225 (112)**
4/5/2023	Sistah Sistah	3 (0)
3/4/2023	Poetraying Ourselves	13 (0)
4/12/2023	Poetraying Ourselves	13 (4)
4/29/2023	Afrikenna	13 (7)
5/8/2023	Warrior Training Zone	4 (3)
5/10/2023	Warrior Training Zone	10 (8)
5/11/2023	Warrior Training Zone	10 (4)
5/15/2023	Santa Clara University: NESBe Club	9 (9)
5/17/2023	Beatmaking Series	7 (6)
5/24/2023	Beatmaking Series	8 (3)
5/31/2023	Beatmaking Series	7 (3)
6/3/2023	Foraging Hike	14 (6)
6/5/2023	Santa Clara University: African Student Association	19 (17)
6/7/2023	Sistah Sistah	2 (2)
6/9/2023	Family Movie Night	4 (1)
6/14/2023	Juneteenth Dinner	30 (12)
6/21/2023	Drum Workshop	8 (1)
	Quarter 4 Totals	**174 (86)**
Y1 Healing Circle Totals		**806 (453)**

vi. Community Tabling Events

During Y1, Ujima Ubuntu Wellness staff have conducted 22 community tabling events, yielding direct contact with 546 community members. As seen below, these community tabling events were largely conducted at African/Black community cultural events and schools/colleges.

Date	Event/Location	Total Event Attendees
7/26/2022	Our Kids Matter	200
8/13/2022	Cameroonian Gala	250
8/27/2022	Black August Block Party	40
9/4/2022	Ethiopian New Year Festival	200
9/22/2022	San Jose State University: BLOC Party	100
	Quarter 1 Total:	**790**
10/13/2022	Santa Clara High School: BSU Meeting	15
10/222022	Maranotha Women's Meeting	25
11/20/2022	Movie Screening: Black Panther	45
12/7/2022	Menlo Park High School: BSU Meeting	16
	Quarter 2 Totals	**101**
1/13/2023	Sunnyvale High School: BSU Club	10
2/4/2023	Black History Month Exhibit	10
2/11/2023	African Film Café	25
2/16/2023	Black History Month Exhibit	18
2/17/2023	Black History Month Exhibit	46
2/18/2023	The CookOut	300
2/25/2023	Black Family Day	250
3/10/2023	Black Student College Union Leadership Conference	200
	Quarter 3 Totals	**859**
4/6/2023	Santa Clara University: Black Market	50
5/15/2023	Santa Clara University: NESBe Club	9
6/5/2023	Santa Clara University: African Student Association	19
6/29/2023	Roots: Portrait Day	50
	Quarter 4 Totals	**128**
Y1 Community Outreach Totals		**1,878**

vii. Referrals for Additional Services/Referrals

During Y1, Ujima Ubuntu Wellness staff have referred a total of twenty-six (26) individuals for additional services/resources (3.2%). Please see below for a description of the agencies and services involved in these referrals.

Ujima's Ubuntu Wellness Center: Y1 Referrals Summary		
Service Type	Agency	Number Referred

Physical Wellness	Kakua	10
Behavioral Health Services	Ujima Adult & Family Services	6
Family Resources	Culturally Coordinated Services	4
Medical Services	Roots Community Health Center	3
Social Support & Networking	Black Family Day Event	2
	Black Outreach San Jose	1
Y1 Referral Totals		**26**

viii. Anti-Stigma Outreach Campaign

During Y1, Ujima has contracted with a community partner to draft and implement their anti-sigma campaign. They have used community events during year 1 to generate videos and pictures clips for use in the final media campaign. For instance, they have crafted videos of activities centered on African/Black youth for use in the broader anti-stigma media campaign.

Ujima's Ubuntu Wellness Center					
	Q1 (7/1/22-9/30/22)	**Q2** (10/1/22-12/31/22)	**Q3** (1/1/23-3/30/23)	**Q4** (4/1/23-6/30/23)	**Y1 TOTALS**
a) Reach 480 individuals via Family Cafe events [unduplicated consumers]	6 [6]	48 [14]	49 [13]	21 [2]	**124 [35]**
b) Reach 500 individuals via Healing Circle events [unduplicated consumers]	116 [74]	291 [181]	225 [112]	174 [86]	**806 [453]**
c) Reach 400 individuals via community outreach (tabling events)	790	101	859	128	**1,878**
d) Refer 20% of clients to additional services	2	2	11	11	**3.2% [N = 26]**

❖ PARTICIPANT SATISFACTION & FEEDBACK

In conjunction with Ujima and the MHSA team, and consistent with best cultural practices for the African/Black community, it was decided to characterize the efficacy and effectiveness of Ujima's Y1 Innovations programming via a qualitative analysis with feedback from participants who engaged in the Healing Circles and the parent Cafés. The analysis included 10 semi-structured interviews based on a pre-set list of five (5) prompts drawn directly from the Innovations Grant application. The prompts are listed below.

Qualitative Interview / Evaluation Guide

i. What have you found to be helpful or meaningful about the Ubuntu events you've attended?
ii. How do these Ubuntu events fit your cultural background?
iii. Do you have any recommendations that could strengthen these Ubuntu events for the community? Examples might be: Different ways for the events to be a better fit with the African Ancestry

community, different kinds of events, any changes to the way events are conducted, ways of informing others about the events?

iv. One hope of these Ubuntu events is to give people from the African Ancestry community access to the information, resources, and referrals for mental health or substance use issues, if and when they're needed. How did the events go in this regard? Any ways for this to be improved?

v. Would you recommend these Ubuntu events to others? Why or why not?

In conjunction with Ujima, it was decided that the program evaluation team would conduct as many of the interviews as possible. However, given historical harms, it was agreed that Ujima staff could also conduct some of the interviews if Ujima participants were not willing to speak with outside professionals. In total, three (3) interviews were conducted by the program evaluation team and seven (7) interviews were conducted by Ujima staff. Interviews ranged in time from 5 minutes to 46 minutes.

Each interview was transcribed, either using live transcription (when interviews were conducted by program evaluation team) or by a combination of audio recordings and transcription software (when interviews were conducted by Ujima staff). These transcriptions were then coded based on the tenets of grounded theory coding, in which every word was evaluated and each relevant comment was assigned a first-order theme. First-order themes were then collated in a coding scheme which yielded secondary themes. These secondary themes were then grouped into Ujima Strengths and Ujima Growth Areas. Please see below for the results, which yielded seven primary strengths and 5 primary growth areas.

❖ STRENGTHS

In all, there were 88 participant comments highlighting the strengths of Ujima's Ubuntu Wellness Center, which were coded as **seven (7) Areas of Strengths**, listed below.

i. **The first strength was <u>Services/Resources (25 comments across 9 interviews)</u>. These comments are best understood as three sub-strengths.** The *first sub-strength was High Quality of Ujima's Ubuntu Wellness Center events* (15 comments). Participants reported that the events were of high quality because they are uniquely curated to fit African/Black culture (e.g., African documentaries, West African dance, conducted by African/Black providers, new activities monthly); because the healing circles are truly healing for African/Black folx; because of the wide variety of community building events (e.g., surfing, poetry, nature hikes); because of the group leaders' implementation skills; and, because of the useful information shared about substance use. The *second sub-strength was Felt Effects on Spiritual/Psychological Well-Being (7 comments).* Participants noted that the Ubuntu Wellness Program events give them a sense of perspective that allows them to better understand and their everyday lives; they also noted that the events have given them useful information about substance use and mental health, with one participant specifying that Ubuntu has taught her effective tips for supporting her daughter's mental health. Participants also reported physiological tension release in their bodies after being in Ubuntu spaces and they also feel improvements in their mental health after shared African/Black experience (e.g., 40 African/Black people sharing yoga on a beach). The *third sub-strength was Ease of Access*, specifically that the events are strong because they are free, do not require any form of commitment, and have no sign-ups.

ii. **The second strength is the <u>Unabashed Centering of African-ness/Black-ness (20 comments across 7 interviews)</u>.** Specifically, participants stated that the Ubuntu Wellness Center only works *because of* the ways in which it centers the African/Black experience above all else (e.g., physical space commemorating African/Black history and Black excellence, programming which authenticity celebrates African-ness/Blackness). They also noted the importance of African/Black food and music in establishing an experience specific to African/Black people. In addition, participants stated that Ujima's Ubuntu Wellness Center excels in the way it seamlessly embraces the experience of African

people who were born in Africa, as well as the descendants of the African people who were forced to come to America against their will. Participants also spoke to the ways in which Ujima's Ubuntu Wellness Center centers African-ness/Black-ness by embracing cultural norms of relationships above all else, the focus on Black Excellence, and the reality that all services are provided solely by African/Black providers.

iii. **The third strength is <u>Sense of Community (12 comments across 7 interviews)</u>.** Participants spoke to the ways in which Ujima's Ubuntu Wellness Center creates a sense of African/Black community by way of authentic African-ness/Blackness, building bonds between African/Black people, building community for Black/African youth, reintroducing the African/Black way of life, and reducing cultural isolation.

iv. **The fourth strength is <u>Referrals/Resources (12 comments across 6 interviews)</u>.** Notably, participants consistently pointed to Ujima as a trust-able agent for current (and future) mental health and substance use resources ("We have a viable resource in our community"). Participants spoke of the ways in which Ujima's Ubuntu Wellness Center has connected them to resources across the broader African/Black community, given resources for free therapy, highlighted the positive effects of therapy, and connected them to other County social services (e.g., diapers and fresh produce at the African American center downtown).

v. **The fifth strength is Building an <u>Exclusive Black Space (8 comments across 7 interviews)</u>.** The power of this strength is almost palpable when interviewing participants, and multiple people emphasized the critical role of *exclusive* African/Black spaces in allowing them to open up to the process of healing. One participant contrasted Ujima's Ubuntu Wellness Center with the African American Center downtown and explained: "We have the African American Services Agency, but they service everybody… when we have spaces that are exclusively for us, the conversation is different… we were able to talk about things we wouldn't normally be able to talk about or vent about, or express our feelings if there [were non-African/Black people there]."

vi. **The sixth strength is A Welcoming Environment for African/Black People (6 comments across 4 interviews)**. In addition to reflections that an exclusive African/Black physical space is critical to feeling welcomed, a number of participants simply characterized Ujima's Ubuntu Wellness Center as "welcoming" and having "a family atmosphere."

vii. **The seventh strength is Intergenerational Approach (5 comments across 4 interviews)**. Participants spoke to the power of Ujima's Ubuntu Wellness Center based on its intergenerational approach. Participants spoke about inviting their family members from other generations ("I had invited my mom, she's not too much of a social person… when she went to the Kwanza event, it was really great because there were a lot of people there networking… people who wouldn't have come together without this event, they came together… found out things about each other… hey, here's my number… my mom was one of those people, too"). Participants also spoke about the emphasis on "intergenerational responsibility" as a takeaway from the events. On a more practical level, participants explained the benefits of hosting events where young children could attend with grandparents and all age groups were welcome to participate together and build community by centering African/Black families.

❖ GROWTH AREAS

In all, there were 27 comments related to growth areas noted by participants in Ujima's Ubuntu Wellness Center, which were coded as **five (5) Areas for Growth**, listed below. It is remarkable that, of these 27 comments, 24 (88.9%) of them represent strong satisfaction with the quality and content of Ubuntu Wellness Programs and are best interpreted as suggestions for expanding the work completed in Y1.

i. **The first growth area was <u>More Activities (9 comments across 5 interviews),</u>** which can be defined as any participant comment suggesting an expansion of Ubuntu Wellness Services, either generally (e.g., "just more funding for more of the great work they're doing"), or specific suggestions (more events focused on rapping, basketball, entrepreneur talks, hosting local Black politicians, coffee events at African/Black-owned coffee shops, etc.).

ii. **The second growth area was <u>More Advertisement (5 comments across 4 interviews),</u>** which included any participant comment suggesting indirect methods of disseminating information about Ujima's Ubuntu Wellness Center events. A majority of these comments were general in nature and represented participants' desire for additional African/Black folx to know about the strong work taking place at Ujima. However, specific recommendations included: more social media recruitment using videos/pictures from Ubuntu Wellness events, and to "deepen [the Ubuntu Wellness Center's] digital footprint.

iii. **The third growth area was <u>More Community Outreach (5 comments across 3 interviews),</u>** which included any recommendation for Ujima to expand in-person efforts at increasing the visibility of Ubuntu services for African/Black people, either generally ("more visibility at events around Santa Clara County") or specifically (e.g., more outreach to churches and more outreach in the Oakland area).

iv. **The fourth growth area was <u>More Explicit Mental Health & Substance Use Focus (3 comments across 2 interviews),</u>** which can be defined as participants' desire for a more clear incorporation of mental health and substance use content within the pre-Healing Circle events. These comments represent participants' internal sense that the pre-Healing Circle events (e.g., dance, drumming, yoga, nature walks) are directly linked to mental health outcomes (e.g., mindfulness, social connection, grounding), and their desire for this connection to be verbalized more explicitly in a group discussion format. Another participant recommended that mental health and substance use be discussed openly in the introductory remarks [<u>note</u>: this comment likely represents some confusion or miscommunication, because Ubuntu Wellness staff report that they always include mental health and substance use remarks at the beginning of every event].

v. **The fifth growth area was <u>More Events Specific to African/Black Men (2 comments within 1 interview)</u>.** These two comments included one general remark about participants seeing a need for Wellness events specific to African/Black men and another comment about the need for events specific to African/Black men in their youth.

In addition to these five primary growth areas, there were three additional growth-focused comments: more events specific to youth, more hands-on activities for children to complete during Ubuntu Wellness events, and more discussion-based feedback with clients.

<u>Ujima's Ubuntu Wellness Center: Participants' Year 1 Feedback, Summary</u>	
<u>Strengths</u>	**<u>Growth Areas</u>**
1. Services/Events	1. More Activities
2. Unapologetic African/Black Cultural Fit	2. More Advertisement
3. Community	3. More Community Outreach
4. Referrals/Resources	4. Explicit Mental Health & Substance Use Focus
5. Exclusive African/Black Spaces	
6. Welcoming Environment	5. Events Specific to Men
7. Intergenerational Approaches	

9. Evaluation Summary

During Y1, Ujima has established the Ubuntu Wellness Center to carry out the Innovations Grant. Their efforts have yielded the following 8 cultural lessons:

i. Community building is a psychological/spiritual intervention for African/Black people.
ii. Referrals for African/Black people are best conducted via empowerment and "planting the contemplation seed."
iii. African/Black-exclusive spaces are critical.
iv. Intergenerational approaches to care are key.
v. African/Black outreach is most effective when conducted via relations with the African/Black network.
vi. Networking with relevant community partners requires the investment of time.
vii. There are unique challenges in recruiting African/Black men for wellness events.
viii. Support groups alone are not an effective outreach technique for African/Black people.

(a) Over Y1, Ujima has established partnerships with local colleges/universities as well as three (3) local African/Black churches (where they have begun holding healing circle events).

(b) During Y 1, Ujima has conducted 29 parent cafés (Sawabona Circles), reaching a total of 35 individuals.

(c) During Y1, Ujima has conducted 75 Healing Circles serving a total of 453 individuals, with qualitative feedback indicating very strong satisfaction with services.

(d) During Y1, Ujima has participated in 21 community tabling events, reaching a total of 570 community members.

(e) During Y1, Ujima has completed warm-handoff referrals for 1.878 individuals.

(f) and g) During Y1, Ujima has contracted with a local agency to initiate their anti-stigma social media campaign.

Ujima has not only made notable strides in reaching and serving African Ancestry individuals, but they have made notable innovations and discoveries about key elements needed to outreach, educate, decrease stigma, and address service connection disparities for the historically underserved African Ancestry community.

Capital Facilities and Technological Needs

Electronic Health Record Maintenance and Provider Support		
Status:	☒Modified	☐ Continuing

Program Description

BHSD believes in producing long-term impact with lasting benefits that move the mental health system towards the goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families, which promote the reduction in disparities to underserved groups. The following efforts include the development of a variety of technology uses and strategies which support integrated service experiences that support the data collection needs of the BHSD.

1. **CFTN Support Staff:** EHR FTE (staff)/Technology Services and Solutions (TSS) ongoing annual costs require an additional transfer from CSS to CFTN to support these ongoing costs. Combined annual ongoing costs are estimated at $2,646,445.14
2. **E.H.R. Project**: Ongoing support for CCPs (County Contracted Agencies) in EHR implementation for FY23. An estimated 15 agencies have gone, or are scheduled to go, live with Provider Connect Enterprise (PCE); PCE is the direct FHIR (Fast Healthcare Interoperability Resources) API (Application Programming Interface) that will directly transmit certain client/service information from the CCP's EHR directly over to the County of Santa Clara EHR System (Netsmart – myAvatar). An additional ~9 agencies have, or will go, live with Provider Connect "NX" (the web portal access to the CSC EHR system) and will use the submission of 837 files for submitting claims. And ~7 more CCPs will connect with PCNX and submit claims manually through that system. Bridge funding to support agencies that are scheduled to go live with the various different levels of integration with myAvatar. Cost related with the actual billing package purchase and for staff time dedicated to integrating with myAvatar. The one-time estimated cost of $ 896,385 to support CCPs with their integration efforts.
3. **Adult Residential Treatment (ART)**: CFTN funds of $1,931,906.73 were used to fund Adult Residential Treatment facilities.

Total CFTN Expenditures

FY 2023	$ **5,474,736.87**

EXHIBITS

PRUDENT RESERVE AND BUDGET SUMMARY

FY2023-24 Through FY2025-26 Mental Health Services Act Annual Update
Funding Summary

County: Santa Clara Date: 2/1/24

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2023/24 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	28,347,152	24,351,204	23,885,466	0	0	
2. Estimated New FY2023/24 Funding	129,244,088	32,311,022	8,502,901	0		
3. Transfer in FY2023/24a/	(7,296,605)			3,993,427	3,303,178	
4. Access Local Prudent Reserve in FY2023/24						0
5. Estimated Available Funding for FY2023/24	150,294,635	56,662,226	32,388,367	3,993,427	3,303,178	
B. Estimated FY2023/24 MHSA Expenditures	110,296,724	39,735,181	10,325,973	3,993,427	3,303,178	
A. Estimated FY 2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	39,997,911	16,927,045	22,062,394	0	0	
2. Estimated New FY2024/25 Funding	91,189,565	22,797,391	5,999,314	0		
3. Transfer in FY2024/25a/	(6,784,207)			3,481,029	3,303,178	
4. Access Local Prudent Reserve in FY2024/25						0
5. Estimated Available Funding for FY2024/25	124,403,269	39,724,436	28,061,708	3,481,029	3,303,178	
B. Estimated FY2024/25 MHSA Expenditures	114,788,085	36,258,005	8,231,942	3,481,029	3,303,178	

FY 2023-24 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Component Worksheet

County: Santa Clara Date: 2/1/24

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. C01 Child Full Service Partnership	9,910,438	3,242,809	3,553,481		3,114,149	
2. T01 Transitional Age Youth FSP	10,086,121	2,913,782	3,923,420		3,248,918	
3. A01 Adult Full Service Partnership	12,205,413	7,644,607	4,560,806			
4. A03 Criminal Justice FSP	6,338,824	3,721,882	2,616,942			
5. A03 Forensic Assertive Community Treatment	6,151,745	4,350,375	1,801,370			
6. OA01 Older Adult Full Service Partnership	2,754,618	1,619,476	1,135,142			
7. A02 Assertive Community Treatment	8,498,432	5,945,308	2,553,124			
8. A04 Crisis Stabilization Unit and Crisis Residential Treatment	5,276,138	2,910,753	2,365,385			
9. A03 Criminal Justice Residential and Outpatient Treatment Programs	3,469,542	3,159,438	92,932			217,172
10. HO01 Permanent Supportive Housing	4,765,333	3,823,646	917,687			24,000
Non-FSP Programs						
1. C03 Children & Family Behavioral Health Outpatient/IOP Services	39,874,227	6,733,179	19,042,011		14,099,037	
2. C03 Specialty Services - Integrated MH/SUD	849,767	353,667	496,100			
3. C03 Foster Care Development	1,184,637	750,658	433,979			
4. C03 Services for Juvenile Justice Involved Youth	3,704,346	2,187,187	874,446		217,779	424,934
5. C03 CSEC Program	886,649	886,649				
6. C03 Mobile Crisis Stabilization Services (MRSS)	1,948,908	1,712,963	235,945			
7. C03 Independent Living Program (ILP)	0	0	0			
8. T02-04 TAY Outpatient Services	1,804,207	655,592	927,793		220,822	
9. T02-04 Intensive Outpatient Program (IOP)	2,083,344	1,041,672	1,041,672			
10. T02-04 TAY Triage to Support Reentry - Not Implemented	0	0	0			
11. T02-04 TAY Crisis and Drop In Center	814,503	814,503				
12. T02-04 TAY Interdisciplinary Service Teams	1,605,016	855,016	750,000			
13. A02 Adult Residential Treatment	9,312,243	5,982,545	3,329,698			
14. A02 Assisted Outpatient Treatment (AOT)	12,959,652	9,682,939	2,679,307			597,406
15. A02 Specialty Outpatient Services	3,770,773	3,770,773				
16. A02 Outpatient Services for Adults	16,834,020	10,834,020	6,000,000			
17. A04 Crisis Stabilization Unit and Crisis Residential Treatment	13,242,579	2,103,393	11,139,186			
18. A02 Hope Services: Integrated Mental Health and Autism Services	2,633,115	1,484,619	1,148,496			
19. A02 CalWORKs Community Health Alliance	2,563,094	1,175,914	705,340			681,840
20. A02 Individualized Supported Services (Employment)	1,680,148	1,680,148				
21. A02/A04 County Clinics	10,361,826	3,925,336	6,046,169			390,321
22. A04 Mental Health Urgent Care	5,080,008	2,628,253	2,451,755			
23. A04 Community Placement Team Services and IMD Alternative Program	1,321,708	578,467	743,241			
24. A03 Criminal Justice Residential and Outpatient Treatment Programs	3,618,822	3,291,588	327,234			
25. A03 Criminal Justice Outpatient Services	2,844,891	1,991,481	853,410			
26. OA02-04 In-Home Outreach Teams	2,045,372	2,045,372				
27. OA02-04 Outpatient Services for Older Adults	3,188,480	1,854,895	1,333,585			
28. OA02-04 Clinical Case Management for Older Adults	0	0	0			
29. OA02-04 Connections Program	430,003	430,003				
30. LP01 Learning Partnership	760,339	760,339				
CSS Administration	753,477	753,477				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	217,612,758	110,296,724	84,079,656	0	20,900,705	2,335,673
FSP Programs as Percent of Total	**63.0%**					

FY 2024-25 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Component Worksheet

County: Santa Clara Date: 2/1/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. C01 Child Full Service Partnership	9,561,488	2,893,859	3,553,481		3,114,149	
2. T01 Transitional Age Youth FSP	9,737,171	2,564,832	3,923,420		3,248,918	
3. A01 Adult Full Service Partnership	10,810,218	7,370,812	3,439,406			
4. A03 Criminal Justice FSP	7,464,763	4,847,821	2,616,942			
5. A03 Forensic Assertive Community Treatment	6,151,745	4,350,375	1,801,370			
6. OA01 Older Adult Full Service Partnership	2,754,618	1,619,476	1,135,142			
7. A02 Assertive Community Treatment	8,498,432	5,945,308	2,553,124			
8. A04 Crisis Stabilization Unit and Crisis Residential Treatment	6,312,820	3,947,435	2,365,385			
9. A03 Criminal Justice Residential and Outpatient Treatment Programs	3,633,752	3,323,648	92,932			217,172
10. HO01 Permanent Supportive Housing	4,786,268	3,844,581	917,687			24,000
Non-FSP Programs						
1. C03 Children & Family Behavioral Health Outpatient/IOP Services	39,760,050	7,898,751	19,762,262		12,099,037	
2. C03 Specialty Services - Integrated MH/SUD	849,767	353,667	496,100			
3. C03 Foster Care Development	1,224,757	790,778	433,979			
4. C03 Services for Juvenile Justice Involved Youth	3,750,455	2,233,296	874,446		217,779	424,934
5. C03 CSEC Program	491,944	491,944				
6. C03 Mobile Crisis Stabilization Services (MRSS)	1,948,908	1,208,715	740,193			
7. C03 Independent Living Program (ILP)	0	0	0			
8. T02-04 TAY Outpatient Services	1,804,207	655,592	927,793		220,822	
9. T02-04 Intensive Outpatient Program (IOP)	1,069,514	534,757	534,757			
10. T02-04 TAY Triage to Support Reentry - Not Implemented	0	0	0			
11. T02-04 TAY Crisis and Drop In Center	814,503	814,503				
12. T02-04 TAY Interdisciplinary Service Teams	1,605,016	855,016	750,000			
13. A02 Adult Residential Treatment	9,312,243	5,982,545	3,329,698			
14. A02 Assisted Outpatient Treatment (AOT)	11,296,904	8,020,191	2,679,307			597,406
15. A02 Specialty Outpatient Services	3,770,773	3,770,773				
16. A02 Outpatient Services for Adults	16,860,670	13,843,215	3,017,455			
17. A04 Crisis Stabilization Unit and Crisis Residential Treatment	15,491,072	4,514,505	10,976,567			
18. A02 Hope Services: Integrated Mental Health and Autism Services	2,633,115	1,484,619	1,148,496			
19. A02 CalWORKs Community Health Alliance	2,570,123	1,182,943	705,340			681,840
20. A02 Individualized Supported Services (Employment)	1,680,148	1,680,148				
21. A02/A04 County Clinics	10,209,470	3,305,065	6,514,084			390,321
22. A04 Mental Health Urgent Care	5,156,209	2,704,454	2,451,755			
23. A04 Community Placement Team Services and IMD Alternative Program	1,349,614	606,373	743,241			
24. A03 Criminal Justice Residential and Outpatient Treatment Programs	3,633,766	3,133,766	500,000			
25. A03 Criminal Justice Outpatient Services	2,844,891	1,991,481	853,410			
26. OA02-04 In-Home Outreach Teams	2,066,729	2,066,729				
27. OA02-04 Outpatient Services for Older Adults	3,203,073	1,869,488	1,333,585			
28. OA02-04 Clinical Case Management for Older Adults	0	0	0			
29. OA02-04 Connections Program	438,281	438,281				
30. LP01 Learning Partnership	833,130	833,130				
CSS Administration	815,213	815,213				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	217,195,820	114,788,085	81,171,357	0	18,900,705	2,335,673
FSP Programs as Percent of Total	**60.7%**					

FY 2023-24 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Clara Date: 2/1/24

9	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. P9 Violence Prevention Program & Intimate Partner Violence Prevention	514,887	514,887				
2. P2 Support for Parents	861,903	861,903				
3. P9 Promotores	688,015	688,015				
4. P9 Older Adult PEI Services	428,730	224,365	204,365			
PEI Programs - Early Intervention						
5. P3 Raising Early Awareness Creating Hope (REACH)	2,274,425	1,315,553	678,634		280,238	
6. P4 Integrated Prevention Services for Cultural Communities (IPSCC)	1,788,419	1,788,419				
7. P9 Elders' Storytelling Program	458,676	458,676				
8. P2 School Linked Services (SLS) Initiative	33,836,128	15,378,706	8,998,554		4,458,868	5,000,000
9. P3 Allcove	1,900,000	1,900,000				
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
10. P9 Older Adult In-Home Peer Respite Program	458,676	458,676				
11. P9 Law Enforcement Training and Mobile De-Escalation Response	256,000	256,000				
PEI Programs - Stigma and Discrimination Reduction						
12. P4 New Refugees Program	779,783	779,783				
13. P1 Cultural Communities Wellness Program (CCWP)	2,357,686	2,357,686				
PEI Programs - Access and Linkage to Treatment						
14. P2 Services for Children 0-5	647,485	647,485				
15. P8 Office of Consumer Affairs	939,523	939,523				
16. P8 Office of Family Affairs	399,631	399,631				
17. P6 Re-Entry Services Team	517,836	517,836				
18. P7 LGBTQ+ Access & Linkage	1,564,372	1,564,372				
19. P9 Behavioral Health Navigator Program	984,510	984,510				
20. P9 Psychiatrict Emergency Response Team (PERT)	1,457,616	1,457,616				
PEI Programs - Suicide Prevention						
21. P5 Suicide Prevention Strategic Plan	4,000,617	3,545,619				454,998
PEI Programs - Improve Timely Access to Services for Underserved Populations						
22. P1 Culture-Specific Wellness Centers	1,454,769	1,454,769				
PEI Administration	1,241,151	1,241,151				
PEI Assigned Funds- CalMHSA	0	0				
Total PEI Program Estimated Expenditures	59,810,838	39,735,181	9,881,553	0	4,739,106	5,454,998

FY 2024-25 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Clara Date: 2/1/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. P9 Violence Prevention Program & Intimate Partner Violence Prevention	0	0				
2. P2 Support for Parents	861,903	594,124	267,779			
3. P9 Promotores	688,015	688,015				
4. P9 Older Adult PEI Services	428,730	224,365	204,365			
PEI Programs - Early Intervention						
5. P3 Raising Early Awareness Creating Hope (REACH)	2,281,929	1,323,057	678,634		280,238	
6. P4 Integrated Prevention Services for Cultural Communities (IPSCC)	1,798,211	1,798,211				
7. P9 Elders' Storytelling Program	458,676	458,676				
8. P2 School Linked Services (SLS) Initiative	22,368,656	8,910,934	8,998,854		4,458,868	
9. P3 Allcove	4,282,012	4,282,012				
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
10. P9 Older Adult In-Home Peer Respite Program	458,676	458,676				
11. P9 Law Enforcement Training and Mobile De-Escalation Response	256,000	256,000				
PEI Programs - Stigma and Discrimination Reduction						
12. P4 New Refugees Program	779,783	779,783				
13. P1 Cultural Communities Wellness Program (CCWP)	2,397,540	2,397,540				
PEI Programs - Access and Linkage to Treatment						
14. P2 Services for Children 0-5	1,635,369	1,635,369				
15. P8 Office of Consumer Affairs	969,221	969,221				
16. P8 Office of Family Affairs	421,525	421,525				
17. P6 Re-Entry Services Team	529,047	529,047				
18. P7 LGBTQ+ Access & Linkage	1,586,653	1,586,653				
19. P9 Behavioral Health Navigator Program	998,434	998,434				
20. P9 Psychiatrict Emergency Response Team (PERT)	1,697,546	1,697,546				
PEI Programs - Suicide Prevention						
21. P5 Suicide Prevention Strategic Plan	3,997,368	3,542,370				454,998
PEI Programs - Improve Timely Access to Services for Underserved Populations						
22. P1 Culture-Specific Wellness Centers	1,454,769	1,454,769				
PEI Administration	1,251,678	1,251,678				
PEI Assigned Funds- CalMHSA	0	0				
Total PEI Program Estimated Expenditures	51,601,741	36,258,005	10,149,632	0	4,739,106	454,998

FY 2023-24 Mental Health Services Act Annual Update
Innovations (INN) Component Worksheet

County: Santa Clara Date: 2/1/24

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN11- Client and Consumer Employment	0	0				
2. INN12- Psychiatric Emergency Response Team (PERT) and Peer Linkage	0	0				
3. INN13- Allcove Implementation Project	1,900,000	1,900,000				
4. INN14- Independent Living Facilities Project	495,000	495,000				
5. INN15- CMR_Community Mobile Response Project	14,459,457	6,900,457		7,559,000		
6. INN16- ICAN_Addressing MH & Trauma in Diverse Communites Project	584,380	584,380				
INN Administration	446,136	446,136				
Total INN Program Estimated Expenditures	17,884,973	10,325,973	0	7,559,000	0	0

FY 2024-25 Mental Health Services Act Annual Update
Innovations (INN) Component Worksheet

County: Santa Clara Date: 2/1/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN11- Client and Consumer Employment	0	0				
2. INN12- Psychiatric Emergency Response Team (PERT) and Peer Linkage	0	0				
3. INN13- Allcove Implementation Project	0	0				
4. INN14- Independent Living Facilities Project	0	0				
5. INN15- CMR_Community Mobile Response Project	7,550,957	7,187,899	363,058			
6. INN16- ICAN_Addressing MH & Trauma in Diverse Communites Project	584,380	584,380				
INN Administration	459,663	459,663				
Total INN Program Estimated Expenditures	8,595,000	8,231,942	363,058	0	0	0

FY 2023-24 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Component Worksheet

County: Santa Clara Date: 2/1/24

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. W1 WET Coordination	304,385	304,385				
2. W2 WET Training	802,617	802,617				
3. W3: WET Career Pathways and Development	2,754,712	2,754,712				
WET Administration	131,713	131,713				
WET Regional Partnership Contribution						
Total WET Program Estimated Expenditures	3,993,427	3,993,427	0	0	0	0

FY 2024-25 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Component Worksheet

County: Santa Clara Date: 2/1/24

	Fiscal Year 2024 /25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. W1 WET Coordination	323,513	323,513				
2. W2 WET Training	822,165	822,165				
3. W3: WET Career Pathways and Development	2,203,638	2,203,638				
WET Administration	131,713	131,713				
WET Regional Partnership Contribution						
Total WET Program Estimated Expenditures	3,481,029	3,481,029	0	0	0	0

FY 2023-24 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Clara Date: 2/1/24

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. SMH Gender Afirming Care	1,500,000	1,500,000				
2. Central Wellness and benefits Center	450,000	450,000				
3.	0					
4.	0					
5.	0					
CFTN Programs - Technological Needs Projects						
6. CFTN Support Staff	1,353,178	1,353,178				
7. E.H.R Project	0					
8.	0					
9.	0					
10.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	3,303,178	3,303,178	0	0	0	0

FY 2024-25 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Clara Date: 2/1/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. SMH Gender Afirming Care	1,500,000	1,500,000				
2. Central Wellness and benefits Center	450,000	450,000				
3.	0					
4.	0					
5.	0					
CFTN Programs - Technological Needs Projects						
6. CFTN Support Staff	1,353,178	1,353,178				
7. E.H.R Project	0					
8.	0					
9.	0					
10.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	3,303,178	3,303,178	0	0	0	0

County of Santa Clara Behavioral Health Services Department

MHSA COUNTY COMPLIANCE CERTIFICATION

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

☒ **Annual Update**

County: Santa Clara

Local Behavioral Health Director	**Program Lead**
Sherri Terao, Ed.D. (408) 885-5776 Sherri.Terao@hhs.sccgov.org	Jeanne Moral, MPA Division Manager, Systems Initiatives, Planning and Communication (408) 885-6867 Jeanne.Moral@hhs.sccgov.org
Local Mental Health Mailing Address: County of Santa Clara Behavioral Health ServicesDepartment Behavioral Health Administration 828 South Bascom Avenue, Suite 200 San Jose, CA 95128	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city, and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and non-supplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate.

The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on June 4, 2024.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant. All documents in the attached annual update are true and correct.

Sherri Terao

Local Behavioral Health Director (PRINT)

Signature

Date

County of Santa Clara Behavioral Health Services Department

COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County/City: Santa Clara

☐ Three-Year Program and Expenditure Plan
☒ Annual Update
☒ Annual Revenue and Expenditure Report

Local Behavioral Health Director	**County Auditor-Controller/City Financial Officer**
Sherri Terao, Ed.D. (408) 885-5776 Sherri.Terao@hhs.sccgov.org	Margaret Olaiya Telephone Number: (408) 299-5201 Margaret.Olaiya@fin.sccgov.org
Local Mailing Address: Santa Clara County Behavioral Health Services Department Administration 828 South Bascom Avenue, Suite 200, San Jose, CA 95128	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and theMental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan orupdate and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years. I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Sherri Terao

Local Behavioral Health Director (PRINT) | Signature | Date

I hereby certify that for the fiscal year ended June 30, 2023, the County/City has maintained an interest- bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the fiscal year ended June 30, 2022. I further certify that for the fiscal year ended June 30, 2023 , the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund. I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Margaret Olaiya

County Auditor Controller/City Financial Officer (PRINT) | Signature | Date

BEHAVIORAL HEALTH BOARD APPROVAL MINUTES

{Information for this section will be entered after this meeting occurs}

COUNTY BOARD OF SUPERVISORS APPROVAL MINUTES

{Information for this section will be entered after this meeting occurs}

APPENDICES

EVALUATION REPORT

2023

The County of Santa Clara
Mental Health Services Act (MHSA)

COMMUNITY PROGRAM PLANNING PROCESS

Informing the FY2025 Annual Update & FY2024 Mid-Year Adjustments

Prepared by:
CommunityConnections
Psychological Associates, Inc.

ACKNOWLEDGEMENTS

The FY2025 Annual Update MHSA Community Planning Process aimed to reach community residents and consumer/family stakeholders of Behavioral Health services across the County, and therefore required outreach and collaboration from multiple County stakeholders. Many individuals and organizations offered their time, energy, and resources to make the community survey and community conversations data collection possible, in a community-wide collaborative effort. We would like to acknowledge the following contributors:

Allcove
Alum Rock Union School District
Asian Americans for Community Involvement
Behavioral Health Contractors Association
Behavioral Health Urgent Care
Bill Wilson Center
CalWORKS Community Health Alliance
Cambrian School District
Caminar
Campbell Union High School District
Campbell Union School District
Central Treatment and Recovery
Central Wellness and Benefits Center
Collaborative Courts, Forensic Diversion and Reintegration-BHSD
Community Solutions
County Behavioral Health Services Department Teams (Access / Unplanned Services, Administrative Services, Children Youth & Families, Finance; and Adult/Older Adult)
County of Santa Clara Probation Department – Juvenile Hall
Cultural Communities Wellness Program
Downtown Behavioral Health
East San Jose Public Library
East Side Union High School District
Evans Lane Wellness & Recovery Center
Forensic Diversion and Reintegration - BHSD
Franklin McKinley School District
Fremont Union High School District
Gardner Health Services, Ethnic Wellness Center
Gilroy Senior Center
Gilroy Unified School District
Indian Health Center
Josefa Chaboya de Narvaez Behavioral Health
Lived Experience Advisory Board Silicon Valley (LEABSV).
Loma Preita School District
Los Altos Union School District
Los Gatos Union School District
Luther Burbank School District
Mekong Community Center
Mexican Consulate
Milpitas Unified School District
Momentum for Health
Moreland School District
Morgan Hill Unified School District
Mothers against Murder
Mount Pleasant Elementary School District
Mountain View Los Altos School District
Mountain View Whisman School District
Muslim Center
Muslim Community Association, Mexican Consulate and the Re-entry Resource Center
National Alliance on Mental Illness-Santa Clara County The Office of LGBTQ+ Affairs
Oak Grove School District
Office of the Public Defender
Orchard School District
Palo Alto Unified School District
Probation
Project Safety Net
Q Corner
Re-entry Services
San Jose State University
San Jose Unified School District
Santa Clara County Office of Education
Silicon Valley Gurdwara
South County Behavioral Health
Stanford University School of Medicine
Telecare Muriel Wright Recovery Center
The LGBTQ Youth Space of Caminar
Ujima
Vietnamese American Service Center (VASC)
Young Men's Christian Association (YMCA) of Silicon Valley

TABLE OF CONTENTS

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2023 Evaluation Report for the Mental Health Services Act (MHSA) Community Program Planning Process

Informing the FY25 MHSA Annual Update and FY24 Mid-Year Review

BACKGROUND

In 2004, residents of the state of California voted in favor of Proposition 63 to create the Mental Health Services Act (MHSA). The MHSA is funded by a 1% tax on Californians with a personal income greater than $1 million. These funds are distributed to each County to expand and transform mental health services in California. Each County engages in a community-driven needs evaluation to inform the following three years of MHSA programming. In the midst of heightened behavioral health needs from the COVID-19 pandemic and the declaration of mental health and substance use disorders as a public health crisis by the Santa Clara Board of Supervisors in early 2022, the County of Santa Clara (SCC) Behavioral Health Services Department (BHSD) conducted a 3 year community planning process in February through September of 2023, to inform the FY2024-26 MHSA budget.

In response to community input and recommendations from this FY2024-26 MHSA community planning process, SCC BHSD identified five (5) department-wide priorities:

1. Ensure Medi-Cal beneficiaries are provided timely access to high quality mental health and substance use treatment services.
2. Increase the availability of treatment beds, permanent housing, and temporary shelter.
3. Proactively address ongoing and emerging needs for specific high-need populations.
4. Develop innovative solutions to address professional workforce shortages.
5. Adapt to and help shape the rapidly shifting state policy landscape.

As part of the FY2025 mid-year MHSA annual budget update, BHSD initiated a community planning process to a) gather consumer input on the five department priorities, and b) identify ongoing and emergent stakeholder and programmatic needs. BHSD contracted with Community Connections Psychological Associates, Inc. (CCPA), who conducted a multi-pronged mixed-methods community program planning process to inform any updates needed for SCC BHSD's FY25 priorities, programs, and/or budget. The current evaluation report details the results of this planning process.

METHODOLOGY

In contrast to the 2022 3-year FY 2024-26 Community Planning Process which aimed to recruit a broad community sample across the enter County's catchment area (i.e., via mailers mailed to a large random sample of households), the 2023 CPP for the FY25 update focused on consumer stakeholder recruitment. In particular, aims of recruitment for the FY2025 community planning process were to engage a robust sample of SCC BHSD consumers and family stakeholders who have had experiences engaging with BHSD services and programs.

As such, consumer stakeholders were invited to participate in a series of 60-90 minute community conversations aimed at gathering consumer stakeholder feedback about areas of BHSD services

that should stay the same or change, along with suggestions or recommendations for BHSD's 5 main goals or priorities (listed below).

5 BHSD Goals or Priorities, Informed by Previous Community Planning Processes

Goal #1 Timely Access	Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services
Goal #2 Housing	Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter
Goal #3 Emerging Needs	Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations
Goal #4 WET	Develop Innovative Solutions to Address Professional Workforce Shortages
Goal #5 Integrated Systems / Policy	Adapt to and Help Shape the Rapidly Shifting State Policy Landscape

In addition, consumer stakeholders and community members were invited to participate in the BHSD Mental Health & Substance Use Consumer Survey (administered from January 1, 2023 through March 21, 2023). Responses were elicited from a diverse range of consumer stakeholders across age, race/ethnicity, geographic region, sexual identity, and gender identity. The qualitative data from community conversations and surveys, and quantitative data from the surveys, were analyzed in a mixed-methods approach to inform concrete recommendations by an independent program evaluation team from Community Connections Psychological Associates (CCPA; team leads Joyce Chu, Ph.D. and Brandon Hoeflein, Ph.D., and team member Stephanie Chin, M.S.).

2 Main Sources of Data

1. Mental Health & Substance Use Consumer Survey
2. 29 Community

1. Community Conversations (Listening Events)

In order to hear directly from community stakeholders, the BHSD partnered with County programs and Community-based partner organizations to host online and in-person 60-90 minute community listening events ("Community Conversations"). A total of 435 community stakeholders participated across 29 community conversations. Community partner organizations who hosted the conversations included the following: Allcove, Asian Americans for Community Involvement,

Behavioral Health Contractors Association, Bill Wilson Center, Community Solutions, County Behavioral Health Services Department Teams (Access / Unplanned Services, Administrative Services, Children Youth & Families, Finance; and Adult/Older Adult), Cultural Communities Wellness Program, East San Jose Public Library, Gardner Health Services, Ethnic Wellness Center, Gilroy Senior Center, Momentum for Health, Mothers against Murder, National Alliance on Mental Illness-Santa Clara County The Office of LGBTQ+ Affairs, Office of the Public Defender, Project Safety Net, Q Corner, Re-entry Services, San Jose State University, Santa Clara County Office of Education, County of Santa Clara Probation Department – Juvenile Hall, Silicon Valley Gurdwara, Stanford University School of Medicine, Vietnamese American Service Center (VASC), Young Men's Christian Association (YMCA) of Silicon Valley, and the LGBTQ Youth Space of Caminar.

The conversations were open to the public and attended by consumers/clients, family members, service providers, and numerous other stakeholders. Community conversation groups targeted a diverse representation of community stakeholders across the SCC community and BHSD systems of care. English-speaking sessions were led and facilitated by members of the CCPA independent evaluation team; non-English speaking sessions were facilitated by a representative from the host organization or County BHSD team. Each conversation included a brief overview of MHSA, followed by three primary discussion prompts:

3 Community Conversation Discussion Prompts

1. In thinking about mental health and substance use services in Santa Clara County, what should stay the same?
2. In thinking about mental health and substance use services in Santa Clara County, what should be added or changed?
3. Suggestions or recommendations for the 5 Behavioral Health Department's Priorities? *(Note: 5 BHSD goals are listed below)*

Community stakeholders participated in each conversation through open verbal conversation or written chat comments (for online sessions). Each conversation was recorded solely for the purpose of facilitating accuracy of data capture and transcription by the independent evaluation team. At the beginning of each community conversation, participants were informed that the session would be recorded, and had the option of opting out of participation. Participants were informed that the recordings and transcripts would only be used for data analysis by the independent/external evaluation team. For in-person community conversations, only audio was recorded, and for online community conversations, names or faces were not be recorded or linked with their comments (thus maintaining anonymity). All verbal and written (chat) comments served as qualitative data for thematic analysis of each individual stakeholder comment.

Data Analysis for Community Conversations

Each community conversation was transcribed, and then coded for individual community comments about the areas of need relevant to BHSD services (strengths were coded and reported separately, above). The data were then coded using a grounded theory approach to identify an overarching set of areas of need (called "primary themes or codes"), listed in order of frequency mentioned. Each primary theme / area of need was also organized into subthemes ("secondary"

themes) to clarify community feedback and organize recommendations. These subthemes provide descriptions and definitions of stakeholders' comments within each overarching area of need (primary theme).

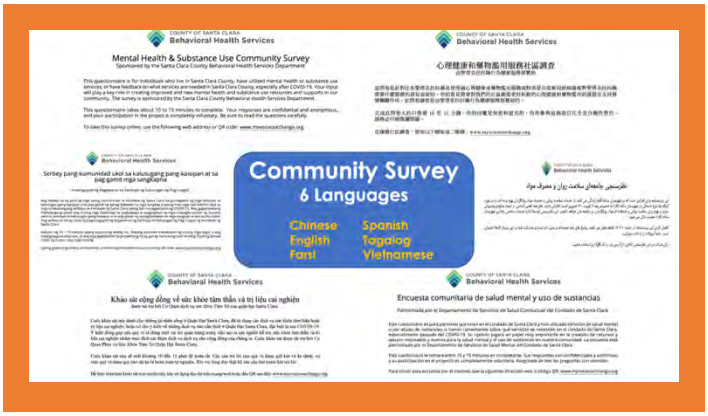
Given that community conversation stakeholders were prompted to comment on any feedback or recommendations for BHSD's five (5) main goals (listed above), each of the areas of need (at the secondary or subtheme level) were compared against the Department goals to identify any overlap and correspondence with the Department's 5 main goals. Goals that corresponded with primary or secondary themes are indicated in all data tables and analyses; this analysis allows for BHSD to consider stakeholder feedback in their decisions and plans as they focus on the 5 department goals. Results for these qualitative analyses are presented in each of the Department, System of Care, and Other Areas of Focus subreports in this overarching program evaluation report.

2. Mental Health & Substance Use Consumer Survey

The original version of SCC BHSD's mental health and substance use survey was created in 2018 by Research Development Associates; this survey was later updated in 2020 and in 2022 by a subcommittee of the SCC MHSA Stakeholder Leadership Committee (which included members from BHSD), with consultation from CCPA. The final survey was vetted by the larger Stakeholder Leadership Committee and the BHSD executive team. Overall, survey items assessed six primary categories, shown below. Many of these survey items were designed to assess consistency of BHSD services with core MHSA principles of cultural competence, community collaboration, consumer and family driven mental health services, integrated service experience, and wellness focus: recovery and resilience. The survey included additional questions on access to care (i.e., community awareness and ease of accessing services) and workforce, education, and training (WET; i.e., interest in and barriers to joining the BHSD workforce), and overall strengths and barriers of BHSD services.

Community Survey: 6 Primary Domains

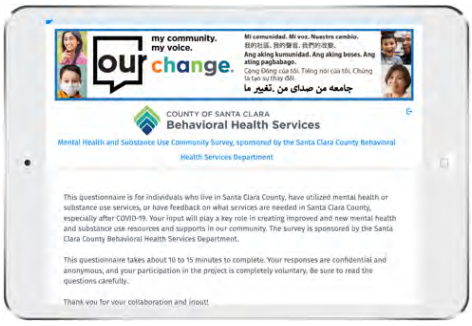
1. Access to Care
2. Quality of Care
3. Cultural Considerations
4. Recovery Orientation
5. Family Inclusion
6. Telehealth



Community surveys were available in the 6 most common threshold languages within SCC: English, Spanish, Vietnamese, Mandarin, Tagalog, and Farsi. All survey responses were collected from January 1, 2023 through March 21, 2023.

Consumer Survey Outreach and Distribution

Outreach for the 2023 consumer stakeholder survey utilized a multi-method approach, with the goal of reaching a diverse representation of County consumers and family stakeholders. First, electronic outreach was utilized to reach individuals via online means. Examples of these online outreach efforts included social media ads, email mailers, and newsletters issued by Behavioral Health Services Department (BHSD) to consistently remind members in the community to complete the survey throughout the months of January through March 2023. The survey was available to complete online or on paper to reach as many community members as possible in Santa Clara County.



Second, to ensure adequate representation of BHSD consumers and family members as respondents to the community survey, BHSD enlisted the assistance of community partners and clinical providers. BHSD community-serving partners took an active role in spreading the word about the survey through their newsletters and distribution lists in English and other threshold languages. Postcards, posters, fliers, and paper copies of the survey were handed out throughout County Clinics, County offices, and Self-help centers, and providers encouraged current consumers of County services to participate in the survey. Copies were also provided to County partners and shared in their centers and networks.

Finally, a concerted effort was made to market the community survey to culturally diverse communities in the County. Announcements were made at Community Conversations targeted at different LGBTQ+, immigrant, refugee, non-English speaking, and ethnic minority communities, and BHSD also engaged community peers to outreach about the survey at places/organizations of community gathering, such as community centers and places of worship, among others.

Data Analysis for the Survey

Survey analyses were divided into several main parts. First, qualitative comments from the survey were combined with comments from the community conversations to yield a unified set of qualitative data. Second, descriptive statistics (i.e., means and standard deviations) were calculated for the 6 major domains that are consistent with MHSA principles, and compared with scores from last year's CPP survey, to track any variations over time. Third, data from the survey's access to care, WET, and strengths and barriers questions were analyzed to inform recommendations.

PARTICIPANTS

1. Community Conversations

See below for a list of each community conversation, along with the number of participants and language in which the conversation was conducted. The Appendix includes data tables for the themes and sub-themes of each Community Conversation.

Community Conversation Groups (Total n = 435)

Region

1. North County Community (32, *English*)
2. South County Older Adults (3, *English*)
3. South County Spanish & English speaking, some unhoused *(42, English & Spanish)*

Children, Youth, Families

4. Youth Group 1 (7, *English*)
5. Youth Group 2, LGBTQ+ (3, *English*)
6. Youth Group 3 (14, *English*)
7. Youth Group 4, University students (12, *English*)
8. Youth who are Unhoused (6, *English*)
9. Family Members, General (10, *English*)
10. Providers: Children, Youth, & Family Services (32, *English*)
11. Young Men Involved in Juvenile Justice *(9, English)*
12. Young Women Involved in Juvenile Justice *(2, English)*

Cultural Communities

13. TGI+ (9, *English*)
14. LGBQPA2S+ (7, *English*)

    Youth Group 2, LGBTQ+ *(3, English)*
15. Spanish Speaking LGBTQ+ Adults (19, *Spanish*)
16. Spanish Speaking Adults (6, *Spanish*)

    South County Spanish & English speaking, some unhoused *(42, English & Spanish)*
17. African Immigrant Community *(15, English)*
18. South Asian (Punjabi) Community (27, *Punjabi*)
19. African American (3, *English*)
20. Vietnamese Community (27, *Vietnamese*)
21. Middle Eastern Community (7, *English*)

Justice-Involved

23. Diversion Community (65, *English*)
24. Reentry Community (18, *English*)

    Young Men Involved in Juvenile Justice *(9, English)*

    Young Women Involved in Juvenile Justice *(2, English)*

Unhoused

25. Unhoused (1, *English*)
26. Adults in Residential/Transitional Housing (Unhoused) *(4, English)*
27. Providers: Supportive Housing (13, *English*)

    South County Spanish & English speaking, some unhoused *(42, English & Spanish)*

    Youth who are Unhoused (6, *English*)

General / Other

28. Providers: Adult & Older Adult (24, *English*)
29. Consumers/Clients, General (4, *English*)

Older Adults

South County Older Adults (3, *English*)

22. Providers: Refugee Services (14, *English*)	

Note: Parentheses include the number of participants in each community conversation, followed by the language in which the conversation was conducted.
Note: Occasionally, multiple individuals attended a Community Conversation from the same device (e.g., couples, families, client-provider dyads using the same laptop). Efforts were made to count all individuals who were present, but these participant counts may under-represent the total number of individuals who participated on Zoom.
Note: Community partner organizations who hosted the conversations included the following: Allcove, Asian Americans for Community Involvement, Behavioral Health Contractors Association, Bill Wilson Center, Community Solutions, County Behavioral Health Services Department Teams (Access / Unplanned Services, Administrative Services, Children Youth & Families, Finance; and Adult/Older Adult), Cultural Communities Wellness Program, East San Jose Public Library, Gardner Health Services, Ethnic Wellness Center, Gilroy Senior Center, Momentum for Health, Mothers against Murder, National Alliance on Mental Illness-Santa Clara County The Office of LGBTQ+ Affairs, Office of the Public Defender, Project Safety Net, Q Corner, Re-entry Services, San Jose State University, Santa Clara County Office of Education, County of Santa Clara Probation Department – Juvenile Hall, Silicon Valley Gurdwara, Stanford University School of Medicine, Vietnamese American Service Center (VASC), Young Men's Christian Association (YMCA) of Silicon Valley, The LGBTQ Youth Space of Caminar

2. Mental Health & Substance Use Survey: Community Participants (Full sample)

A total of 744 participants initiated the Mental Health & Substance Use Community Survey. All survey responses were included for individuals who reported that they are a resident of Santa Clara County, that they live in a specific region of Santa Clara County, or reported receiving services from an agency within Santa Clara County. If a survey response did not meet at least one of these criteria (e.g., residing in the County, residing in a County region, receiving Mental Health & Substance Use services), they were excluded from the final sample (n = 77). Of these responses, 76 were situations in which someone opened the survey online and closed it without answering any questions at all; the other case was an individual who specifically stated that they lived far outside of Santa Clara County and did not receive any Mental Health & Substance Use services within the last year. The final community sample included 667 individuals. Below are details about the demographics of this full community sample.

Community Participants (Full Sample): Race and Ethnicity

Participants in the current survey were prompted to select their specific ethnic origin(s) subcategories (i.e., Japanese or Filipino) under a larger racial or ethnic category (i.e., Black, African, or African American), with the option to select only the broader racial/ethnic category (e.g., Black). Race/ethnicity was reported by 576 respondents (86.3%). See the tables below for a full breakdown of race/ethnicity among participants. When looking at race/ethnicity data below, note that it was common for individuals to identify with multiple sub-identities (e.g., Western European and Southern European). In addition, 77 individuals identified as "multi-racial," which is defined as any individual who identified with multiple race/ethnicity categories (e.g., Pacific Islander and Black; Middle Eastern and Hispanic/Latino/a/x).

Based on feedback from last year's survey, the race/ethnicity items were updated such that they no longer forced respondents to select a specific ethnic origin subcategory (e.g., Iranian); this year, they were given the option to simply select the broader category. In comparison to last year's race/ethnicity results, there were far fewer comments (n = 3) critiquing the formatting of race/ethnicity.

Native American, American Indian, or Alaskan Native [n = 44; 7.6%]	
Central/South American tribal affiliation	6 (13.6%)
North American tribal affiliation	3 (6.8%)
Non-Specific	35 (79.5%)

Black, African, African American [n = 80; 13.9%]	
East Africa	21 (26.3%)
Caribbean	4 (5.0%)
Sub-Saharan Africa	2 (2.5%)
West Africa	2 (2.5%)
Southern Africa	0 (0%)
Non-Specific	58 (72.3%)

White, Caucasian, European [n = 208; 36.1%]	
Northern European	29 (13.9%)
Western European	20 (9.6%)
Eastern European	15 (7.2%)
Southern European	13 (6.3%)
Canadian	3 (1.4%)
Australian	1 (0.5%)
New Zealander	1 (0.5%)
Caribbean	0 (0.0%)
Non-Specific	126 (60.6%)

Hispanic or Latino/a/x [n = 186; 32.3%]	
Mexican	81 (43.5%)
Puerto Rican	7 (3.8%)
South American	6 (3.2%)
Central American	6 (3.2%)
Spaniard	4 (2.2%)
Caribbean	0 (0.0%)
Non-Specific	82 (44.1%)

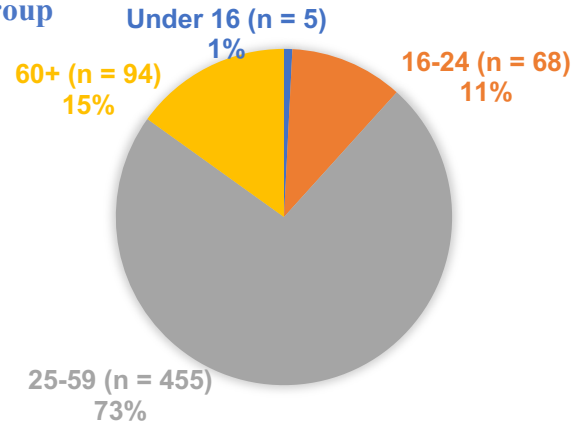
Middle Eastern, North/West African [n = 13; 2.3%]	
Afghan	13 (100%)
Iranian	8 (1.5%)
North Africa	1 (15.4%)
Israeli	1 (7.7%)
Syrian	1 (7.7%)
Jordanian	1 (7.7%)
Lebanese	1 (7.7%)
Yemeni	1 (7.7%)
Iraqi	0 (0%)
Other Gulf State	0 (0%)
Saudi	0 (0%)
Non-Specific	0 (0.0%)

Asian or Asian American [n = 178; 30.9%]	
Vietnamese	67 (37.6%)
Chinese	32 (18.0%)
Filipino	19 (10.7%)
Southeast Asian	12 (6.7%)
South Asian	12 (6.7%)
Korean	7 (3.9%)
Japanese	4 (2.2%)
Non-Specific	25 (14.0%)

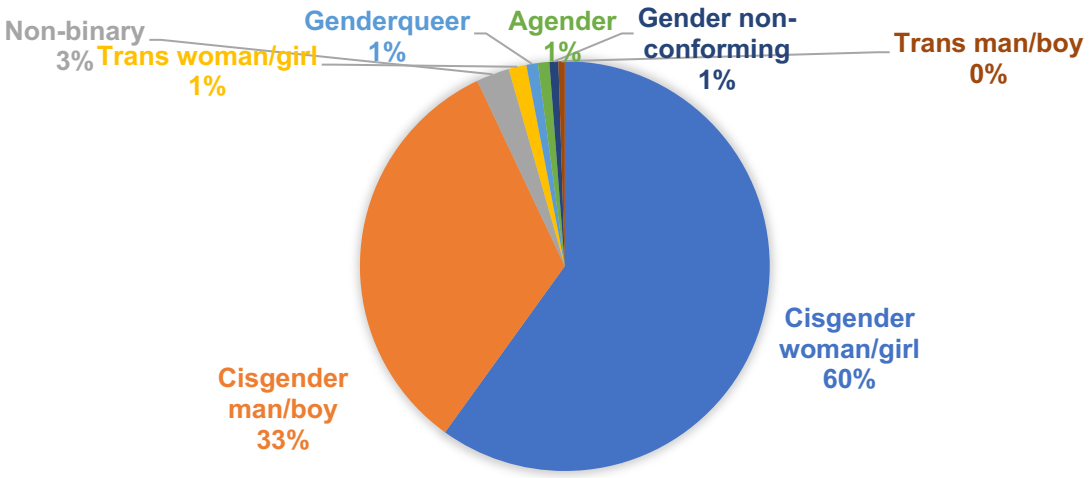
Pacific Islander / Native Hawaiian [n = 7; 1.2%]	
Samoan	2 (28.6%)
Marshallese	1 (14.3%)
Hawaiian	1 (14.3%)
Fijian	0 (0%)
Tongan	0 (0%)
Guamanian / Chamorro	0 (0%)
Non-Specific	3 (42.9%)

Community Participants (Full Sample): Age Group

Age group was reported by 622 respondents (93.3%). The most common age group was 25-59 years of age (n = 455, 73%), followed by 60 years and older (n =94, 15%), 16-24 years old (n = 68, 11%), and less than 16 years of age (n = 5, 1%).



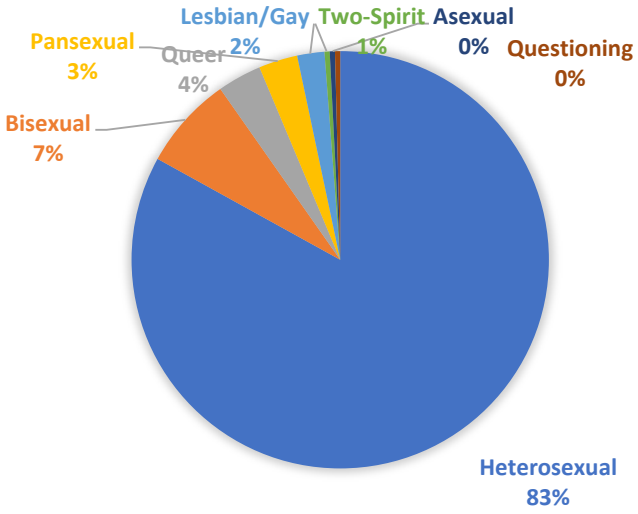
Community Participants (Full Sample): Gender Identity

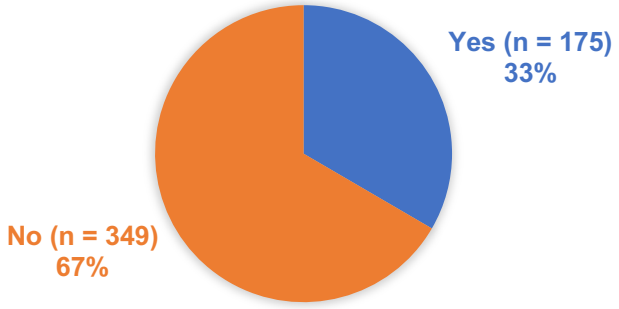


Gender identity was reported by 422 respondents (63.3%). The most common responses were cisgender woman/girl (n = 252, 59.7%), cisgender man/boy (n = 139, 32.9%), and gender non-binary (n = 11, 3%). In all, 30 (7.1%) of participants identified as transgender or gender non-binary.

Community Participants (Full Sample): Sexual Identity or Sexual Orientation

Sexual identity was reported by 473 respondents (70.9%). The most common responses were heterosexual/straight (n = 391, 82.7%), bisexual (n = 34, 7.2%), and queer (n = 16, 3.4%). In all, 80 (16.9%) of participants identified as LGBQAP2S+.



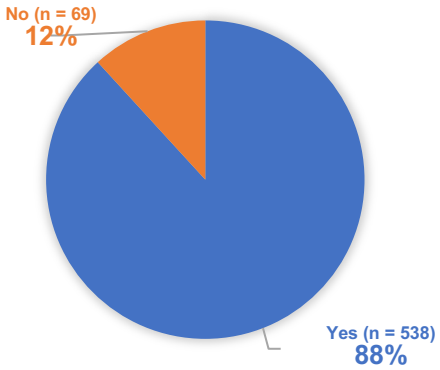


Community Participants (Full Sample): Disability Status

Disability status was reported by 524 respondents (78.9%). When asked, 175 respondents (33.4%) stated that they do have a disability, while 349 (66.6%) stated that they do not have a disability.

Community Participants (Full Sample): Housing Status

Housing status was reported by 607 respondents (91.0%). When asked if they have been living in stable housing over the past 2 months, 538 (88.2%) of respondents stated "yes," while 69 (11.3%) stated "no."

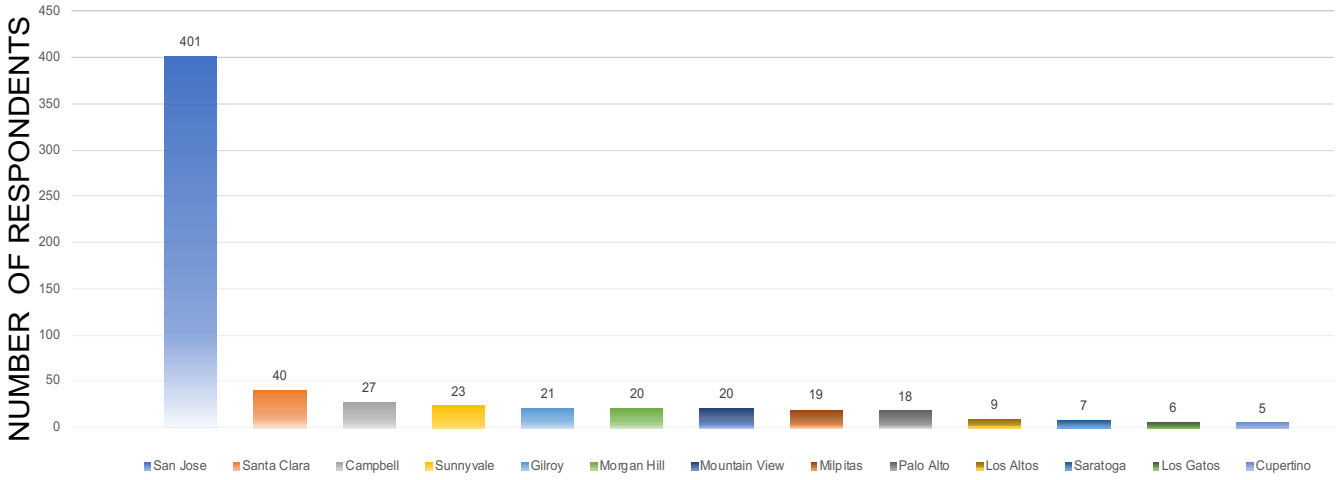


Community Participants (Full Sample): Preferred Language

Preferred language was reported by 522 respondents (83.7%). The most common response was English (n = 437, 91.1%), followed by Vietnamese (n = 46, 8.8 %), Spanish (n = 27, 5.2%), Mandarin (n = 8, 1.5%), and Farsi (n = 1).

Community Participants (Full Sample): County Region

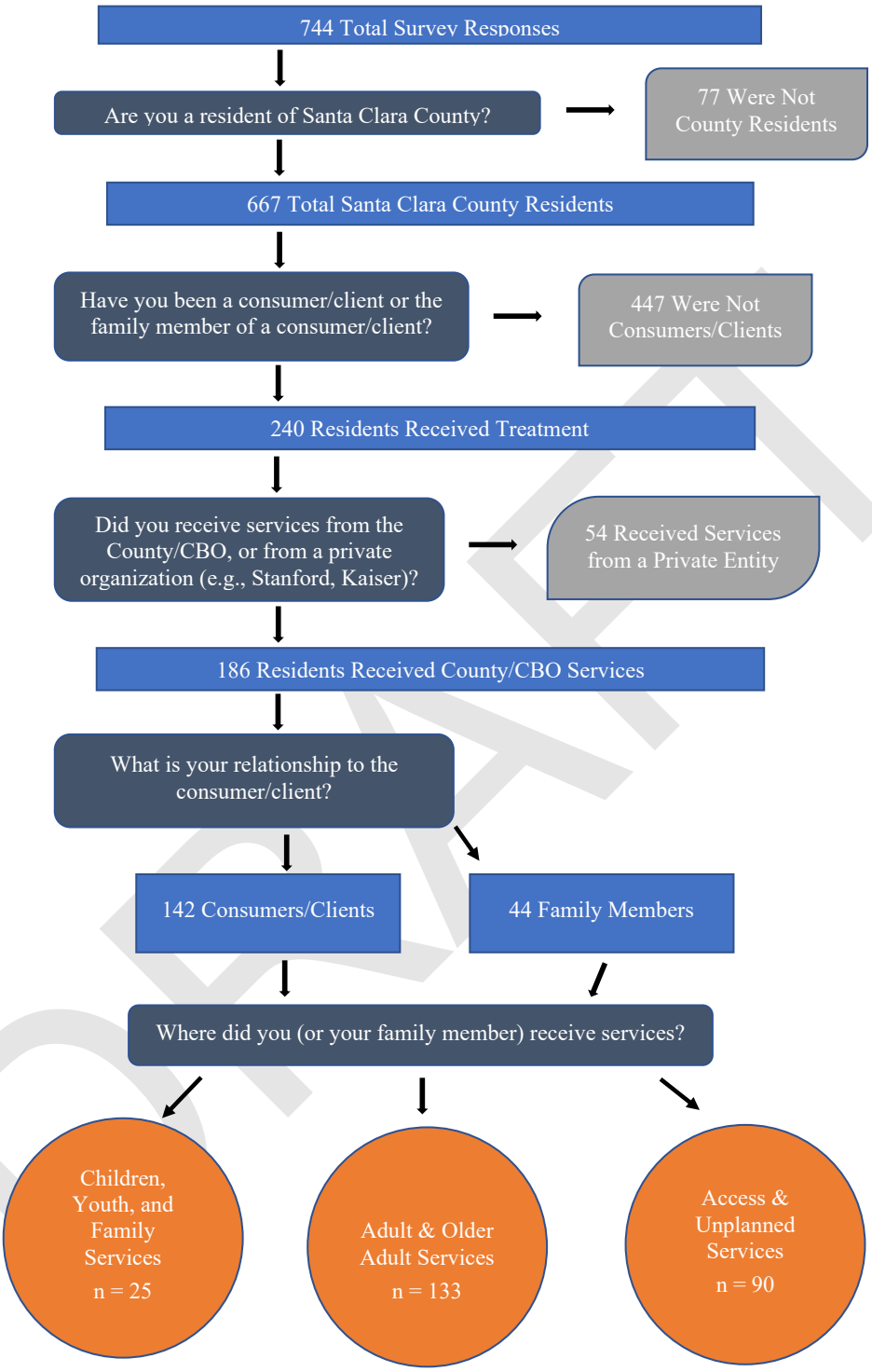
County region was reported by 611 respondents (91.6%). The most common regions were San Jose (n = 401, 5.6%), Santa Clara (n = 40, 6.5%), and Sunnyvale (n = 23, 3.8%).



3. Mental Health & Substance Use Survey: Consumer/Family Participants

Of the 667 community survey respondents, 240 individuals identified as consumers or family members, and 186 (142 clients/consumers and 44 family members) of these 240 received their services from SCC programs rather than private entities. See below for a flow chart of survey respondents.

Flow Chart of Survey Respondents



Note: Numbers may not add up to totals because of missing responses / skipped items. See the previous page for a definition/breakdown of the specific programs within each system of care.

The 186 BHSD consumers/family member respondents were classified by the systems of care from which they received services over the past year, as well as their reported primary program for services over the last year (when available). Specifically, 133 received care from SCC Adult and Older Adult (AOA) Services, 25 received care from SCC Children, Youth and Family (CYF) Services, and 90 engaged with SCC Access and Unplanned Services. See the table below for additional details.

Table: Specific Programs Within 3 SCC Systems of Care From Which Consumer/Client/Family Survey Respondents Primarily Received Services

System of Care	Program	n
Children, Youth, &Family (n = 25, 13.4%)	Mental Health & Substance Use Services for Children, Youth, and Families	11
	Mental Health & Substance Use Services for Transitional Age Youth (TAY)	6
Adult & Older Adult (n = 133, 71.5%)	Mental Health & Substance Use Services, 26-59	51
	Mental Health & Substance Use Services, 60+	12
	Criminal Justice	6
Access & Unplanned Services (n = 90, 48.3%)	Behavioral Health Call Center Access Line	19
	988	15
	EPS	13
	Drop-in or Walk-in service options	11
	Mental Health Urgent Care	10
	Suicide/Crisis Hotline	9
	Mobile Crisis Response Team	7
	Substance Use Services Access Line	5
	LGBTQ+ Services	4
	Children's Mobile Crisis Response Team (Pacific Clinics)	3
	Crisis Text Line	3
	Peer Navigator Program	3

**Note: Percentages were calculated with 186 (the number of consumers/family members who responded) as the denominator. Percentages will add up to greater than 100% as a number of respondents received services from multiple systems of care (e.g., Access and Adult & Older Adult).*

Full demographic data for the consumer/client/family member survey sample are presented below.

Consumer / Family Members: Race & Ethnicity

Native American, American Indian, or Alaskan Native [n = 14; 7.7%]	
Central/South American tribal affiliation	4 (28.6%)
North American tribal affiliation	1 (7.1%)
Non-Specific	9 (64.3%)

Pacific Islander / Native Hawaiian [n = 2; 1.1%]	
Samoan	2 (100%)
Marshallese	0 (0%)
Hawaiian	0 (0%)
Fijian	0 (0%)
Tongan	0 (0%)
Guamanian / Chamorro	0 (0%)
Non-Specific	0 (0%)

Black, African, African American [n = 31; 17.1%]	
East Africa	12 (38.7%)
West Africa	1 (3.2%)
Caribbean	1 (3.2%)
Sub-Saharan Africa	1 (3.2%)
Southern Africa	0 (0.0%)
Non-Specific	16 (51.6%)

Hispanic or Latino/a/x [n = 56; 30.9%]	
Mexican	20 (35.7%)
Puerto Rican	4 (7.1%)
Central American	2 (3.6%)
South American	1 (1.8%)
Caribbean	0 (0.0%)
Spaniard	0 (0.0%)
Non-Specific	29 (51.8%)

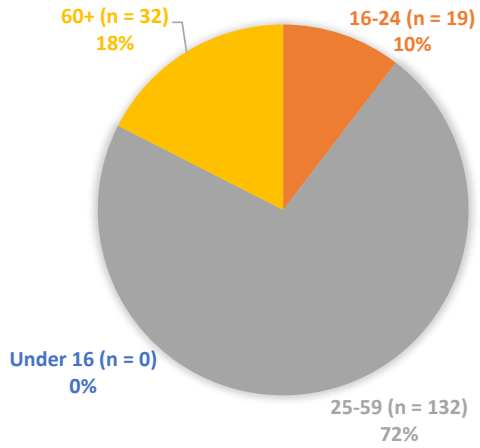
Asian or Asian American [n = 41; 22.7%]	
Vietnamese	14 (34.1%)
Chinese	8 (19.5%)
Filipino	5 (12.2%)
Southeast Asian	3 (7.3%)
Korean	1 (2.4%)
Japanese	1 (2.4%)
South Asian	1 (2.4%)
Non-Specific	8 (19.5%)

White, Caucasian, European [n = 60; 30.1%]	
Northern European	13 (21.7%)
Southern European	8 (13.3%)
Western European	8 (13.3%)
Eastern European	4(6.7%)
Australian	1 (1.7%)
Canadian	0 (0.0%)
New Zealander	0 (0.0%)
Caribbean	0 (0.0%)
Non-Specific	26 (43.3%)

Middle Eastern, North/West African [n = 4; 2.2%]	
Afghan	4 (100%)
Iranian	2 (50%)
North Africa	1 (25%)
Syrian	1 (25%)
Israeli	0 (0%)
Jordanian	0 (0%)
Lebanese	0 (0%)
Yemeni	0 (0%)
Saudi	0 (0%)
Non-Specific	0 (0%)

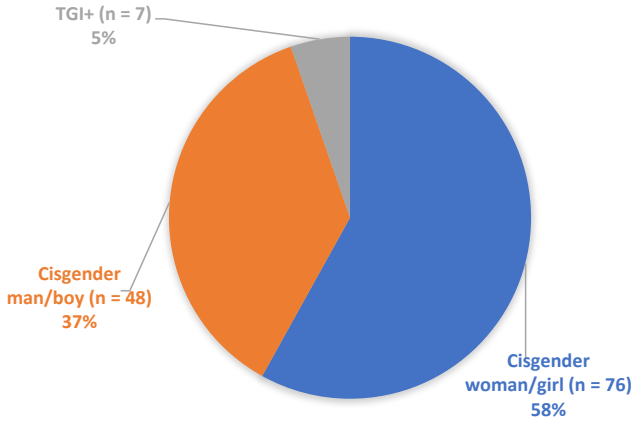
Consumers/Family Members: Age Group

Age group was reported by 183 respondents (98.3%). The most common age group was 25-59 years of age (n = 132, 72%), followed by 60 years and older (n =32, 18%), 16-24 years old (n = 19, 10%), and less than 16 years of age (n = 0).

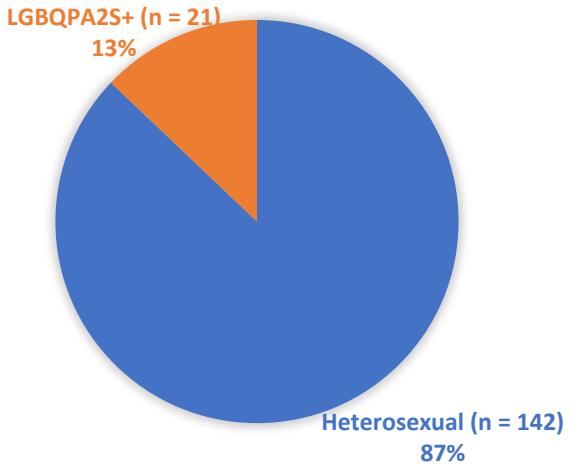


Consumer/Family Members: Gender Identity

Gender identity was reported by 131 respondents (70.4%). The most common responses were cisgender woman/girl (n = 76, 58%), cisgender man/boy (n = 48, 37%), and transgender or gender non-binary (n = 7, 5%). In all, 30 (7.1%) of consumer/family member participants identified as transgender or gender non-binary.



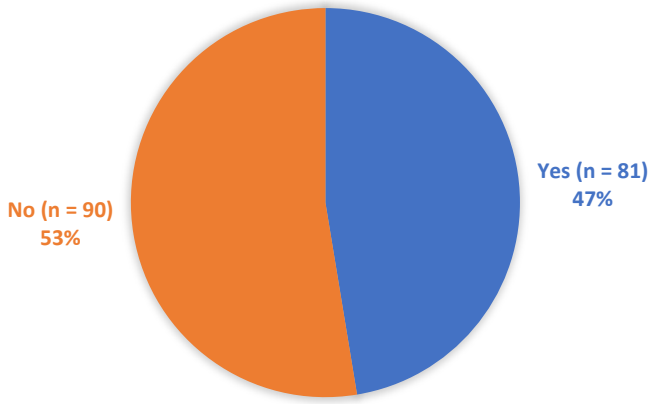
Consumers/Family Members: Sexual Identity or Sexual Orientation



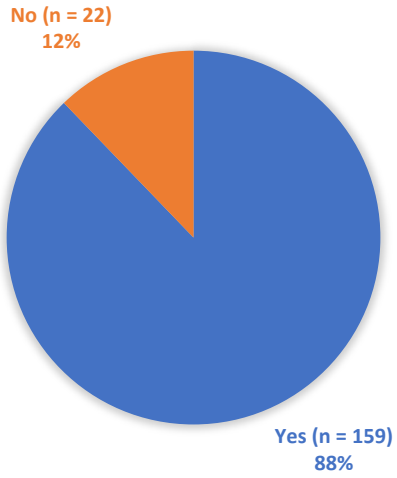
Of those who reported their sexual identity (n=163), the most common responses were heterosexual/straight (n = 142, 87.1%), bisexual (n = 8, 4.9%), and pansexual (n = 4, 4.9%). In all, 21 (12.9%) of consumer/family member participants identified as LGBQPA2S+"

Consumer/Family Members: Disability Status

Disability status was reported by 171 consumer/family member respondents (91.9%). When asked, 47 respondents (47%) stated that they do have a disability, while 90 (53%) stated that they do not have a disability.



Consumer/Family Members: Housing Status

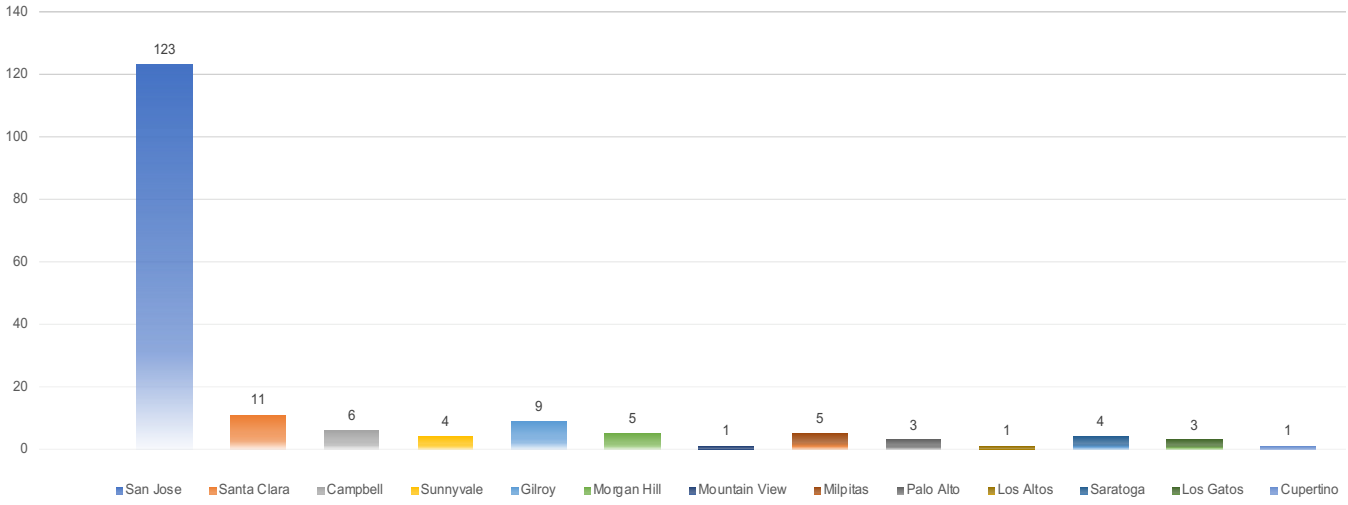


Housing status was reported by 181 respondents (97.3%). When asked if they have been living in stable housing over the past 2 months, 159 (88%) of consumer/family member respondents stated "yes," while 22 (12%) stated "no."

Consumer/Family Members: Preferred Language

Amongst the consumer/family member respondents, of those who reported their language preference (n = 168, 90.3%), the most common response was English (n = 141, 83.9%), followed by Vietnamese (n = 11, 6.5 %), Spanish (n= 6, 3.6%), and Mandarin (6 = 6, 3.6%)."

Consumers/Family Members: City of Residence



4. Groups Underrepresented in Previous CPP Efforts

South County Participants

Given previous CPP community stakeholder comments about the unique needs of South County residents, concerted efforts were made to ensure outreach to and participation of South County

stakeholders. Following is a summary of South County participation in the 2023 CPP process for the FY2025 Annual Update.

2 South County-related Community Conversations

45 South County stakeholders in Community Conversations

48 stakeholder comments re: South County

14 South County consumers or family members on the survey

Unhoused Participants

SCC stakeholders without stable housing have posed challenges to CPP engagement, particularly given the increased reliance on remote and online administration of the CPP in prime 2020-2022 COVID-19 pandemic years. CPP community stakeholders from previous years commented about the need for more participation from unhoused and unstably housed stakeholders. As such, concerted efforts were made in the 2023 CPP to ensure outreach to and participation of stakeholders for the unhoused and unstably housed population. Following is a summary of unhoused/unstably housed stakeholder participation in the 2023 CPP process for the FY2025 Annual Update.

5 Unhoused-related Community Conversations

26 Unhoused stakeholders in Community Conversations

134 stakeholder comments about housing

On the Survey: 69 individuals who not stably housed

22 were BHSD clients
7 were community members
31 did not answer items to determine if they were consumers/family members

Youth Participants

Previous CPP processes also noted that need for targeted outreach to youth, to fill previous gaps in their participation. Through concerted efforts at outreach and partnerships with the Santa Clara County Office of Education and other youth-focused programs and organizations, youth participation was robust in the 2023 CPP. Of note, the community conversation modality

garnered a larger response from youth as compared to written paper and online surveys, pointing the possibility that youth prefer the live conversational modality of engagement.

9 Youth-related Community Conversations

95 Youth stakeholders in Community Conversations

441 stakeholder comments re: Youth

25 Youth consumers or family members on the survey

5. Mental Health & Substance Use Survey: CYF System of Care Consumer/Family Participants

There were 25 CYF consumer stakeholders who responded to the survey; 52% (n = 13) identified as clients/consumers and 48% (n = 12) identified as family members. These survey participants reported receiving services from the following programs (some may have endorsed more than one service): 15 from Mental Health & Substance Use Services for Children, Youth, and Families, 7 from Mental Health & Substance Use Services for Transitional Age Youth (TAY), 5 from LGBTQ+ Services and Programs, and 5 from Criminal Justice Services.

The survey consumers/family who received Children, Family, and Youth Services (CYF) were 45.4% Hispanic/Latino/a/e, 33.3% White, 20.1% Asian, and 16.7% Black. With regards to gender identity, 70% identified as cisgender women and 30% as cisgender men/boys. They were primarily adults aged 25-59 (64%), with 24% ages 16-24 and 12% ages 60+. 81% identified as heterosexual, and 19% identified as lesbian, gay, bisexual, queer, asexual, pansexual, and two-spirit (LGBQAP2S+). Note that LGBQAP2S+ individuals were analyzed in the aggregate instead of listing individual identities. This decision was made to protect them from being identified (given the relatively low sample size) and to highlight the needs of the community instead of individual identities. Full demographic information is below.

STRUCTURE OF THE EVALUATION REPORT

The following sections of the evaluation report include an Executive Summary of Recommendations, followed by data and summaries of findings focused on five major sections:

1. Findings from consumers, clients, family members, and other stakeholders for Santa Clara County BHSD mental health and substance use services

2. Findings from consumers, clients, family members, and other stakeholders for three major BHSD systems of care and other focused areas

    - Children, Youth and Family (CYF) BHSD Services
    - Adult and Older Adult (AOA) BHSD Services
    - Access and Unplanned BHSD Services
    - Workforce, Education, and Planning
    - Unhoused populations

3. Community needs of community-level survey respondents

Each section and sub-section starts with a summary of findings and details the relevant analysis of data. Data tables can be found in the Appendix.

OVERALL EXECUTIVE SUMMARY OF RECOMMENDATIONS

This executive summary details the data-driven recommendations of the FY25 County of Santa Clara Community Planning Process (conducted in January through March of 2023), organized by major sections of the report: BHSD level recommendations, BHSD System of Care (CYF, AOA, and Access & Unplanned Services) recommendations, and community level recommendations. After analyzing the mixed-method qualitative and quantitative data, the Community Connections Psychological Associates (CCPA) team synthesized data findings into the following set of recommendations for consideration by BHSD stakeholders. Recommendations are linked to the 5 priorities set by BHSD:

Goal #1 Timely Access	Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services
Goal #2 Housing	Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter
Goal #3 Emerging Needs	Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations
Goal #4 WET	Develop Innovative Solutions to Address Professional Workforce Shortages
Goal #5 Integrated Systems / Policy	Adapt to and Help Shape the Rapidly Shifting State Policy Landscape

	Behavioral Health Services Department (BHSD)-Level Recommendations	BHSD Goal #
Additional Treatment Services	1. **More treatment services for high-need populations**, particularly youth, LGBTQ+ individuals, refugees, immigrants, and women. 2. **Increase capacity for substance use-related services and programs**, particularly detox services, dual diagnosis treatment, and youth substance use treatment and prevention. 3. **Reduce stigma among parents by addressing gaps in parental understanding of mental health and substance use**, to facilitate youth access to / engagement in services. 4. **Continue and expand support to facilitate youth access to Wellness Centers (both school- and non-school-based)**, including after-school hours access in physical centers. 5. **Expand criminal justice services**, including treatment in jail, re-entry vocational centers, longer-term re-entry services, and family therapy treatment for youth in juvenile prison. 6. **Continue LGBTQ+ services**, listed as a top 5 strength for BHSD. 7. **Maintain telehealth options while expanding in-person services**, for the benefit of consumers (especially youth) and employee job satisfaction. 8. **Continue and expand BHSD services for those who are unhoused**, including outreach, case management for benefits, and treatment	3 (Emerging Needs)
Workforce, Education, & Training (WET)	1. **Increase staff positions/hires.** Continue innovative methods of retaining staff members and filling open vacancies, particularly peer support, therapists, case managers, diversion services staff, and youth-focused staff. 2. **Culturally matched staff**. Consumer stakeholders requested hiring staff members who are matched on demographic characteristics like LGBTQ+, marginalized, and racial and ethnic minority identities. 3. **Consider essential strategies to retain staff and enhance the work environment** (i.e., staff benefits, efforts to prevent burnout, and reductions in workload). 4. **More trainings for staff, particularly cultural and LGBTQ+ trainings** (e.g., LGBTQ+, Black and African Ancestry culture, Middle Eastern culture, DEI approaches). 5. **Increase staff pay**, adjusted for Bay Area cost-of-living, particularly for Permanent Supportive Housing staff, paraprofessionals, CBO staff, and psychiatrists. 6. **Consider innovations in the recruitment pipeline** such as increasing intern stipends, working with colleges to educate and recruit graduates, shifting more responsibilities to paraprofessionals, focused efforts for LGBTQ+ staff, and	4 (WET)

	exploring exceptions for individuals applying with credentials from outside the US. 7. **Widely market job openings and provide application support**, to address barriers to obtaining applicants for BHSD positions.	
Access to Care	1. **Continue to increase community awareness and accessibility of BHSD services, particularly 988 and the peer navigator program.** Stakeholders identified ease of access through many current County efforts as a strength, while also highlighting a strong need to continue expanding these efforts. 2. **Faster/easier connection to treatment services.** Stakeholders noted the need to decrease the wait for treatment services and decreased barriers to program entry (e.g., decreasing paperwork and making the steps more clear), which is linked to the desire for additional treatment services and the need for additional clinical staff. 3. **Improve call center integrated screening process** to ensure a better fit of referrals with services, based on more thorough information gathering (i.e. on preferences for care (medication, psychotherapy, both), types of symptoms, prior service usage, and other domains that deserve further exploration) 4. **Increase options to access care without the Call Center**, particularly by agency-to-agency direct referrals.	1 (Timely Access)
	5. **Continue language availability at the Call Centers.** 6. **Increase language/translation services in treatment**, particularly in-person and for Spanish, Vietnamese, and Punjabi. 7. **Offer clients the practical supports needed to participate in treatment, particularly transportation and childcare.** The latter option may increase parent engagement, and therefore youth access as well.	Not listed
Prevention & Outreach	1. **Increase community awareness and decrease stigma for mental health and substance use through community helper trainings and outreach**, particularly in-person where diverse communities gather, and through a variety of venues, partners, and community helpers where individuals first find out about services. 2. **Expand ethnic-specific outreach efforts** to address discrimination, low Mental Health & Substance Use awareness, and high stigma among underserved ethnic minority populations, at places where ethnic communities gather and trust. 3. **Expand outreach to youth through schools and college campuses**.	Not listed
Collaborative & Integrated Care	1. **Streamline organizational structures to facilitate a unified system between BHSD and external services (**i.e., referrals, paperwork, data, billing, electronic health records, etc. for public schools and universities, community emergency services, the	5 (Integrated Systems / Policy)

	County's health and hospital system, law enforcement, and primary care) 2. **Increase communication and coordination between internal BHSD programs** to facilitate smooth transitions, minimize overlaps, and highlight gaps in care for clients. 3. **Collaborate with Santa Clara County schools to implement peer referral systems,** so that youth can confidentially refer each other for services.	
Housing	1. **Increase housing availability,** including long-term housing stabilization, more permanent supportive housing, and more temporary housing (e.g., shelters).	2 (Housing)
Quality of Care	1. **Implement and disseminate quality control measures**, such as creating a mechanism for reporting dissatisfaction with BHSD services. 2. **Facilitate additional LGBTQ+ training for staff at transitional & temporary housing sites** to address issues of anti-LGBTQ+ prejudice. 3. **Continue current efforts at implementing recovery-oriented approaches**, including recruiting and training staff members who can implement consumer-focused recovery plans	Not listed
Miscell-aneous	1. **Separate Middle Eastern vs. North African on demographic questions.** A primary theme from the Middle Eastern community conversation was a strong recommendation for BHSD to separate out demographics for those who identify as Middle Eastern and those who identify as North African.	Not listed

Note: *"Not listed" means that the area of need is not listed in the description of the current 5 BHSD goals*

	Children, Youth, & Families System of Care Recommendations	BHSD Goal #
Additional Treatment Services	1. **Expand the variety and overall availability of CYF-specific services and treatment**, including sexual assault prevention and intervention and outpatient services. 2. **Reduce stigma among parents by addressing gaps in parental understanding of mental health and substance use**, to facilitate youth access to / engagement in services. 3. **Increase capacity for youth and school substance use-related services and programs** 4. **Continue and expand support to facilitate youth access to Wellness Centers (both school- and non-school-based)**, including after-school hours access in physical centers. 5. **Enhance services for high-need but treatment-declining TAY individuals.** Consider innovative approaches to engagement of TAY at high risk for crisis due to declining treatment, and those in need of conservatorship or assisted outpatient treatment.	3 (Emerging Needs)

Workforce, Education, & Training (WET)	1. **Increase CYF-focused staff**, particularly youth peer support staff and therapists in schools. 2. **Culturally matched CYF staff**. Consumer stakeholders requested hiring staff members who are matched on demographic characteristics like race, ethnicity, LGBTQ+, or other marginalized identities. 3. **Consider essential strategies to retain CYF staff** (i.e., trainings, increasing pay, enhancing workplace environment and benefits)	4 (WET)
Prevention & Outreach	1. **Expand families' knowledge of mental health and substance use through increased community helper trainings and outreach.** 2. **Expand outreach to youth through schools and college campuses.** 3. **Increase capacity for mental health & substance use education and prevention in schools**.	Not listed
Access to Care	1. **Increase options to access care without the Call Center**, particularly by agency-to-agency direct referrals. 2. **Continue to increase youth awareness of BHSD services.**	1 (Timely Access)
	3. **Increase language/translation services in CYF treatment**, particularly in-person and for Spanish and Vietnamese. 4. **Offer CYF clients the practical supports needed to participate in treatment, particularly transportation and childcare.** The latter option may increase parent engagement, and therefore youth access as well.	Not listed
Collaborative & Integrated Care	1. **Facilitate smooth integrated care across all County services**. CYF should consider efforts to increase collaboration between CYF treatment and other County services (e.g., primary care), as well as a single electronic medical record for all County services. **Collaborate with Santa Clara County schools to implement peer referral systems,** so that youth can confidentially refer each other for services.	5 (Integrated Systems / Policy)
Housing	1. **Increase CYF housing availability**, including long-term housing stabilization, more permanent supportive housing, and more temporary housing (e.g., shelters).	2 (Housing)
Quality of Care	1. **Facilitate additional LGBTQ+ training for staff at transitional & temporary housing sites** to address issues of anti-LGBTQ+ prejudice	Not listed

Note: *"Not listed" means that the area of need is not listed in the description of the current 5 BHSD goals*

	Access & Unplanned Services Recommendations	BHSD Goal #
Access to Care	8. **Continue to increase community awareness and accessibility of BHSD services, particularly 988 and the peer navigator**	1 (Timely Access)

	program. Stakeholders identified ease of access through many current County efforts as a strength, while also highlighting a strong need to continue expanding these efforts. 9. **Faster/easier connection to treatment services.** Stakeholders noted the need to decrease the wait for treatment services and decreased barriers to program entry (e.g., decreasing paperwork and making the steps more clear), which is linked to the desire for additional treatment services and the need for additional clinical staff. 10. **Improve call center integrated screening process** to ensure a better fit of referrals with services, based on more thorough information gathering (i.e. on preferences for care (medication, psychotherapy, both), types of symptoms, prior service usage, and other domains that deserve further exploration) 11. **Increase options to access care without the Call Center**, particularly by agency-to-agency direct referrals.	
	12. **Continue language availability at the Call Centers.** 13. **Increase language/translation services in treatment**, particularly in-person and for Spanish, Vietnamese, and Punjabi. 14. **Offer clients the practical supports needed to participate in treatment, particularly transportation and childcare.** The latter option may increase parent engagement, and therefore youth access as well.	Not listed
Prevention & Outreach	4. **Increase community awareness and decrease stigma for mental health and substance use through community helper trainings and outreach**, particularly in-person where diverse communities gather, and through a variety of venues, partners, and community helpers where individuals first find out about services. 5. **Expand ethnic-specific outreach efforts** to address discrimination, low Mental Health & Substance Use awareness, and high stigma among underserved ethnic minority populations, at places where ethnic communities gather and trust. 6. **Expand outreach to youth through schools and college campuses**.	Not listed
Additional Treatment Services	6. **Expand the variety and availability of LGBTQ+ services**, including integrated efforts throughout all other County services, LGBTQ+-specific physical spaces, and TGI+ sanctuary efforts. 7. **Continue and expand crisis care efforts** such as mobile crisis, options that don't involve police accompaniment, and after-hours care. 8. **Enhance services for high-need but treatment-declining individuals**, including innovative engagement of TAY and adults at high risk for crisis due to declining treatment, and those in need of conservatorship or assisted outpatient treatment.	3 (Emerging Needs)

Workforce, Education, & Training (WET)	4. **Culturally matched staff in Access and Unplanned Services**, particularly LGBTQ+, TGI+, Spanish-speaking, and African Ancestry women. 5. **Continue and expand LGBQPA2S+ and TGI+ trainings for staff.** 6. **Increase staff positions and retention by** hiring more clinical staff, retaining staff, increasing staff pay, and including spaces for pronouns on Teams profiles and County forms. 7. **Consider specialized recruitment strategies for LGBTQ+ staff**, such as recruiting from outside the general BHSD applicant pool, adding LGBTQ+ specific interview items, focusing on recruitment of LGBTQ+ bilingual staff, and being flexible with education requirements.	4 (WET)
Collaborative & Integrated Care	1. **Facilitate integrated continuity of care between Access & Unplanned Services with other County services**, by having a unified EHR and improving referrals and trainings with adjunctive service entities like law enforcement and medical services.	5 (Integrated Systems / Policy)

Note: *"Not listed" means that the area of need is not listed in the description of the current 5 BHSD goals*

Workforce, Education, and Training Recommendations	BHSD Goal #
1. **Increase staff positions/hires.** Continue innovative methods of retaining staff members and filling open vacancies, particularly peer support, therapists, case managers, diversion services staff, and youth-focused staff. 2. **Culturally matched staff**. Consumer stakeholders requested hiring staff members who are matched on demographic characteristics like LGBTQ+, marginalized, and racial and ethnic minority identities. 3. **Consider essential strategies to retain staff and enhance the work environment** (i.e., staff benefits, efforts to prevent burnout, and reductions in workload). 4. **More trainings for staff, particularly cultural and LGBTQ+ trainings** (e.g., LGBTQ+, Black and African Ancestry culture, Middle Eastern culture, DEI approaches). 5. **Increase staff pay**, adjusted for Bay Area cost-of-living, particularly for Permanent Supportive Housing staff, paraprofessionals, CBO staff, and psychiatrists. 6. **Consider innovations in the recruitment pipeline** such as increasing intern stipends, working with colleges to educate and recruit graduates, shifting more responsibilities to paraprofessionals, focused efforts for LGBTQ+ staff, and exploring exceptions for individuals applying with credentials from outside the US. 7. **Widely market job openings and provide application support**, to address barriers to obtaining applicants for BHSD positions.	4 (WET)

Community-Level Recommendations
1. Continue and expand current BHSD services to ameliorate untreated mental health need in the community. 2. Increase service access and awareness in the community by providing additional community education and in-person outreach to community organizations and religious/spiritual centers.

	Adult & Older Adult Services Recommendations	BHSD Goal #
Additional Treatment Services	1. **Keep AOA Outpatient Treatment Services Flexible with Expanded Offerings to Meet the Changing Needs of the Community**, including services to reduce isolation, supported employment, services in client's homes, support groups, step-down treatment services after hospitalization, and longer-term treatment. 2. **Expand Criminal Justice Services**, including Reentry services Diversion services, more emphasis on treatment over incarceration, expanded Mental Health & Substance Use services within prisons, and training for AOA providers to service criminal justice clients. 3. **Expand Housing-Related Treatment Services.** For <u>those not currently involved in a BHSD-related housing program, case management</u> during the housing application process was mentioned, and for <u>those currently involved in a BHSD-related housing program</u>, stakeholders suggested additional resources for scattered-site Permanent Supportive Housing staff, psychiatry/therapy at all PSH sites, and Mental Health & Substance Use treatment within temporary/transitional housing sites. 4. **Expand AOA Substance Use Treatment Service (SUTS),** especially dual diagnosis treatment, harm reduction, medical detox capacity, and residential treatment programs. 5. **Increase AOA Capacity for Residential & Inpatient Beds.** 6. **Enhance Services for Immigrants & Refugees** to support acculturation challenges in the immigration and relocation process, services for those without legal status or documentation, LGBTQ+ education, and employment support.	3 (Emerging Needs)
Workforce, Education, & Training (WET)	7. **WET.** AOA should continue, and ideally enhance, efforts to recruit and retain clinical providers who culturally match the communities they serve. *Note: Refer to the WET section for recommendations that may be relevant for the AOA system of care.*	4 (WET)
Collaborative & Integrated Care	8. **Improve AOA's Collaboration With Other Santa Clara County Departments**, particularly medical services and the SCC Office of Supportive Housing. 9. **Enhance AOA's Collaboration and Integration With Other BHSD Programs/Clinics/CBOs**, particularly Diversion	5 (Integrated Systems / Policy)

	services, and between inpatient staff and Permanent Supportive Housing staff when consumers discharge from BHSD hospitals.	
Access to Care	**10. Decrease Barriers to Accessing AOA Services** by improving availability of language/translation services and transportation support. 11. *Note: Please refer to the Access portion of the Access & Unplanned section for a more detailed set of recommendations that may be relevant for the AOA system of care.*	Not listed
	12. **Improve Processes/Procedures for Accessing AOA Services,** including assistance navigating the BHSD system, less paperwork and fewer admission requirements for accessing services, improvements to the Call Center screening too, non-Call Center access options.	1 (Timely Access)
Housing	**13. Increase Housing Availability,** with specific requests for LGBTQ+-specific housing, more flex funds, housing options for those in wheelchairs, and housing options for Criminal Justice consumers	2 (Housing)
Prevention & Outreach	14. **Improve AOA Outreach/Prevention Efforts** to increase psychoeducation and decrease stigma, with suggestions for outreach at religious/spiritual venues.	Not listed
Quality of Care	**15. Ensure Good Quality of Care** with anti-LGBTQ+ discrimination efforts within BHSD housing services and improving quality of care from AOA providers in a variety of settings (e.g., therapists, psychiatrists, orientation to residential programs, planfulness around the 90 days of initial re-entry services).	Not listed

Note: *"Not listed" means that the area of need is not listed in the description of the current 5 BHSD goals*

Housing-Related Recommendations	BHSD Goal #
1. Increase Housing Availability, with specific requests for LGBTQ+-specific housing, more flex funds, housing options for those in wheelchairs, and housing options for Criminal Justice consumers.	2 Housing
2. Expand Housing-Related Treatment Services. For those not currently involved in a BHSD-related housing program, case management during the housing application process was mentioned, and for those currently involved in a BHSD-related housing program, stakeholders suggested additional resources for scattered-site Permanent Supportive Housing staff, psychiatry/therapy at all PSH sites, and Mental Health & Substance Use treatment within temporary/transitional housing sites.	3 Emerging Needs
3. Enhance Collaboration and Integration When Permanent Supportive Housing Consumers are Discharged from Psychiatric Hospitalizations, between hospital staff and PSH staff.	5

4. Improve AOA's Collaboration With Office of Supportive Housing, especially as the collaboration affects PSH staff and programming.	5
5. Improve BHSD-CBO Contract Flexibility for PSH agencies for activities such as burnout prevention, client advocacy, time spent traveling to clients, and Mental Health & Substance Use training.	3 4 Emerging Needs
6. Consider Innovative Ways to Retain Clinical Staff Who Support Housing Programs (i.e., reducing staff productivity requirements, reducing burnout through vicarious trauma support, increasing PSH staff pay for dual skillsets in therapy and housing).	4 WET
7. Increase Unhoused Access to Care Through Potential Options for Direct Agency Referral.	1 Timely Access
8. Quality of Care: Increase the Cultural Safety of LGBTQ+ Housing Programs, by facilitating anti-LGBTQ+ discrimination training for housing staff and ensuring consumers know the proper avenues of reporting anti-LGBTQ+ discrimination.	Not Listed

Note: *"Not listed" means that the area of need is not listed in the description of the current 5 BHSD goals*

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EXECUTIVE SUMMARY: BHSD DEPARTMENT-LEVEL ANALYSIS

Results indicated that the 63.6% of this year's stakeholder comments correspond with, and thus provide feedback and recommendations for, BSHD's 5 main goals. In general, community comments and Department goals were highly correlated for Treatment Services; Workforce, Education, and Training, Enhanced Collaborative & Integrated Care; and the need for more Housing. Specific strengths and areas of need are detailed below.

Strengths of BHSD Services

Feedback from community consumers, families, and other stakeholders indicates that BHSD's **primary strengths** are the county-sponsored clinics, programs, and agencies implementing services, and the high quality of care from BHSD agencies. Additionally, stakeholders often mentioned BHSD efforts related to youth/school services. Community survey responses were largely consistent, noting the top three BHSD accomplishments as: services being helpful to consumers, coordinated care, and patient-focused recovery within BHSD services.

Areas of Need for BHSD Services

At the same, time, feedback from consumers, family members, and other stakeholders also pointed to top recommendations for areas of need within BHSD services. The top-identified need was More Treatment Services (specifically youth services, detox services, and criminal justice services). This finding is consistent with survey results, as the top 3 needs identified by survey respondents were: "there aren't enough services" and "we need different types of services." The second top community stakeholder need was Workforce, Education, and Training (e.g., more clinical staff, culturally-matched staff, reduced staff turnover).

Taken together, the community conversation and survey findings yielded 27 recommendations for the Behavioral Health Services Department, listed below in order of most frequently mentioned community stakeholder-identified needs. A majority (63%) of these recommendations correspond with and thus provide guidance for BHSD as they focus on the department's 5 main goals. Overlap of stakeholder-identified recommendations with the 5 departmental goals is indicated in the first column of the recommendations table.

Additional Treatment Services: Recommendations from Stakeholder-Identified Need #1

Corresponding Department Goal #	Description of Recommendation
3 Emerging Needs	**1. More treatment services for high-need populations**. Stakeholders noted the need for additional services for youth, LGBTQ+ individuals, refugees, immigrants, and women.

3 Emerging Needs	**2. Increase capacity for substance use-related services and programs.** Stakeholders specifically identified a need for additional detox services, dual diagnosis treatment, and youth substance use treatment and prevention.
3 Emerging Needs	**3. Reduce stigma among parents by addressing gaps in parental understanding of mental health and substance use**. BHSD should consider innovative interventions that will reduce parental stigma, which was listed as a primary barrier to youth receiving mental health and substance use services. It may be helpful to consider collaborations with Santa Clara County Office of Education, or individual school districts, in order to implement programming at parent events. Alternatively, this may be an ideal opportunity to incorporate in-person outreach to community events/organizations, especially religious/spiritual organizations, as the Suicide Prevention & Oversight Committee is already well-trained in gatekeeper trainings.
3 Emerging Needs	**4. Continue and expand support to facilitate youth access to Wellness Centers (both school- and non-school-based).** School Wellness Centers were listed consistently as a primary strength, and stakeholders mentioned the importance of BHSD continuing its support in maintaining this resource for youth. Youth consumers also noted the need for additional physical spaces for youth wellness centers, especially after at least one location was shut down during the COVID-19 pandemic. Youth consumers noted the importance of after-school-hours access to resources, general support, and treatment services.
3 Emerging Needs	**5. Expand criminal justice services.** Continue and expand treatment and supports for justice-involved communities, including treatment in jail, re-entry vocational centers, longer-term re-entry services, and family therapy treatment for youth in juvenile prison.
3 Emerging Needs	**6. Continue LGBTQ+ services.** Similar to last year, LGBTQ+ services was listed as a top 5 strength for BHSD.
3 Emerging Needs	**7. Maintain telehealth options while expanding in-person services.** BHSD should consider the continuation of all telehealth options, for the benefit of consumers (especially youth) and employee job satisfaction. Simultaneously, BHSD should consider options to resume and/or increase in-person services as public health conditions allow, such as: ⇒ In-person treatment ⇒ In-person gatekeeper trainings for mental health, substance use, and suicide prevention
3 Emerging Needs	**8. Continue and expand BHSD services for those who are unhoused.** Stakeholders recommended expanding outreach to those who are unhoused, expanding case management to those seeking housing including benefits), and expanding treatment.

Workforce, Education, and Training: Recommendations from Stakeholder-Identified Need #2 (see WET sub-report for more detailed information):

Corresponding Department Goal #	Description of Recommendation
4 WET	1. **Increase staff positions / hires.** Given that the top need across all community conversations was "More Treatment Services," it is recommended that BHSD continue innovative methods of hiring staff members and filling open vacancies, particularly peer support, therapists, case managers, diversion services staff, youth-focused staff.
4 WET	2. **Culturally matched staff**. Consumer stakeholders requested hiring staff members who are matched on demographic characteristics like LGBTQ+, marginalized, and racial and ethnic minority (e.g., Middle Eastern, African immigrant women, Spanish-speaking) identities.
4 WET	3. **Consider essential strategies to retain staff and enhance the work environment**, such as enhancing staff benefits (e.g., childcare, reinstating COVID-19 sick pay, support for further trainings/education), preventing burnout (e.g., vicarious trauma resources, support for permanent supporting staff and anti-LGBTQ+ workplace aggression), and reducing workload (e.g., smaller clinical caseloads, reduced requirements for permanent supportive housing staff).
4 WET	4. **More trainings for staff, particularly cultural and LGBTQ+ trainings.** Suggestions for cultural-focused trainings included: LGBTQ+ psychology, Black culture, Middle Eastern culture, and DEI approaches. Stakeholders also suggested a variety of other topics such as AB1424, trauma-informed care, harm reduction and others.
4 WET	5. **Increase staff pay.** Stakeholders suggested increasing pay for all clinical staff, and ensuring pay is adjusted for Bay Area cost-of-living. Other suggestions for increased compensation focused on: Permanent Supportive Housing staff, paraprofessionals, CBO staff, and psychiatrists.
4 WET	6. **Consider innovations in the recruitment pipeline** such as increasing intern stipends, working with colleges to educate and recruit graduates, shifting more responsibilities to paraprofessionals, focused efforts for LGBTQ+ staff, and exploring exceptions for individuals applying with credentials from outside the US.
4 WET	7. **Widely market job openings and provide application support**, to address barriers to obtaining applicants for BHSD positions. Though 193 survey respondents expressed interest in BHSD employment, mismatching education background, not knowing where to find job openings, and needing application support were listed as top reasons for not applying for BHSD positions.

Access: Recommendations from Stakeholder-Identified Need #3:

Corresponding Department Goal #	Description of Recommendation
1 Timely Access	1. **Continue to increase community awareness and accessibility of BHSD services, particularly 988 and the peer navigator program.** Ease of accessing services (i.e., via 988, mobile clinics/vans) was mentioned as a strength in BHSD services, and 988, drop-in/walk-in services, and the peer navigator program were mentioned as the three easiest to access BHSD services. However, needing even greater awareness, access, and clarity about the process of accessing services were also the top need discussed within the area of Access. It is recommended that BHSD continue their efforts to increase community awareness of its innovative programs facilitating access (e.g., 988, walk-in services and the Peer Navigator Program).
1 Timely Access	2. **Faster/easier connection to treatment services.** Stakeholders noted the need to decrease the wait for treatment services and decreased barriers to program entry (e.g., decreasing paperwork and making the steps more clear), which is linked to the desire for additional treatment services and the need for additional clinical staff.
1 Timely Access	3. **Improve call center integrated screening processes.** While BHSD is actively pursuing timely access to care, a number of stakeholders noted a decline in clinically useful information collected from the Call Center, leading to greater burden on clinics/agencies and consumer frustration when they are routed to a service inconsistent with their needs. It is encouraged that the Call Center ensure a balance between timely care with thorough information gathering. It may be helpful to gather additional information from front-line staff about the specific information they would like to see collected by the Call Center, but initial recommendations included: • Consumer desire for medication, psychotherapy, or both • Types of symptoms: Psychotic symptoms, suicidality, eating disorders, etc. • Prior BHSD service usage: history of hospitalization and other use
1 Timely Access	4. **Increase options to access care without the Call Center.** There was a call to establish a path for accessing BHSD services without calling the Call Centers. Suggestions focused on allowing for agency-to-agency direct referrals.
Not listed	5. **Continue language availability at the Call Centers.** Stakeholders noted the positive impact of language availability at the Call Centers and recommended that BHSD continue this availability.
Not listed	6. **Increase language/translation services.** While stakeholders did mention the improvements in language availability within the Call Centers, they strongly expressed the need for additional language/translation services when actively engaged in treatment. The most common language

	requested was Spanish, followed by Vietnamese and Punjabi. Stakeholders noted the problematic nature of tele-translation services and highly requested on-site, in-person translation.
Not listed	7. **Offer clients the practical supports needed to participate in treatment, particularly transportation and childcare.** Stakeholders discussed that transportation assistance and vouchers would help some individuals access services. In addition, youth and parents both noted a need for childcare assistance as a need for parents to receive treatment. BHSD may want to consider innovative approaches to this childcare as a barrier in order to facilitate parent engagement in BHSD services and, ultimately, to ultimately facilitate youth mental health and substance use treatment.

Prevention & Outreach: Recommendations from Stakeholder-Identified Need #4

Corresponding Department Goal #	Description of Recommendation
Not listed	1. **Increase community awareness and decrease stigma for mental health and substance use through community helper trainings and outreach.** Stakeholders noted a deficit in general community member awareness of mental health and substance use issues. It is recommended that BHSD expand community helper/gatekeeper trainings to cover the diverse needs of the County, particularly in-person where communities gather (e.g., parents, youth, substances, on social media, child abuse, Sikh, Hispanic/Latin/o/a/e, immigrants, at faith-based organizations, etc.). Outreach should occur through the variety of venues, partners, and community helpers that represent where individuals first find out about services (i.e., via providers, word of mouth, 988 or the call center, online, directly through clinics).
Not listed	2. **Expand ethnic-specific outreach efforts.** Stakeholders highlighted the need to address discrimination, low Mental Health & Substance Use awareness, and high stigma among underserved ethnic minority populations (e.g., Middle Eastern, South Asian, immigrants, African American), at places where ethnic communities gather and trust.
Not listed	3. **Expand outreach to youth through schools and college campuses**.

Collaborative & Integrated Care: Recommendations from Stakeholder-Identified Need #5

Corresponding Department Goal #	Description of Recommendation
5 Integrated Systems / Policy	1. **Streamline organizational structures (i.e., referrals, paperwork, data, billing, electronic health records, etc.) to facilitate a unified system between BHSD and external services.** Example external entities included public schools and universities, community emergency

	services, the County's health and hospital system, law enforcement, and primary care. Consider solutions consistent with the functions of a single County-wide EHR to allow for better collaboration between BHSD services and medical/educational services, as well as the need for easier/faster access to PCP services for BHSD consumers.
5 Integrated Systems / Policy	**2. Increase communication and coordination between internal BHSD programs to facilitate smooth transitions, minimize overlaps, and highlight gaps in care for clients.**
5 Integrated Systems / Policy	**3. Collaborate with Santa Clara County schools to implement peer referral systems.** One of the suggestions from youth consumers was to replicate existing school peer referral systems within schools, such that youth can confidentially refer each other for mental health or substance use services and receive care within a few days.

Recommendations from Stakeholder-Identified Need 6: Housing

Corresponding Department Goal #	Description of Recommendation
2 Housing	**1. Increase housing availability,** including long-term housing stabilization, more permanent supportive housing, and more temporary housing (e.g., shelters).

Recommendations for Theme 7: Quality of Services

Corresponding Department Goal #	Description of Recommendation
Not listed	**1. Continue current efforts at implementing recovery-oriented approaches.** BHSD is encouraged to continue current efforts in recruiting and training staff members who can implement consumer-focused recovery plans.
Not listed	**2. Implement and disseminate quality control measures.** The County should consider either (a) creating a mechanism for reporting dissatisfaction with BHSD services, or if such a mechanism already exists (b) enhance the visibility of this mechanism on-site at housing service locations.
Not listed	**3. Facilitate additional LGBTQ+ training for staff at transitional & temporary housing sites.** Data from the community conversations revealed stakeholder dissatisfaction with anti-LGBTQ+ prejudice within BHSD transitional and temporary housing sites. It is highly recommended that BHSD prioritize housing sites for additional LGBTQ+ training.

Miscellaneous Recommendations

Corresponding Department Goal #	Description of Recommendation
Not listed	**1. Middle Eastern vs. North African:** In addition, it is important to note that a primary theme from the Middle Eastern community conversation was a strong recommendation for BHSD to separate out demographics for those who identify as Middle Eastern and those who identify as North African.

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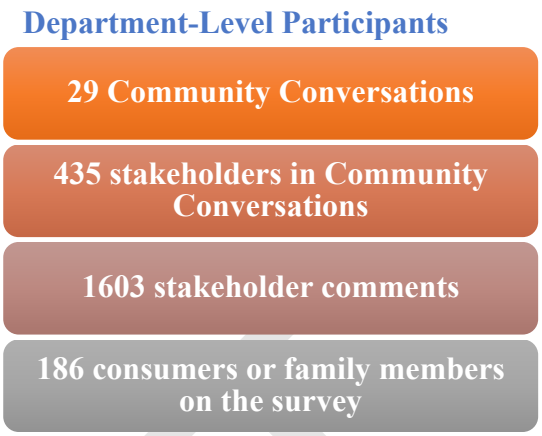
Department-level Consumer Stakeholder Participants

In total, participant data for the Community Planning Process at the department level came from 435 stakeholders who participated in 29 community conversations, yielding 1603 stakeholder comments, combined with 186 consumers or family members on the consumer survey.



Of the 667 total survey respondents, there were 186 respondents who identified as consumers or family members. Of these individuals, 76.3% (n = 142) identified as clients/consumers, and 38.5% (n = 44) identified as family members. Of the 186 consumers, 181 reported their race/ethnicity. The most common racial/ethnic identities were Hispanic/Latino/a/x (30.9%), White (30.1%), and Asian (22.7%). In addition, the most common sexual orientation, gender identity, and city of residence were heterosexual (86%), cisgender women (58%), and residence in the San Jose area (66.1%), respectively.

Within the 1,603 comments from qualitative responses on the survey along with 29 BHSD community conversations hosted from January through March of 2023, 7 primary areas of need arose listed in Department-level Appendix tables alongside the number of comments in each primary area of need. Each primary area of need is listed alongside its secondary themes that clarify community feedback and organize recommendations.

Together, these qualitative and quantitative data from the survey and community conversations informed the Department-level recommendations described in subsequent sections.

Behavioral Health Services Department (BHSD) Strengths

In the community survey, consumers/clients and their family members were asked to identify strengths of the BHSD system from a list of choices; 164 individuals answered. The top strengths (listed below) indicate positive experiences with BHSD services overall. Consumers/family members expressed satisfaction with the helpfulness of BHSD services; they noted appreciation for collaborative care across BHSD agencies/services. Additionally, consumers/family members expressed gratitude for BHSD's focused on consumer-centered recovery. Finally, consumers/family members noted appreciation for services providers who understand their problems and services providers who can engage with their cultural background.

Top 5 BHSD Services Strengths from the Survey

1. Services are helpful
2. My mental health and substance use treatment providers talk to each other and coordinate services with other agencies.
3. Services are focused on patient-centered recovery.
4. Service providers understand my needs.
5. Services are provided by people who understand or share my culture and/or speak my language.

Multiple strengths were also noted by stakeholders during the Community Conversations. The **top strength** noted during these conversations was **county organizations** (e.g., Evans Lane) **and county-sponsored organizations** (e.g., Goodwill, Allcove). The second strength noted across multiple community conversations was **Quality of Care**. Additional strengths included: youth/school services, access, LGBTQ+ services, expanded outpatient treatment, outreach/prevention, criminal justice services, telehealth options, housing services, and workforce, education, and training efforts. See the Appendix for a full list of the strengths mentioned across all community conversations.

Top 5 BHSD Strengths Identified in Community Conversations

1. Service Agencies (both County programs/clinics and CBOs)
2. Quality of Care
3. Youth/School Services
4. Access
5. LGBTQ+ Services

Areas of Need for BHSD Services

Within the community survey, consumers/clients and their family members were asked to identify areas of need for Santa Clara County BHSD from a list of choices. A total of 157 individuals responded to this item on the survey. The top area of need was a call for greater integration in their County services, which matches Theme #5 from the community conversation needs: "More Collaboration & Integrated Care." The second area for need noted by survey respondents was a need for services that are more focused on patient-centered recovery. The third and fourth areas for need was a general desire for additional treatment services, which is consistent with Theme #1 from the community conversations: "Additional Treatment Services." The final area of need noted by consumers/family members on the survey was the need to increase the helpfulness of services and referrals. See the Appendix for a ranked list of areas of need noted by community survey respondents.

Top 5 BHSD Areas of Need

1. Services providers should talk to each other and coordinate services with other agencies.
2. Services should be focused on patient-centered recovery.
3. There aren't enough services.
4. We need different types of services.
5. Services and referrals should be helpful

These data matched themes from the community conversations. Similar to last year's findings, **the top theme across all community conversations was "Additional Treatment Services,"** which was defined as any community stakeholder request for specific therapy services or more availability of therapy services. However, this year, the most common sub-themes were: 1) more youth treatment (e.g., school services, youth substance use prevention), 2) detoxification services, 3) criminal justice services, 4) more residential/inpatient beds, and 5) additional LGBTQ+ services.

Similar to last year's findings, the top theme across all community conversations was **"Additional Treatment Services"**

A WET Need

Consumers identified a need to hire more staff from diverse backgrounds

"A lot of my friends face…the deterioration of their mental health because of their family situation and a lot of factors that contribute to that are… cultural factors")

Similar to last year's community planning process, the **second theme across all community conversations was Workforce, Education, and Training (WET),** which was defined as any community stakeholder comment expressing the need to hire staff generally, to hire staff from a specific discipline, to reduce staff turnover, or to increase staff knowledge/skills on a specific topic. This year's comments were predominantly focused on the need for more clinical staff generally, as well as the need for more peer support, more case managers, and more therapists/counselors.

The remaining prominent themes were: **access (theme 3), prevention/outreach services (theme 4), collaborative/integrated care (theme 5), housing (theme 6),** and **improved quality of care (theme 7)**. See the Appendix for a list of the top themes endorsed across all community conversations. Subthemes and comments from each of these prominent areas of need are described below.

Stakeholder Identified Need #1: More Treatment Services

The #1 mentioned stakeholder need was: *More Treatment Services*, defined as any stakeholder comment which suggested the need to expand the type of BHSD services offered (e.g., parent-focused services) or to expand capacity for current BHSD service offerings (e.g., additional detox beds). Within this category, the primary areas of need were:

Additional Services for Youth

Stakeholders noted the need for additional school services, youth substance use prevention, and youth parent services. Most prominent was a very strong call to address or reduce stigma held by

parents, which may serve as a barrier to youth receiving treatment. Suggestions included: including stigma reduction in required school activities for parents (e.g., orientation events). There was also a call for services to address inter-generational cultural divides within multi-generational homes. It is important to note that youth in prison expressed appreciation for family therapy taking place in prison, and they also requested an expansion of these services.

"The parents are not getting the support, or…the education"

"NAMI came to our school, and did a presentation, and we had a few hundred people…go, and that was really cool"

More Detoxification Services

"Getting ahold of detox… it takes days and by that time we lose the client"

Stakeholders noted a need to increase capacity for social and medical detox services.

More Criminal Justice Services

Stakeholders expressed the need for additional behavioral health treatment within prison (adult and youth). Stakeholders noted a desire to shift the Department's criminal justice treatment approach and adopt an approach in which criminal justice services are available throughout BHSD instead of solely through the Criminal Justice division, with an understanding of the training that this shift would require.

More Residential/Inpatient Beds

Similar to previous assessments, stakeholders noted the need to increase capacity for residential and inpatient beds.

More LGBTQ+ Services

While LGBTQ+ services were consistently listed as a strength, there was also apparent need for more of such services across multiple community conversations, specifically a call for more LGBTQ+-identified staff members, more LGBTQ+-identified counselors to serve the Santa Clara County LGBTQ+ community, and additional resources for providing therapy services within the County's cutting-edge Gender Affirming Clinic.

Treatment for Those who are Unhoused

Stakeholders consistently noted the need for additional treatment for those who are unhoused. Specific suggestions included in-person prevention/outreach and BHSD staff going out into the community to treat unhoused individuals "where they are at."

For additional information on the other areas of need within *More Treatment Services*, see the appendix for the table titled "Stakeholder-Identified Needs from Community Conversations, Aggregate, with Sub-Themes."

Information for the 5 Department Goals: Treatment Services
In considering the Department's Goals, it is notable that, of the 498 stakeholder comments made within this category, 72.7% of them mapped onto the County's Goal #3: Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations, and may provide consumer stakeholder driven information for BHSD as they focus on Goal #3. Those comments which did not map onto Goal #3 were the stakeholder calls for additional services for immigrants and refugees, additional crisis care services, other miscellaneous treatment services.

The following recommendations are made based on stakeholder community conversation feedback and survey data relevant to this stakeholder-identified need of *More Treatment Services*:

Additional Treatment Services: Recommendations from Stakeholder-Identified Need #1

Corresponding Department Goal #	Description of Recommendation
3 Emerging Needs	**1. More treatment services for high-need populations**. Stakeholders noted the need for additional services for youth, LGBTQ+ individuals, refugees, immigrants, and women.
3 Emerging Needs	**2. Increase capacity for substance use-related services and programs.** Stakeholders specifically identified a need for additional detox services, dual diagnosis treatment, and youth substance use treatment and prevention.
3 Emerging Needs	**3. Reduce stigma among parents by addressing gaps in parental understanding of mental health and substance use**. BHSD should consider innovative interventions that will reduce parental stigma, which was listed as a primary barrier to youth receiving mental health and substance use services. It may be helpful to consider collaborations with Santa Clara County Office of Education, or individual school districts, in order to implement programming at parent events. Alternatively, this may be an ideal opportunity to incorporate in-person outreach to community events/organizations, especially religious/spiritual organizations, as the Suicide Prevention & Oversight Committee is already well-trained in gatekeeper trainings.
3 Emerging Needs	**4. Continue and expand support to facilitate youth access to Wellness Centers (both school- and non-school-based).** School Wellness Centers were listed consistently as a primary strength, and stakeholders mentioned the importance of BHSD continuing its support in maintaining this resource for youth. Youth consumers also noted the need for additional physical spaces for youth wellness centers, especially after at least one location was shut down during the COVID-19 pandemic. Youth

	consumers noted the importance of after-school-hours access to resources, general support, and treatment services.
3 Emerging Needs	**5. Expand criminal justice services.** Continue and expand treatment and supports for justice-involved communities, including treatment in jail, re-entry vocational centers, longer-term re-entry services, and family therapy treatment for youth in juvenile prison.
3 Emerging Needs	**6. Continue LGBTQ+ services.** Similar to last year, LGBTQ+ services was listed as a top 5 strength for BHSD.
3 Emerging Needs	**7. Maintain telehealth options while expanding in-person services.** BHSD should consider the continuation of all telehealth options, for the benefit of consumers (especially youth) and employee job satisfaction. Simultaneously, BHSD should consider options to resume and/or increase in-person services as public health conditions allow, such as: i. In-person treatment ii. In-person gatekeeper trainings for mental health, substance use, and suicide prevention
3 Emerging Needs	**8. Continue and expand BHSD services for those who are unhoused.** Stakeholders recommended expanding outreach to those who are unhoused, expanding case management to those seeking housing including benefits), and expanding treatment.

Stakeholder Identified Need #2: Workforce, Education, & Training

WET: Stakeholders requested the following types of additional staff:

1. Peer Support Specialists
2. Therapists/Counselors
3. Case Managers
4. Psychiatrists
5. CIT Staff

The #2 mentioned stakeholder need was: *Workforce, Education, & Training*, defined as any stakeholder comment which suggested the need to increase staff or change anything related to staff (e.g., additional training). Community members were most likely to note the need for more staff generally, but they also mentioned specific professions, listed to the left in order of most-to-least requested.

"Have mental health counselors for public elementary schools"

In addition, stakeholders offered suggestions on factors to consider when recruiting and hiring additional clinical staff, which largely revolved around the community's desire for more staff members who are culturally-matched (e.g., LGBTQ+, Hispanic/Latino/a/e). Community

"You need to recruit people from that [ethnic] community who know this stuff [the culture]"

members also advocated for innovative approaches for reducing staff turnover, additional staff training (e.g., cultural considerations generally, LGBTQ+ considerations, DEI approaches, trauma-informed care, Middle Eastern culture, Black culture, and AB1424 forms), and increased staff pay.

"Not enough practitioners equals far too long between appointments"

For additional information on the other areas of need within *Workforce, Education, & Training*, see the WET sub-report, as well as the appendix for the table titled "Stakeholder-Identified Needs from Community Conversations, Aggregate, with Sub-Themes."

Information for the 5 Department Goals: WET

In considering the Department's Goals, it is notable that 100% of these comments were aligned with BHSD Goal #4: Develop Innovative Solutions to Address Professional Workforce Shortages, and provide information for BHSD as they focus on departmental goal #4.

The following recommendations are made based on stakeholder community conversation feedback and survey data relevant to the #2 most-mentioned stakeholder need, *Workforce, Education, & Training*:

Corresponding Department Goal #	Description of Recommendation
4 WET	1. **Increase staff positions / hires.** Given that the top need across all community conversations was "More Treatment Services," it is recommended that BHSD continue innovative methods of hiring staff members and filling open vacancies, particularly peer support, therapists, case managers, diversion services staff, youth-focused staff.
4 WET	2. **Culturally matched staff**. Consumer stakeholders requested hiring staff members who are matched on demographic characteristics like LGBTQ+, marginalized, and racial and ethnic minority (e.g., Middle Eastern, African immigrant women, Spanish-speaking) identities.
4 WET	3. **Consider essential strategies to retain staff and enhance the work environment**, such as enhancing staff benefits (e.g., childcare, reinstating COVID-19 sick pay, support for further trainings/education), preventing burnout (e.g., vicarious trauma resources, support for permanent supporting staff and anti-LGBTQ+ workplace aggression), and reducing workload (e.g., smaller clinical caseloads, reduced requirements for permanent supportive housing staff).
4 WET	4. **More trainings for staff, particularly cultural and LGBTQ+ trainings.** Suggestions for cultural-focused trainings included: LGBTQ+ psychology, Black culture, Middle Eastern culture, and DEI approaches. Stakeholders also suggested a variety of other topics such as AB1424, trauma-informed care, harm reduction and others.
4 WET	5. **Increase staff pay.** Stakeholders suggested increasing pay for all clinical staff, and ensuring pay is adjusted for Bay Area cost-of-living. Other

	suggestions for increased compensation focused on: Permanent Supportive Housing staff, paraprofessionals, CBO staff, and psychiatrists.
4 WET	**6. Consider innovations in the recruitment pipeline** such as increasing intern stipends, working with colleges to educate and recruit graduates, shifting more responsibilities to paraprofessionals, focused efforts for LGBTQ+ staff, and exploring exceptions for individuals applying with credentials from outside the US.
4 WET	**7. Widely market job openings and provide application support**, to address barriers to obtaining applicants for BHSD positions. Though 193 survey respondents expressed interest in BHSD employment, mismatching education background, not knowing where to find job openings, and needing application support were listed as top reasons for not applying for BHSD positions.

Stakeholder Identified Need #3: Access to Care

The #3 mentioned stakeholder need was: *Access to Care* (235 comments), defined as any stakeholder comment about the need to increase the ease of accessing BHSD services, improve current access services (e.g., Call Center), or decrease barriers to accessing care. Access to care also appeared in the top 5 BHSD service strengths identified in community conversations, and the survey data identified the following relative strengths: the Suicide and Crisis Hotline, Adult services, and 988 were the services that consumers were most aware of, and services such as 988, the suicide and crisis hotline, the peer navigator program older adult services, and LGBTQ+ services were easiest to access.

All 667 community survey respondents were asked whether they knew where to access mental health and substance use services, and if they knew who to call for mental health and substance use services. On average, community members stated it was mostly true (2.9) that they know where to go to get mental health and substance use services. They also reported that it was, on average, mostly true (3.0) that they knew who to call to get mental health and substance use services.

However, Access to Care was the third most frequently mentioned area of need, and stakeholders mentioned specific areas in need of continued improvement. For example, stakeholders noted that a major barrier to community members accessing services is a general lack of awareness of BHSD services within Santa Clara County. In other words, community members noted that BHSD services seem incredibly helpful but that they don't know how to refer friends and family without knowledge of what BHSD offers and that the first step must be community awareness of the options they could potentially access. Example stakeholder quotes included those listed on the right.

> "The community needs to know where to get these services… how do they even know that the services exist?"
>
> "…total lack of knowledge of what's available"
>
> "From the County, if you can provide a resource cheat sheet that would be great that we can share with kids as well."

Stakeholders also identified a need for more language/translation services. Stakeholders specifically identified language needs in Spanish (e.g., treatment services in Spanish, BHSD forms in Spanish, and Spanish-speaking resources in South County), Vietnamese, Punjabi, and other languages listed in the Appendix. See example stakeholder quotes below:

> "There's 17% of Vietnamese community in Santa Clara County and we have a million and a half people in the county, and we don't have a person in custody to communicate with those client(s)…"
>
> "Let's say I am a new Punjabi to the country. Our feeling is if I call the 988 number, I don't know who is going to answer and if I can understand them and if they can help me out. So, if there is an option for Punjabi language option on the 988…"
>
> "If the clients cannot talk for themselves because of language barrier or the County does not have the right staff with the right language skill to help them. We are not helping our clients…"

Stakeholders discussed a need for easier/faster access to treatment services, including: increasing stakeholder awareness of access processes/procedures, decreasing the wait for starting treatment services, and general comments to "make it easier to access services."

Stakeholders also wanting to see improvements to the Call Center wait times, processes, and the integrated screening process (i.e., to make referrals a better fit with the needs of the client). For example, there were calls to reduce the wait for people calling into the Call Center. The integrated screening process comments acknowledged the balance between call center time lengths versus clinical data collection and noted that recent shifts at the Call Center seem to prioritize timeliness over thorough data collection, with specific recommendations to collect information on suicidality, psychotic symptoms, previous County service engagement, and the consumer's desire for psychotherapy, medications, or both.

"I think that too much emphasis is being made on timely as opposed to correct access. The evaluation of the call center is of the most important to me. I'm shocked by some of the referrals that we received..."

"…call center screenings...asking some very specific questions about psychosis level, about level of acuity. Just a running list and asking them, Do you want meds, or do you want therapy?"

Other areas of need identified in the Access to Care area included more practical supports for transportation and child care to allow parents and other clients to attend services. For example, stakeholders noted their inability to access BHSD services due to the logistics of travel within Santa Clara County. Stakeholders also emphasized wanting to have the option of more direct agency-to-agency referrals that don't involve the Call Center.

For additional information on the other areas of need within *Access to Care*, see the appendix for the table titled "Stakeholder-Identified Needs from Community Conversations, Aggregate, with Sub-Themes."

Information for the 5 Department Goals: Timely Access to Care

In considering the Department's Goals, 38% of these comments mapped onto BHSD Goal #1: Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services. Of not, stakeholder comments predominantly focused on increasing community awareness of services they can access and decreasing barriers to accessing care, while the County Goal #5 is focused on timely and efficient access to care. Comments and suggestions on timely access to care provide information for BHSD when focusing on department goal #1.

The following recommendations are made based on stakeholder community conversation feedback and survey data relevant to the #3 most-mentioned stakeholder need, *Access to Care*:

Access: Recommendations from Stakeholder-Identified Need #3:

Corresponding Department Goal #	Description of Recommendation
1 Timely Access	**1. Continue to increase community awareness and accessibility of BHSD services, particularly 988 and the peer navigator program.** Ease of accessing services (i.e., via 988, mobile clinics/vans) was mentioned as a strength in BHSD services, and 988 and the peer navigator program were mentioned as among the easiest to access BHSD services. However, needing even greater awareness, access, and clarity about the process of accessing services were also the top need discussed within the area of Access. It is recommended that BHSD continue their efforts to increase community awareness of its innovative programs facilitating access (e.g., 988 and the Peer Navigator Program).
1 Timely Access	**2. Faster / easier connection to treatment services.** Stakeholders noted the need to decrease the wait for treatment services and decreased barriers to program entry (e.g., decreasing paperwork and making the steps more clear), which is linked to the desire for additional treatment services and the need for additional clinical staff.
1 Timely Access	**3. Improve call center integrated screening processes.** While BHSD is actively pursuing timely access to care, a number of stakeholders noted a decline in clinically useful information collected from the Call Center, leading to greater burden on clinics/agencies and consumer frustration when they are routed to a service inconsistent with their needs. It is encouraged that the Call Center ensure a balance between timely care with thorough information gathering. It may be helpful to gather additional information from front-line staff about the specific information they would like to see collected by the Call Center, but initial recommendations included: • Consumer desire for medication, psychotherapy, or both • Types of symptoms: Psychotic symptoms, suicidality, eating disorders, etc. • Prior BHSD service usage: history of hospitalization and other use
1 Timely Access	**4. Increase options to access care without the Call Center.** There was a call to establish a path for accessing BHSD services without calling the Call Centers. Suggestions focused on allowing for agency-to-agency direct referrals.
Not listed	**5. Continue language availability at the Call Centers.** Stakeholders noted the positive impact of language availability at the Call Centers and recommended that BHSD continue this availability.
Not listed	**6. Increase language/translation services.** While stakeholders did mention the improvements in language availability within the Call Centers, they strongly expressed the need for additional language/translation services

	when actively engaged in treatment. The most common language requested was Spanish, followed by Vietnamese and Punjabi. Stakeholders noted the problematic nature of tele-translation services and highly requested on-site, in-person translation.
Not listed	7. **Offer clients the practical supports needed to participate in treatment, particularly transportation and childcare.** Stakeholders discussed that transportation assistance and vouchers would help some individuals access services. In addition, youth and parents both noted a need for childcare assistance as a need for parents to receive treatment. BHSD may want to consider innovative approaches to this childcare as a barrier in order to facilitate parent engagement in BHSD services and, ultimately, to ultimately facilitate youth mental health and substance use treatment.

Stakeholder Identified Need #4: More Prevention/Outreach Services

Community members who responded to the survey (n = 667) were asked about their satisfaction with BHSD outreach and prevention services. This survey item was answered by 382 individuals; on average, respondents stated that it was mostly true (M = 2.5) that they were satisfied with BHSD outreach and prevention services.

186 consumers/clients/family members on the survey were asked about their experiences with outreach efforts related to mental health and substance use services. When asked about how they initially learned of BHSD services (participants were asked to choose all that apply), 153 individuals responded; the most common responses were *From a Provider* (n = 57, 37.3%), *Word of Mouth* (n = 39, 25.5%), and *Call Center or Access Line* (n = 36, 23.5%); see chart below for full results. Results showed that consumers find out about services from a wide variety of sources, and point to the importance of outreach to a variety of venues, partners, and community helpers.

How did you initially find out about mental health and substance use services?	
From a Provider	37.3% (n = 57)
Word of Mouth	25.5% (n = 39)
Call Center or Access Line	23.5% (n = 36)
The Internet	19.6% (n = 30)
Walk-In	11.8% (n = 18)
Called the Clinic	10.5% (n = 16)
988	2.6% (n = 4)

Consistent with providers being the most commonly reported source of outreach and education about BHSD services, 143 individuals stated that it was "mostly true" (2.99) that County staff/providers talked with them about resources/services that might help them.

In community conversations, **Outreach and Prevention were the second most commonly identified need (179 comments),** defined as any stakeholder related to the BHSD's current

outreach and prevention services, as well as any comment about communities in need of for targeted outreach/prevention. Within this category, the primary areas for need were:

- General stakeholder requests for prevention/outreach
- Reduce community mental health stigma
- More school-based outreach
- More ethnic-specific outreach

"more education on what mental health is … many of us in our culture… we don't even know what mental health is"

"Do they ever do commercials? Like commercials where we could see black folk getting services where they can see that it's okay... that would be nice to see…"

"You'd have to approach the priests [or other religious leaders] first, they could bring up [mental health]…"

Specifically, stakeholders noted a primary need to decrease community stigma, specifically in parents, youth, and immigrants; stakeholders recommended that BHSD coordinate with religious/spiritual leaders/organizations to facilitate this change. Stakeholders also noted the need to increase general community awareness of mental health and substance use, with a number of participants stating that many people in Santa Clara County have limited knowledge on these topics.

Example consumer stakeholder quotes within this area of need included the following:

"Training a little bit more people in the community on how to support [those with Mental Health & Substance Use problems]"

"Informational campaigns are needed for emerging drugs like fentanyl and xylazine"

Stakeholders suggested enhanced ethnic-specific outreach/prevention, such as anti-discrimination trainings in schools and other County venues, outreach and TV commercials to reach African American communities, and additional resources (e.g., CCWP team, wellness center) for the Middle Eastern community; see appendix for additional suggestions.

"…when I was in high school in the county I didn't know that there was a county…I didn't understand that there was something out there that could do something to help…And I think a lot of high school students don't.. it would be great for them."

"I have used [college counseling services], and it's a wonderful service. … I feel like a lot of [the college counselors], they're not aware of additional services that the county can offer. So I was never redirected elsewhere for any of the… other services outside of just what [college counseling] offered…"

Community members noted the need for additional outreach to public schools (e.g., primary and secondary schools) as well as local colleges (e.g., college campuses generally as well as the college campus counseling clinics). Additional comments spoke to the need to train community members to recognize symptoms and refer to BHSD (e.g., Mental Health First Aid, Be Sensitive, Be Brave), as well as the need to outreach to those who are unhoused, include more events in BHSD outreach services, enhance substance use prevention, and facilitate outreach to religious/spiritual organizations.

Information for the 5 Department Goals: Prevention and Outreach
In considering the Department's Goals, 1.9% of these stakeholder comments directly mapped onto BHSD Goal #3: Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations.

The following recommendations are made based on stakeholder community conversation feedback and survey data relevant to the #4 most-mentioned stakeholder need, *More Prevention/Outreach Services*:

Prevention & Outreach: Recommendations from Stakeholder-Identified Need #4

Corresponding Department Goal #	Description of Recommendation
Not listed	**1. Increase community awareness and decrease stigma for mental health and substance use through community helper trainings and outreach.** Stakeholders noted a deficit in general community member awareness of mental health and substance use issues. It is recommended that BHSD expand community helper/gatekeeper trainings to cover the diverse needs of the County, particularly in-person where communities gather (e.g., parents, youth, substances, on social media, child abuse, Sikh, Hispanic/Latin/o/a/e, immigrants, at faith-based organizations, etc.). Outreach should occur through the variety of venues, partners, and community helpers that represent where individuals first find out about services (i.e., via providers, word of mouth, 988 or the call center, online, directly through clinics).
Not listed	**2. Expand ethnic-specific outreach efforts.** Stakeholders highlighted the need to address discrimination, low Mental Health & Substance Use awareness, and high stigma among underserved ethnic minority populations (e.g., Middle Eastern, South Asian, immigrants, African American), at places where ethnic communities gather and trust.
Not listed	**3. Expand outreach to youth through schools and college campuses**.

Stakeholder Identified Need #5: Improve Collaborative & Integrated Care

"Every organization seems like we're doing our own thing, communication is missing… the people who fall off are [consumers]"

Communication and coordination of services between providers was mentioned by survey respondents as both a strength ("My mental health and substance use treatment providers talk to each other and coordinate services with other agencies" was the second ranked strength), and an area of need ("Services providers should talk to each other and coordinate services with other agencies" was the top ranked area of need). These results may underscore the importance of the issue of integrated and coordinated services to consumers and family members.

Indeed, the #5 most frequently mentioned stakeholder need in community conversations was: *Improve Collaborative & Integrated Care*, defined as any stakeholder comment about the need to enhance collaborative/Integrated care within BHSD services and any comment about the need to enhance collaborative/Integrated care between BHSD and other County departments (e.g., education, medical care).

"Very little communication between BH Urgent Care with our CBOs to make a smoother transition process for urgent care clients accessing psychiatry services in CBOs"

Specifically, stakeholders noted the need for Integrated/collaborative care (a) between BHSD and other County services (e.g., Office of Housing, Office of Education), (b) within BHSD agencies/departments, and (c) between BHSD and non-County agencies (e.g., Kaiser).

"...collaboration with school wellness centers … it's unclear what [their] role will be as schools increase their own BH staff."

Regarding (a) BHSD-County integration/collaboration, stakeholders noted the need for a single County-wide EHR which would allow for better collaboration between BHSD services and medical/educational services, as well as the need for easier/faster access to PCP services for BHSD consumers. A majority of these comments focused on the need to better collaborate with SCC public schools and universities. Stakeholders also pointed to a need to streamline organizational structures (i.e., referrals, paperwork, data, billing, electronic health records, etc.) to facilitate a unified system between BHSD and external services.

Regarding (a) within-BHSD integration/ collaboration, stakeholders noted the need for increased communication and coordination between internal BHSD programs to facilitate smooth transitions, minimize overlaps, and highlight gaps in care for clients. They also discussed the need for a single electronic health record (EHR) that would allow providers to see the entirety of a consumer's records and current treatment services.

"I absolutely hate psyching myself up for phone calls with long hold times, so I never reached out to the partner agency. It's also incredibly exhausting to explain my mental health history, giving enough detail but not so much that it's unhelpful to them. It would be wonderful if I could've dropped in the one time to get everything started, and then had every other service contact me directly to set up what I needed."

"…having 2 data sources is really [a] challenge and 2 audits and double documentation and double billing is really challenging... So our staff are doing double the work, but they're required to have the same amount of productivity, and that's all because of the way the contracts [are] written…"

Regarding (c) BHSD-non-County integration/collaboration, stakeholders noted the need for greater collaboration with SCC entities such as Kaiser and Stanford.

For additional information on the other areas of need within *Improve Collaborative & Integrated Care*, see the appendix for the table titled "Stakeholder-Identified Needs from Community Conversations, Aggregate, with Sub-Themes."

Information for the 5 Department Goals: Improve Collaborative & Integrated Care
In considering the Department's Goals, it is notable that 100% of these comments were congruent with BHSD Goal #5: Adapt to and Help Shape the Rapidly Shifting State Policy Landscape.

The following recommendations are made based on stakeholder community conversation feedback and survey data relevant to the #5 most-mentioned stakeholder need, *Improve Collaborative & Integrated Care*:

Collaborative & Integrated Care: Recommendations from Stakeholder-Identified Need #5

Corresponding Department Goal #	Description of Recommendation
5 Integrated Systems / Policy	4. **Streamline organizational structures (i.e., referrals, paperwork, data, billing, electronic health records, etc.) to facilitate a unified system between BHSD and external services.** Example external entities included public schools and universities, community emergency services, the County's health and hospital system, law enforcement, and primary care. Consider solutions consistent with the functions of a single

	County-wide EHR to allow for better collaboration between BHSD services and medical/educational services, as well as the need for easier/faster access to PCP services for BHSD consumers.
5 Integrated Systems / Policy	**5. Increase communication and coordination between internal BHSD programs to facilitate smooth transitions, minimize overlaps, and highlight gaps in care for clients.**
5 Integrated Systems / Policy	**6. Collaborate with Santa Clara County schools to implement peer referral systems.** One of the suggestions from youth consumers was to replicate existing school peer referral systems within schools, such that youth can confidentially refer each other for mental health or substance use services and receive care within a few days.

Stakeholder Identified Need #6: More Housing

The #6 most frequently mentioned stakeholder need was: *More Housing*, defined as any comment related to the need for additional housing spots or availability. Importantly, this category does not include comments related to treatment for those who are unhoused or outreach to those who are unhoused; those comments are captured under *More Treatment Services*. In general, community stakeholders spoke generally of the need for additional housing, more shelters, more permanent supportive housing, and more transitional housing.

"Especially with the families, too… single mom with two kids…if you don't' call every day you lose your spot [on the list]"

"The permanent housing and waiting list is ridiculous… a year long"

"A lot of our youth are homeless and don't have a place to stay"

For additional information on the other areas of need within *More Housing*, see the appendix for the table titled "Stakeholder-Identified Needs from Community Conversations, Aggregate, with Sub-Themes."

Information for the 5 Department Goals: Housing
In considering the Department's Goals, it is notable that 100% of stakeholder housing comments were in line with BHSD Goal #2: Increase the Availability of Treatment Beds, Permanent Housing, and Temporary Shelter.

The following recommendations are made based on stakeholder community conversation feedback and survey data relevant to the #6 most-mentioned stakeholder need, *More Housing*:

Recommendations from Stakeholder-Identified Need 6: Housing

Corresponding Department Goal #	Description of Recommendation
2 Housing	**2. Increase housing availability,** including long-term housing stabilization, more permanent supportive housing, and more temporary housing (e.g., shelters).

Stakeholder Identified Need #7: Improve Quality of BHSD Services

The #7 most frequently mentioned stakeholder need was: *Improve the Quality of BHSD Services*, defined as any comment about the need to remediate or promote high-quality care from BHSD. This theme was marked comments indicating the need to improve the quality of clinical care provided by staff members, increase kindness in BHSD staff, and adopt a person-first approach in all interactions. It is important to note that the proportion of comments in this category reduced from 7.2% of comments in 2022, down to 3.7% of stakeholder comments in 2023.

"It's hit or miss on the quality of [providers]"

About half of these comments came from open-ended responses to the survey and seem to refer to specific incidents of poor care (e.g., therapist missing therapy sessions, providers "forcing" them to take medications instead of engage in therapy, etc.). Because these comments came from written survey responses, there was no opportunity for follow-up to gather additional detail or context; as such, it is not clear if these comments represent a string of isolated incidents or a broader pattern in BHSD care.

The other half of these comments came from community conversations in which stakeholders spoke of anti-LGBTQ+ discrimination in BHSD-funded housing sites (6 comments), as well as staff members who seemed largely disengaged and not fully invested in the work. These comments support a call for better monitoring at housing sites and for more interventions to decrease staff burnout.

"Some of the 988 people are not… the 988 person wasn't willing to help us with resources, they just totally shut us down"

"Better and more clear reporting structure when there are instances of bias that occur… making it very clear what the steps to reporting are…"

For additional information on the other areas of need within *Improve the Quality of BHSD Services*, see the appendix for the table titled "Stakeholder-Identified Needs from Community Conversations, Aggregate, with Sub-Themes."

Information for the 5 Department Goals: Improve Quality of BHSD Services
No comments from this theme mapped onto the Department's five (5) Goals.

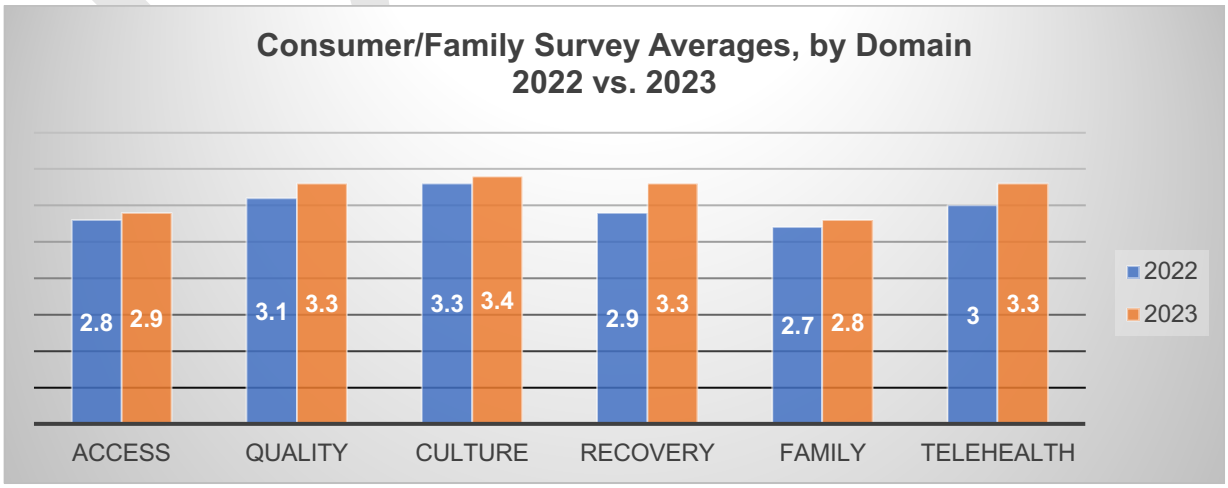
The following recommendations are made based on stakeholder community conversation feedback and survey data relevant to the #7 most-mentioned stakeholder need, *Improve the Quality of BHSD Services*:

Recommendations for Theme 7: Quality of Services

Corresponding Department Goal #	Description of Recommendation
Not listed	1. **Continue current efforts at implementing recovery-oriented approaches.** BHSD is encouraged to continue current efforts in recruiting and training staff members who can implement consumer-focused recovery plans.
Not listed	2. **Implement and disseminate quality control measures.** The County should consider either (a) creating a mechanism for reporting dissatisfaction with BHSD services, or if such a mechanism already exists (b) enhance the visibility of this mechanism on-site at housing service locations.
Not listed	3. **Facilitate additional LGBTQ+ training for staff at transitional & temporary housing sites.** Data from the community conversations revealed stakeholder dissatisfaction with anti-LGBTQ+ prejudice within BHSD transitional and temporary housing sites. It is highly recommended that BHSD prioritize housing sites for additional LGBTQ+ training.

Department-Level Scores and Changes in MHSA-Related Survey Domains

There was remarkable stability on the 6 MHSA-related survey domains from 2022 to 2023. Seen in the chart below, there was no change in interpretation year-by-year. Specifically, all survey domains fell in the "moderately satisfied" range for 2022 and 2023. Below, there is a detailed description of this year's six MHSA-related survey domains.



Consumer/Client/Family Survey Data, Quality of Care

Consumers/clients/family members responded to four (4) questions about the quality of BHSD services; these questions assessed consumer-provider communication, feeling safe and respected, their BHSD team's professionalism, and general satisfaction with BHSD services. Overall, responses to these items were very stable from last year, with no notable changes. **Specifically, consumers/clients and their family members reported being satisfied (M = 3.3, s.d. = 0.9) with their BHSD service quality of care, on average.**

When analyzed by the specific item averages, consumers/family respondents stated that it was mostly true (3.3) that their provider creates a safe and respectful space. They noted that it was mostly true (3.3) that they have good communication with their provider. Consumer/family respondents reported that it was mostly true (3.4) that their BHSD team acts professionally. They indicated that it was mostly true (3.1) that they are satisfied with their BHSD services.

Consumer/Client/Family Survey Data, Access to Care

In contrast to general community members, consumers/clients/family members reported that they mostly knew how to access services, though were neutral in their response about how hard it was to get service connected (see Appendix for Access to Care item scores for consumers). For example, on average, consumers/clients/family members stated that it was mostly true (2.8) that they know where to go to receive services. They reported that it was mostly true (2.9) that they know who to call to receive services. Consumers/clients/family members noted that it was mostly true (3.0) that providers informed them about resources/services that might help them. They reported that it was not very hard (2.8) to get connected to their BHSD provider. They also stated that it was mostly true (3.1) that their BHSD team provides care when they need it. **Overall, on average, consumers/clients and their family members reported being satisfied (M = 2.9, s.d., = .7) with their ability to access BHSD services.**

When asked how many weeks they had to wait before starting treatment, answers ranged from 0 to 52 weeks, with an average of 4.5 weeks (median = 3 weeks). The most common response to this item was 1 week (n = 25). Of note, 48.5% of consumers/family members reported waiting less than 2 weeks to get connected (last year: 55.4%), and 73.8% reported waiting 4 weeks or less (last year: 77.2%). Note that there were three responses considered to be outliers, which are not calculated in the number above.

48.5% of consumers waited 2 weeks or less for treatment. The most common wait was 1 month

129 out 186 consumers/family members responded to an item asking how they were connected to their mental health or substance use provider. People were able to select multiple answers. The three most common methods by which consumers were connected to their providers are listed below. Notably, "internet" was not in the top four most common methods last year, so it may help BHSD to consider that this method is becoming more common.

3 most common methods by which consumers were connected to their providers

1. By referral from other providers (44.2%)
2. By word of mouth (30.2%)
3. Internet (23.3%)

Consumer/Client/Family Survey Data, Family Inclusion

Consumers/clients/family members responded to three (3) questions about the incorporation of family into their BHSD services; these questions assessed the extent to which they were given the option to include their family, the extent to which BHSD providers helped family to better understand the consumer, and the extent to which family members supported their recovery. **Overall, consumers/clients and their family members reported being satisfied (M = 2.8, s.d. = 1.0) with the inclusion of family as part of their BHSD services, on average.**

When analyzed by the specific item averages, BHSD consumers/clients/family members stated that it was mostly true (2.9) that they were given the option to include their family members. They noted that it was a little bit true (2.4) that BHSD services helped their families better understand them. They also reported that it was mostly true (3.0) that their family members support their recovery.

Consumer/Client/Family Survey Data, Telehealth

One hundred forty two (142) consumers/clients stated that they received telehealth services within the last year. The most common number of telehealth sessions was 7-11 (45.8%). See table below for full results.

Number of Telehealth Sessions Within the Last Year	N = 142
1-3	36 (25.4%)
4-6	17 (12.0%)
7-11	13 (9.2%)
12-19	11 (7.7%)
20+	12 (8.5%)

These telehealth consumers/clients responded to three questions about the quality of their BHSD telehealth services; these questions assessed telehealth comfort, telehealth provider satisfaction, and technology/internet access challenges. **Overall, consumers/clients and their family members reported being satisfied (M = 3.3, s.d. = 0.6) with BHSD telehealth services, on average.**

When analyzed by the specific item averages, BHSD telehealth consumers/clients stated that it was mostly true (3.0) that they were satisfied with the care they received via telehealth. They also reported that they had very few challenges (3.1) accessing telehealth due to technology/internet challenges. These individuals also strongly agreed (3.6) that the County should continue offering telehealth as a treatment option.

Consumer/Client/Family Survey Data, Recovery Orientation

Consumers/clients/family members responded to two (2) questions about the incorporation of recovery principles in their BHSD services; these questions assessed consumer perception of having choices/options in their services, and consumer perception that services are focused on their goals/needs. **In summary, consumers/clients and their family members reported being satisfied (M = 3.3, s.d. = 0.8) with the recovery orientation of their BHSD services, on average.**

When analyzed by the specific item averages, consumers/family respondents stated that it was mostly true (3.3) that they have choices and options in their care. They noted that it was mostly true (3.3) that their BHSD services are focused on their individual goals and needs.

Consumer/Client/Family Survey Data, Cultural Considerations

Consumers/clients/family members responded to three (3) questions about ways in which their BHSD services were culturally appropriate; these questions assessed the perception of feeling understood culturally, the perception that their identities were respected, and the availability of services in their language. Overall, responses to these items were very stable from last year, with no notable changes. **In summary, consumers/clients and their family members reported being satisfied (M = 3.4, s.d. = 0.7) with BHSD provision of culturally considerate services, on average.**

When analyzed by the specific item averages, BHSD consumers/client/family members stated that it was mostly true (3.2) that their provider understood their culture. They noted that it was mostly true (3.4) that they their providers respected their cultural identities. They also reported that it was very true (3.7) that BHSD provided services in their language.

EXECUTIVE SUMMARY

Based on community stakeholder feedback, a **core strength** of CYF services included current outreach and prevention efforts, especially the Downtown San Jose Youth Wellness Center and the School Wellness Centers. Additional core strengths included: general satisfaction with CYF services and satisfaction with expanded CYF-specific outpatient services. These strengths, along with areas of need identified by consumer stakeholders in the community survey and community conversations, yielded the following recommendations.

CYF System of Care Recommendations *(mapped onto Department-level Goals)*

The below recommendations should be implemented within the larger context of the department-level recommendations from the BHSD department-level analysis of the current report. Many of the 5 BHSD priorities were mirrored or called out in the CYF-focused data. These corresponding BHSD priorities have been noted below, with the addition and integration of CYF-related comments / data.

CYF Additional Treatment Services: Recommendations from Stakeholder-Identified Need #3

Corresponding Department Goal #	Description of Recommendation
3 Emerging Needs	**9. Expand the variety and overall availability of CYF-specific services and treatment**, including sexual assault prevention and intervention and outpatient services (e.g., Early childhood services, Strengthening Family workshops, TAY services, family therapy for juveniles in jail, and family system approaches to care).
3 Emerging Needs	**10. Reduce stigma among parents by addressing gaps in parental understanding of mental health and substance use**. BHSD should consider innovative interventions that will reduce parental stigma, which was listed as a primary barrier to youth receiving mental health and substance use services. It may be helpful to consider collaborations with Santa Clara County Office of Education, or individual school districts, in order to implement programming at parent events. Alternatively, this may be an ideal opportunity to incorporate in-person outreach to community events/organizations, especially religious/spiritual organizations, as the Suicide Prevention & Oversight Committee is already well-trained in gatekeeper trainings.
3 Emerging Needs	**11. Increase capacity for youth and school substance use-related services and programs.** Stakeholders specifically identified a need for additional dual diagnosis treatment for youth and detox services.

3 Emerging Needs	**12. Continue and expand support to facilitate youth access to Wellness Centers (both school- and non-school-based).** School Wellness Centers were listed consistently as a primary strength, and stakeholders mentioned the importance of BHSD continuing its support in maintaining this resource for youth. Youth consumers also noted the need for additional physical spaces for youth wellness centers, especially after at least one location was shut down during the COVID-19 pandemic. Youth consumers noted the importance of after-school-hours access to resources, general support, and treatment services.
3 Emerging Needs	**13. Enhance services for high-need but treatment-declining TAY individuals.** Stakeholders called for the innovative engagement of TAY at high risk for crisis due to declining treatment, and those in need of conservatorship or assisted outpatient treatment.

CYF Workforce, Education, and Training: Recommendations from Stakeholder-Identified Need #2:

Corresponding Department Goal #	Description of Recommendation
4 WET	**8. Increase CYF-focused staff.** CYF stakeholders noted the need for additional clinical staff. There was a specific call for additional youth peer support staff and more therapists in schools.
4 WET	**9. Culturally matched CYF staff**. Consumer stakeholders requested hiring staff members who are matched on demographic characteristics like race, ethnicity, LGBTQ+, or other marginalized identities.
4 WET	**10. Consider essential strategies to retain CYF staff** (i.e., trainings, increasing pay, enhancing workplace environment and benefits)

CYF Prevention & Outreach: Recommendations from Stakeholder-Identified Need #3

Corresponding Department Goal #	Description of Recommendation
Not listed	**1. Expand families' knowledge of mental health and substance use through increased community helper trainings and outreach.** Stakeholders noted a deficit in stigma and awareness of mental health and substance use issues, and a need for education of families.
Not listed	**2. Expand outreach to youth through schools and college campuses**.
Not listed	**3. Increase capacity for mental health & substance use education and prevention in schools**.

CYF Access: Recommendations from Stakeholder-Identified Need #4:

Corresponding Department Goal #	Description of Recommendation
1 Timely Access	**1. Increase options to access care without the Call Center.** There was a call to establish a path for accessing BHSD services without calling the Call Centers. Suggestions focused on allowing for agency-to-agency direct referrals.
Not listed	**2. Increase CYF language/translation services.** CYF stakeholders expressed the need for additional language/translation services when actively engaged in treatment. The most common languages requested were Spanish and Vietnamese. Stakeholders noted the problematic nature of tele-translation services and highly requested on-site, in-person translation.
1 Timely Access	**3. Continue to increase youth awareness of BHSD services.** Stakeholders noted that many SCC youth are unaware of BHSD services and the ways that they might benefit.
Not listed	**4. Offer CYF clients the practical supports needed to participate in treatment, particularly transportation and childcare.** Stakeholders discussed that transportation assistance and vouchers would help some individuals access services. In addition, youth and parents both noted a need for childcare assistance as a need for parents to receive treatment. BHSD may want to consider innovative approaches to this childcare as a barrier in order to facilitate parent engagement in BHSD services and, ultimately, to ultimately facilitate youth mental health and substance use treatment.

CYF Collaborative & Integrative Care: Recommendations from Stakeholder-Identified Need #5

Corresponding Department Goal #	Description of Recommendation
5 Integrated Systems / Policy	**2. Facilitate smooth integrated care across all County services**. CYF should consider efforts to increase collaboration between CYF treatment and other County services (e.g., primary care), as well as a single electronic medical record for all County services.
5 Integrated Systems / Policy	**3. Collaborate with Santa Clara County schools to implement peer referral systems.** One of the suggestions from youth consumers was to replicate existing school peer referral systems within schools, such that youth can confidentially refer each other for mental health or substance use services and receive care within a few days.

CYF Housing: Recommendations from Stakeholder-Identified Need #6

Corresponding Department Goal #	Description of Recommendation
2 Housing	**3. Increase housing availability.** CYF consumers noted the need for long-term housing stabilization, more permanent supportive housing, and more temporary housing (e.g., shelters).

CYF Quality of Care: Recommendations from Stakeholder-Identified Need #7

Corresponding Department Goal #	Description of Recommendation
Not listed	**1. Create a more LGBTQ+ affirming environment in temporary/transitional housing sites.** CYF stakeholders commented on the need for decreased incidents and improved reporting processes for anti-LGBTQ+ discrimination events at BHSD temporary/transitional housing sites.

NAVIGATION MENU OF EXECUTIVE SUMMARIES *(click to navigate to page)*

Overall Executive Summary of Recommendations (page 19)

Executive Summary: BHSD Department-Level Analysis (page 29)

Children, Youth, and Family (CYF) Services (page 58)

Access & Unplanned Services (page 70)

Workforce, Education, & Training (page 84)

Adults & Older Adult (AOA) Services (page 91)

Housing-Related Analyses (page 107)

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CYF System of Care Consumer Stakeholder Participants

In total, participant data for the Community Planning Process from the Children, Family, and Youth Services (CYF) system of care came from 95 stakeholders who participated in 9 community conversations, yielding 441 stakeholder comments, combined with 25 consumers or family members on the consumer survey.

CYF-Level Participants

- **9 Community Conversations**
- **95 stakeholders in Community Conversations**
- **441 stakeholder comments**
- **25 consumers or family members on the survey**

Of the 25 total survey respondents, 52% (n = 13) identified as clients/consumers and 48% (n = 12) identified as family members. These survey participants reported receiving services from the following programs (some may have endorsed more than one service): 15 from Mental Health & Substance Use Services for Children, Youth, and Families, 7 from Mental Health & Substance Use Services for Transitional Age Youth (TAY), 5 from LGBTQ+ Services and Programs, and 5 from Criminal Justice Services. The survey consumers/family who received Children, Family, and Youth Services (CYF) were 45.4% Hispanic/Latino/a/e, 33.3% White, 20.1% Asian, and 16.7% Black. With regards to gender identity, 70% identified as cisgender women and 30% as cisgender men/boys. They were primarily adults/family members aged 25-59 (64%), with 24% ages 16-24 and 12% ages 60+. 81% identified as heterosexual, and 19% identified as lesbian, gay, bisexual, queer, asexual, pansexual, and two-spirit (LGBQAP2S+). Primary city of residence was San Jose (80%; n=20).

Community conversations and qualitative responses on the survey were coded for 441 comments related to Children, Youth, and Family services from two combined sources: the 9 CYF focused community conversations (95 stakeholders spanning 5 youth-focused groups, 2 youth criminal justice focused groups, 1 family-focused group, and one CYF provider group), as well as any family and youth-related comments from all non-CYF focused community conversations. Within these 441 comments, 7 primary areas of need arose listed in CYF Appendix tables alongside the number of comments in each primary area of need. Each primary area of need is listed alongside its secondary themes that clarify community feedback and organize recommendations.

Together, these qualitative and quantitative data from the survey and community conversations informed the CYF System of Care recommendations described in subsequent sections.

CYF System of Care Strengths

Top 2 CYF strengths identified in community conversations:
Student Wellness centers & high quality of treatment services

The greatest CYF system of care strengths identified by stakeholders were: the student wellness centers, the quality of BHSD services, therapy options (e.g., early childhood services, Strengthening Families workshops, TAY services, family systems services), and BHSD services in juvenile prison.

CYF: Greater Number and Variety of Treatment Services

The greatest stakeholder need identified in CYF community conversations was the **need for a greater number and variety of treatment services** (185 comments). For example, stakeholders pointed to the need for additional school services to address youth's concerns about parents accessing their therapy records, or to expand sexual assault prevention services. Others discussed wanting more peer-training, to assist in referring friends who are in need of services.

Highest CYF need from community conversations: Greater number & variety of treatment services
(particularly school services, substance use prevention and treatment, parent education, support for attaining benefits, and more treatment options)

"[NAMI] came over to our school and did a presentation… that was really cool"

"There's a lot of hesitancy on our school campus because of the confidentiality fear that it's going to get reported back to them [parents]"

"A mental referral form where we can refer yourself or your friends"

Several comments also highlighted the need to attend to youth grappling with substance use issues as part of their behavioral health journey. For example, youth stakeholders also pointed to a need for **more substance use prevention, education and treatment.** They called for efforts such as more mental health education that addresses substance use and treatment that aims to prevent the development of substance use problems. Stakeholders also called for more youth substance use treatment services, including more dual diagnosis treatment for youth and more detox services.

"It's really important to address how substance abuse and mental health, they're interconnected… they're very much related… and so I feel like in general, the broad umbrella of substance use can be used as an unhealthy coping mechanism"

"let's talk about being well… being happy and feeling better without using…"

"When the [immigrant] youth arrive here, there's a lot of assimilation acculturation that can actually increase the substance use…"

Another major concern mentioned within the need for additional treatment services was wanting greater psychoeducation for parents on mental health and substance use issues, to address the reluctance and stigma amongst parents that can serve as a barrier to youth service access.

"making sure parents [in a setting] where they're going to pay attention, they can actually know what mental health services are"

"I feel like having services online can help because if there's a lot of parent stigma…"

CYF stakeholders noted the need to establish pre-crisis services for individuals with serious mental illness who tend to decline treatment. Specifically, stakeholders noted the need for innovative efforts to engage TAY-aged adults who are unable to recognize the need for mental health.

"…my son is 20 even when he was younger it was still hard to get him treatment if he didn't want it, they would say No, if he doesn't want to. There's nothing we can do about it, and that's frustrating being a mother and going through this this process…we just

Stakeholders noted a pattern of concerned family members reaching out to the County for help with 18-22-year-olds who often live in the home with deteriorating mental health presentations without support from the County due to the consumer declining treatment. While legal considerations should be considered, this need presents an opportunity for BHSD to innovatively meet the needs of these individuals (e.g., a specific outreach program, specific family support materials, specific family coaching, a method of expedited access if the consumer verbally accepts treatment at any point).

"When I call these emergency crisis lines for mental health, they always tell me she has to be in manic mode in order for us to come out. Manic mode, what when she kills me or kills herself or somebody else…why does it have to be so severe for them to come out? Why can't somebody have mental health issues and somebody that loves them call up and [they] do an evaluation on my friend?"

Most other comments related to additional services included wanting more therapy (telehealth, longer-term options), residential/inpatient beds, support attaining benefits, and immigration- and refugee support for youth and transitional-aged youth. Additional detail can be found in the CYF Appendix Table describing comments on CYF areas of need.

CYF: Workforce, Education, and Training

The **second most commonly identified need (62 comments)** was *Workforce, Education, and Training*. Specifically, CYF consumers/family members called for **more peer and clinical staff**, including more youth peer support, therapists in schools, and clinical staff focused on youth in general. Stakeholders suggested recruiting from college students to address any workforce shortages.

"[Youth] probably need, the younger minds, to kind of understand what they need and provide help" - a parent consumer

"The counselor we have is shared with another school, and they're not licensed… [we need to] make sure that a lot of services that are offered in schools are verified" - a TAY participant

Comments also illuminated the importance of addressing **culture and diversity in staffing needs**. For example, stakeholders asked for more staff who represent marginalized identities (e.g., LGBTQ+-

identified clinical staff, other marginalized identities, Middle Eastern staff). They mentioned that because cultural factors play an important role in youth's experience of behavioral health issues, there is a need for culturally-attuned and culturally-matched staff to address these needs.

"Specialized recruitment… a lot of times these positions get filled just by the County hiring system… so outdated… and these are the folx who have lived experience, expertise, supporting LGBQ+ folx…"

"The limit in diversity in regards to who you can consult to... is a big issue, one of the problems that a lot of my friends face is ... the deterioration of their mental health because of their family situation and a lot of the factors that contribute are because of cultural factors…" – a TAY participant

Stakeholders identified several essential strategies needed to increase the number of peer and clinical staff available to youth, including **reducing staff turnover, increasing staff pay, and providing trainings for staff** (e.g., on LGBTQ+ issues, training for counselors, on cultural and Middle Eastern issues). Specific strategies to reduce staff turnover included reinstating COVID-19 sick pay policies, needing a space for pronouns on all County documents (i.e., to create an inclusive work environment), providing tuition assistance, and addressing burnout.

CYF: Outreach and Prevention Services

The **third most commonly identified CYF need (38 comments)** was *Outreach & Prevention* services. A major theme was the need to reduce mental health and substance use stigma in the community, particularly by providing more psychoeducation in schools and increasing access to mental health and substance use information. Youth particularly discussed wanting to **educate and decrease stigma among parents**, in order to address the concern that parents' lack of knowledge about behavioral health and its services serve as a barrier to youth service access. Specific topics and/or strategies for education included: vaping prevention, integrating activities into education efforts to increase engagement, and ethnic specific outreach)

"Just more on outreach specifically because … I'm coming to school at [a university] in Santa Clara County, and… I just haven't heard about these services…"

"putting funding into marketing and promoting such resources to students would be great"

"when it comes to mental health, at least like my parents specifically, they're not very receptive"

"there are a lot of [youth] who say 'Oh I don't need it, yeah, it's bad, but I don't need that… for them, it seems like a hassle…'"

"different activities that they can do… because I remember at times youth are like we wanna go bowling, we wanna go here…"

Other suggestions for meeting the need for prevention outreach focused on **increasing college students' awareness of BHSD services**, through more presence on and partnership with college campuses, counseling centers, or professors. Finally, a few stakeholders pointed to the need to include younger students in these outreach efforts:

"[We need] prevention for the middle schools, for the elementary schools, for the kids to know these topics"

CYF: Access to Care

"being able to take direct referrals and not have to go through the county, I think, could really help with access" – CYF provider

The **fourth most commonly identified CYF need (29 comments)** was *Access to Care*. Specifically, consumers/family members noted the need for **greater access to care without using the Call Center**; they mentioned ideas such as being able to make referrals without Call Center involvement (including for unhoused individuals), enhanced walk-in options, and the need for agencies to be able to refer directly to each other.

"We are wanting to help my nephew who is 20 years old, he is using drugs. And his mom…has found places outside of Santa Clara County where they are helping her, where they are willing to help her. But not this in this county. You only have the option to talk to Gateway. So, you want to talk to a rehab center? You call. You want to sign up? No. You know what? You have to call this Gateway, you have to be referred."

Language and translation needs were also highlighted as an access to care issue, with stakeholders specifically mentioning the need for in-person translation services as services in Spanish and Vietnamese.

"…Improvement to language services… families often have to wait, or maybe check for another place to go because those services are… not the same as having a person in the room speaking the same language…"

Stakeholders also noted **transportation and childcare services** as significant barriers to accessing BHSD services, and suggested providing more support for these practical needs.

"Many parents cannot receive services... because they don't have any means or resources for childcare…"

CYF: Collaboration and Integrative Care

The **fifth most commonly identified CYF need (20 comments)** was *collaboration and integrative care*, especially regarding collaboration between BHSD and other County services. Specifically, CYF consumers/family members clearly expressed a need for greater collaboration

with medical/PCP services and the need for a single EMR to facilitate integrative care across County services.

> "You have to wait 30 days so they can find a primary doctor…"
> "30 days and that's if it runs smoothly"
> "And even after 30 days the wait to see a doctor is 3 months…"

CYF: Housing

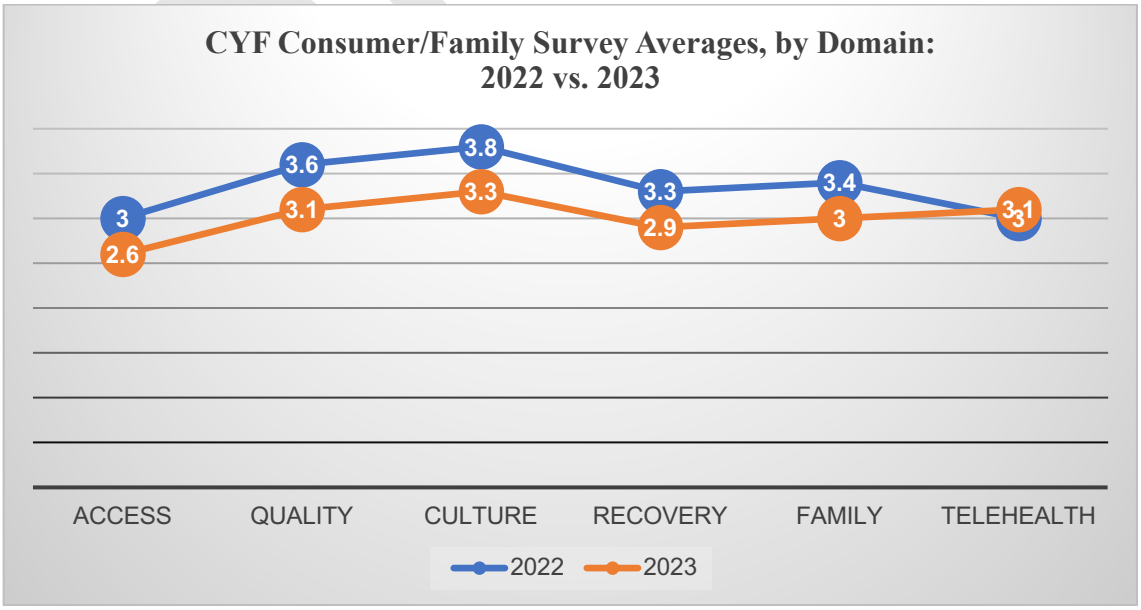
The **sixth most commonly identified CYF need (15 comments)** was *housing*, which largely consisted of calls for additional housing for families (i.e., more housing in general, as well as temporary and permanent supportive housing). Speaking to the difficulties accessing available housing, on stakeholder shared: "especially with the families too… single mom with two kids… you don't call every day, you lose your spot").

CYF: Improved Quality of Care

The **final identified CYF need (8 comments)** was *improved quality of care*, which generally consisted of a need for reporting anti-LGBTQ+ discrimination by housing center staff ("even in [LGBTQ+-specific] housing, there's been complaints… and that's just unacceptable").

CYF Scores and Changes in MHSA-Related Survey Domains

CYF survey domain averages are listed in the Appendix. CYF clients/consumers/family members were generally satisfied within each survey domain: Access to Care, Quality of Care, Recovery, Cultural Considerations, Family Inclusion, and Telehealth. Compared to last year's survey findings (see Chart below), this year's results indicate a mild decrease in satisfaction. Specifically, both Quality of Care and Cultural Considerations were rated as "very satisfied" last year (3.6 and 3.8, respectively); this year, they are rated as "mostly satisfied" (3.1 and 3.3, respectively).



Full data from each Community Conversation (themes, sub-themes, frequencies) are available in the Appendix. The paragraphs below provide summaries of each community conversation.

Youth Group #1 (n = 7)

Four strengths were mentioned, all based on CYF-focused community organizations: CYF CBOs providing low-cost care, psychiatry services, and services of good quality. In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need for increased telehealth options for youth services (e.g., "Online services should probably be more accessible because I feel like they're not"), as well as a need to increase family psychoeducation ("it would be having more conversations or having more ads or more things online that talk about how mental health is important"). The **second identified need** was *Workforce, Education, and Training;* youth noted a need for: more licensed therapists for youth and more youth counselors on school campuses ("I know that the counselor that we have is shared with another school, and they're also not licensed…") . Additionally, youth noted the need to reduce stigma in youth via mental health substance use education in schools ("I'm not sure if it's entirely rooted in stigma, but there are a lot of people who are like 'Oh, I don't need it … yeah [my mental health] is bad, but I don't need that.'" For further information, see the community conversation data table in the Appendix.

Youth Group #2, LGBTQ+ (n=3)

Three strengths were mentioned: telehealth options, community-based organizations (e.g., Q Corner, Youth Space), and the MHSA community planning process). In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*, with stakeholders noting the need for services to reduce isolation, more dual diagnosis treatment, and more LGBTQ+ services. The **second identified need** was *Housing*, specifically more stable housing options in the community. For further information, see the community conversation data Table in the Appendix.

Youth Group #3 (n=14)

Four strengths were mentioned: easy access to BHSD, Goodwill, in-house school therapist quality, school Wellness centers, easy access to BHSD services, community-based organizations (e.g., Goodwill). In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*, with stakeholders noting the need for increased youth substance use prevention, the need, and a better system of limiting parental access to youth therapy discussion content, and increased sexual education in schools to prevent sexual assault. The **second identified need** was *Workforce, Education, and Training*, specifically the need for additional culturally-matched staff (e.g., more staff from marginalized backgrounds, more LGBTQ+-identified staff). For further information, see the community conversation data Table in the Appendix.

Youth Group #4, University Students (n=12)

Two strengths were mentioned: county-based organizations (AACI, Rebekah's Children's Services) and the expanded outpatient services ("one [thing] in particular that I think that definitely should stay the same are the outpatient treatment services"). In terms of current needs/changes, the **primary identified need** during this conversation was *Outreach & Prevention*, with stakeholders noting the need to increase college student awareness of BHSD services, to increase college

counseling centers' awareness of BHS services, and to outreach to the unhoused college students living in their cars on campus. The **second identified need** was *Workforce, Education, and Training*, specifically more therapists in school settings. This suggestion was paired with a recommendation for a better bridge to BHSD services for college students who need additional care beyond college counseling. For further information, see the community conversation data Table in the Appendix.

Youth Men Involved in Juvenile Justice (n = 9)

Two strengths were mentioned: quality of Mental Health & Substance Use treatment in juvenile jail and family-focused therapy options for juveniles in jail. In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*, with stakeholders noting the need to expand the Mental Health & Substance Use treatment services in prison ("maybe more behavioral health…"). The **second identified need** was *Workforce, Education, and Training*, specifically more therapists in juvenile jail settings ("they have full caseloads sometimes, or they have to see a lot of people during the day"). For further information, see the community conversation data Table in the Appendix.

Youth Women Involved in Juvenile Justice (n = 2)

No strengths were mentioned. The only **identified suggestion** was to stop requiring juveniles to complete Mental Health & Substance Use treatment in jail. For further information, see the community conversation data Table in the Appendix.

Family Members, General (n = 10)

Nine strengths were identified: telehealth options, the Behavioral Health Navigator Program, mobile crisis teams, criminal justice services, 988, police intervention in mental health crisis situations, MH treatment court, and the new behavioral health center being built. In terms of current needs/changes, the **primary identified need** during this conversation was *Family & Youth*; specifically, stakeholders noted the need to include families in treatment (e.g., when police release someone after a mental health-related problem, need to train staff on how to include the family). Within this theme, they also noted the need for a program aimed at young legal adults (e.g., 18-26) who are in acute need of treatment but decline services. Stakeholders also discussed the need for additional inpatient/residential beds, dual diagnosis care, and greater use of injectables to treat psychosis. For further information, see the community conversation data table in the Appendix.

Providers: Children, Youth, and Family Services (n = 32)

The **two identified strengths** were telehealth services and county-based LGBTQ+ organizations. In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; the specific needs were LGBTQ+ youth services (specifically TGI+ youth), youth eating disorder treatment, and services for neurodivergent youth. The **second identified need** was *Workforce, Education, and Training (WET)*, specifically the need to hire more clinical staff and increase clinical staff trainings on social media and substance use (e.g., motivational interviewing, harm reduction). Additionally, stakeholders noted the need for more family services/therapy, more school services, and better access for the underinsured. For further information, see the community conversation data table in the Appendix.

EXECUTIVE SUMMARY

Based on community stakeholder feedback, a **core strength** of Access & Unplanned services included current access processes/procedures (e.g., 988, mobile mental health trucks/vans, and services offered at locations/times that are convenient). Additional core strengths included LGBTQ+ services, outreach & prevention, and specific crisis services (specifically the Mobile Crisis Teams). These strengths, along with areas for growth identified by consumers in the community survey and community conversations, yielded the following recommendations.

Access & Unplanned Services: System of Care Recommendations *(mapped onto BHSD Goals)*

The below recommendations should be implemented within the larger context of the department-level recommendations from the BHSD department-level analysis of the current report. Several specific department-level priorities were mirrored or called out in the Access & Unplanned-focused data. These department-level priorities have been inserted below, with the addition and integration of Access & Unplanned-related comments / data. Together, they constitute 17 Access & Unplanned System of Care recommendations:

Access: Recommendations from Stakeholder-Identified Need #1:

Corresponding Department Goal #	Description of Recommendation
1 Timely Access	**8. Continue to increase community awareness and accessibility of BHSD services, particularly 988 and the peer navigator program.** Ease of accessing services (i.e., via 988, mobile clinics/vans) was mentioned as a strength in BHSD services, and 988 and the peer navigator program were mentioned as among the easiest to access BHSD services. However, needing even greater awareness, access, and clarity about the process of accessing services were also the top need discussed within the area of Access. It is recommended that BHSD continue their efforts to increase community awareness of its innovative programs facilitating access (e.g., 988 and the Peer Navigator Program).
1 Timely Access	**9. Faster / easier connection to treatment services.** Stakeholders noted the need to decrease the wait for treatment services and decreased barriers to program entry (e.g., decreasing paperwork and making the steps more clear), which is linked to the desire for additional treatment services and the need for additional clinical staff.
1 Timely Access	**10. Improve call center integrated screening processes.** While BHSD is actively pursuing timely access to care, a number of stakeholders noted a decline in clinically useful information collected from the Call Center, leading to greater burden on clinics/agencies and consumer frustration when they are routed to a service inconsistent with their needs. It is

	encouraged that the Call Center ensure a balance between timely care with thorough information gathering. It may be helpful to gather additional information from front-line staff about the specific information they would like to see collected by the Call Center, but initial recommendations included: • Consumer desire for medication, psychotherapy, or both • Types of symptoms: Psychotic symptoms, suicidality, eating disorders, etc. • Prior BHSD service usage: history of hospitalization and other use
1 Timely Access	**11. Increase options to access care without the Call Center.** There was a call to establish a path for accessing BHSD services without calling the Call Centers. Suggestions focused on allowing for agency-to-agency direct referrals.
Not listed	**12. Continue language availability at the Call Centers.** Stakeholders noted the positive impact of language availability at the Call Centers and recommended that BHSD continue this availability.
Not listed	**13. Increase language/translation services.** While stakeholders did mention the improvements in language availability within the Call Centers, they strongly expressed the need for additional language/translation services when actively engaged in treatment. The most common language requested was Spanish, followed by Vietnamese and Punjabi. Stakeholders noted the problematic nature of tele-translation services and highly requested on-site, in-person translation.
Not listed	**14. Offer clients the practical supports needed to participate in treatment, particularly transportation and childcare.** Stakeholders discussed that transportation assistance and vouchers would help some individuals access services. In addition, youth and parents both noted a need for childcare assistance as a need for parents to receive treatment. BHSD may want to consider innovative approaches to this childcare as a barrier in order to facilitate parent engagement in BHSD services and, ultimately, to ultimately facilitate youth mental health and substance use treatment.

Prevention and Outreach: Recommendations from Stakeholder-Identified Need #2:

Corresponding Department Goal #	Description of Recommendation
Not listed	**14. Increase community awareness and decrease stigma for mental health and substance use through community helper trainings and outreach.** Stakeholders noted a deficit in general community member awareness of mental health and substance use issues. It is recommended that BHSD expand community helper/gatekeeper trainings to cover the diverse needs of the County, particularly in-person where communities

	gather (e.g., parents, youth, substances, on social media, child abuse, Sikh, Hispanic/Latin/o/a/e, immigrants, at faith-based organizations, etc.). Outreach should occur through the variety of venues, partners, and community helpers that represent where individuals first find out about services (i.e., via providers, word of mouth, 988 or the call center, online, directly through clinics).
Not listed	**15. Expand ethnic-specific outreach efforts.** Stakeholders highlighted the need to address discrimination, low Mental Health & Substance Use awareness, and high stigma among underserved ethnic minority populations (e.g., Middle Eastern, South Asian, immigrants, African American), at places where ethnic communities gather and trust.
Not listed	**16. Expand outreach to youth through schools and college campuses**.

Additional Treatment Services: Recommendations from Stakeholder-Identified Need #3

Corresponding Department Goal #	Description of Recommendation
3 Emerging Needs	**1. Expand the variety and availability of LGBTQ+ services.** Stakeholders noted the need to expand LGBTQ+ programs that are integrated throughout all other County services (e.g., to reach LGBTQ+ individuals who are older adults, bilingual, in South County, Hispanic/Latin/o/a/e, have substance use needs, etc.). Stakeholders also called for more LGBTQ+-specific physical spaces, and TGI+ sanctuary efforts that are also integrated throughout the County (e.g., legal settings, TGI+-led organizations, residential aftercare post gender affirmation care, SOGI data collection)
3 Emerging Needs	**2. Continue and expand crisis care efforts** such as mobile crisis, options that don't involve police accompaniment, and after-hours care.
3 Emerging Needs	**3. Enhance services for high-need but treatment-declining individuals.** Stakeholders called for the innovative engagement of TAY and adults at high risk for crisis due to declining treatment, and those in need of conservatorship or assisted outpatient treatment.

Workforce, Education, and Training: Recommendations from Stakeholder-Identified Need #4

Corresponding Department Goal #	Description of Recommendation
4 WET	**1. Culturally matched staff in Access and Unplanned Services**. Consumer stakeholders requested hiring staff members who are matched on demographic characteristics, particularly LGBTQ+, TGI+, Spanish-speaking, and African Ancestry women.

4 WET	**2. Continue and expand LGBQPA2S+ and TGI+ trainings for staff.**
4 WET	**3. Increase staff positions and retention by** hiring more clinical staff, retaining staff, increasing staff pay, and including spaces for pronouns on Teams profiles and County forms.
4 WET	**4. Consider specialized recruitment strategies for LGBTQ+ staff**, such as recruiting from outside the general BHSD applicant pool, adding LGBTQ+ specific interview items, focusing on recruitment of LGBTQ+ bilingual staff, and being flexible with education requirements.

Collaborative & Integrative Care: Recommendations from Stakeholder-Identified Need #5

5 Integrated Systems / Policy	**9. Facilitate integrated continuity of care between Access & Unplanned Services with other County services**, by having a unified EHR and improving referrals and trainings with adjunctive service entities like law enforcement and medical services.

NAVIGATION MENU OF EXECUTIVE SUMMARIES *(click to navigate to page)*

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Executive Summary: BHSD Department-Level Analysis (page 29)

Children, Youth, and Family (CYF) Services (page 58)

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Workforce, Education, & Training (page 84)

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Access & Unplanned Services: Consumer Stakeholder Participants

In total, participant data for the Community Planning Process from the Access and Unplanned Services system of care came from stakeholders across all of the 29 community conversations, yielding 577 stakeholder comments, combined with 90 consumers or family members on the survey.

AUP-Level Participants

577 stakeholder comments

90 consumers or family members on the survey

Of the 90 total Access & Unplanned Services survey respondents, 80% (n = 72) identified as clients/consumers and 20% (n = 18) identified as family members. See the table below for the specific programs with which respondents identified.

Access & Unplanned Services Survey Respondents, by Program	n
Behavioral Health Call Center Access Line	19
988	15
EPS	13
Drop-in or Walk-in service options	11
Mental Health Urgent Care	10
Suicide/Crisis Hotline	9
Mobile Crisis Response Team	7
Substance Use Services Access Line	5
LGBTQ+ Services	4
Children's Mobile Crisis Response Team (Pacific Clinics)	3
Crisis Text Line	3
Peer Navigator Program	3

The survey consumers/family who received Access & Unplanned Services were 42.7% Hispanic/Latino/a/e; 42.7% White; 18.3% Asian; 12.2% Black; 12.2% Native American, American Indian, Alaskan Native; and 2.4% Middle Eastern / North African. With regards to gender identity, 61.5% identified as cisgender women, 29.2% as cisgender men/boys, and 9.2% TGI+. They were primarily adults/family members aged 25-59 (80%), with 12.2% ages 60+, and 7.8% ages 16-24. 84% identified as heterosexual, and 69% identified as lesbian, gay, bisexual, queer, asexual, pansexual, and two-spirit (LGBQPA2S+). Primary city of residence was San Jose (64%; n = 57). 90% reported that they have been stably housed over the past 12 months, and 10% (n = 9) reported that they were not stably housed over the past year.

Community conversations and qualitative survey responses were coded and yielded 577 comments related to Access & Unplanned Services. All 29 community conversations were coded to identify stakeholder comments related to access and unplanned services. Within these 577 comments, 5 primary areas of need arose listed in Access and Unplanned Services Appendix tables alongside the number of comments in each primary area of need. Each primary area of need is listed alongside its secondary themes that clarify community feedback and organize recommendations.

Together, these qualitative and quantitative data from the survey and community conversations informed the Access & Unplanned Services System of Care recommendations described in subsequent sections.

Access & Unplanned services System of Care: Strengths

The top Access & Unplanned Services strength identified in community conversations: Helpful processes/services for facilitating access to BHSD services

Based on community stakeholder feedback, a **core strength** of Access & Unplanned services included current access processes/procedures (e.g., 988, mobile mental health trucks/vans, and services offered at locations/times that are convenient. Additional core strengths included LGBTQ+ services, outreach & prevention, and specific crisis services (specifically the Mobile Crisis Teams).

ACCESS & UNPLANNED SERVICES: Areas of Need

Access & Unplanned Services: Access

The most frequently mentioned stakeholder need in Access and Unplanned Services comments was Access to Care (235 comments), defined as any stakeholder comment about the need to increase the ease of accessing BHSD services, improve current access services (e.g., Call Center), or decrease barriers to accessing care. Access to care also appeared in the top 5 BHSD service strengths identified in community conversations, and the survey data identified the following relative strengths: the Suicide and Crisis Hotline, Adult services, and 988 were the services that consumers were most aware of, and services such as 988, the suicide and crisis hotline, the peer navigator program older adult services, and LGBTQ+ services were easiest to access.

All 667 community survey respondents were asked whether they knew where to access mental health and substance use services, and if they knew who to call for mental health and substance use services. On average, community members stated it was mostly true (2.9) that they know where to go to get mental health and substance use services. They also reported that it was, on average, mostly true (3.0) that they knew who to call to get mental health and substance use services.

However, stakeholders mentioned specific areas in need of continued improvement. For example, stakeholders noted that a major barrier to community members accessing services is a general lack of awareness of BHSD services within Santa Clara County. In other words, community members noted that BHSD services seem incredibly helpful but that they

"The community needs to know where to get these services… how do they even know that the services exist?"

"…total lack of knowledge of what's available"

"From the County, if you can provide a resource cheat sheet that would be great that we can share with kids as well."

don’t know how to refer friends and family without knowledge of what BHSD offers and that the first step must be community awareness of the options they could potentially access. Example stakeholder quotes included those listed above.

Stakeholders also identified a need for more language/translation services. Stakeholders specifically identified language needs in Spanish (e.g., treatment services in Spanish, BHSD forms in Spanish, and Spanish-speaking resources in South County), Vietnamese, Punjabi, and other languages listed in the Appendix. See example stakeholder quotes below:

> “There's 17% of Vietnamese community in Santa Clara County and we have a million and a half people in the county, and we don't have a person in custody to communicate with those client(s)…"
>
> "Let’s say I am a new Punjabi to the country. Our feeling is if I call the 988 number, I don’t know who is going to answer and if I can understand them and if they can help me out. So, if there is an option for Punjabi language option on the 988…"
>
> "If the clients cannot talk for themselves because of language barrier or the County does not have the right staff with the right language skill to help them. We are not helping our clients…"

Stakeholders discussed a need for easier/faster access to treatment services, including: increasing stakeholder awareness of access processes/procedures, decreasing the wait for starting treatment services, and general comments to “make it easier to access services.”

Stakeholders also wanting to see improvements to the Call Center wait times, processes, and the integrated screening process (i.e., to make referrals a better fit with the needs of the client). For example, there were calls to reduce the wait for people calling into the Call Center. The integrated screening process comments acknowledged the balance between call center time lengths versus clinical data collection and noted that recent shifts at the Call Center seem to prioritize timeliness over thorough data collection, with specific recommendations to collect information on suicidality, psychotic symptoms, previous County service engagement, and the consumer’s desire for psychotherapy, medications, or both.

> “I think that too much emphasis is being made on timely as opposed to correct access. The evaluation of the call center is of the most important to me. I'm shocked by some of the referrals that we received..."
>
> “…call center screenings...asking some very specific questions about psychosis level, about level of acuity. Just a running list and asking them, Do you want meds, or do you want therapy?”

Other areas of need identified in the Access to Care area included more practical supports for transportation and child care to allow parents and other clients to attend services. For example, stakeholders noted their inability to access BHSD services due to the logistics of travel within Santa Clara County. Stakeholders also emphasized wanting to have the option of more direct agency-to-agency referrals that don't involve the Call Center.

For additional information on the other areas of need within *Access to Care*, see the appendix for the table titled "Stakeholder-Identified Needs from Community Conversations, Aggregate, with Sub-Themes."

Access & Unplanned Services: Outreach & Prevention

Community members who responded to the survey (n = 667) were asked about their satisfaction with BHSD outreach and prevention services. 382 individuals answered this survey item; on average they stated that it was mostly true (M = 2.5) that they were satisfied with BHSD outreach and prevention services.

186 consumers/clients/family members on the survey were asked about their experiences with outreach efforts related to mental health and substance use services. When asked about how they initially learned of BHSD services (participants were asked to choose all that apply), 153 individuals responded; the most common responses were *From a Provider* (n = 57, 37.3%), *Word of Mouth* (n = 39, 25.5%), and *Call Center or Access Line* (n = 36, 23.5%); see chart below for full results. Results showed that consumers find out about services from a wide variety of sources, and point to the importance of outreach to a variety of venues, partners, and community helpers.

How did you initially find out about mental health and substance use services?	
From a Provider	37.3% (n = 57)
Word of Mouth	25.5% (n = 39)
Call Center or Access Line	23.5% (n = 36)
The Internet	19.6% (n = 30)
Walk-In	11.8% (n = 18)
Called the Clinic	10.5% (n = 16)
988	2.6% (n = 4)

Consistent with providers being the most commonly reported source of outreach and education about BHSD services, 143 individuals stated that it was "mostly true" (2.99) that County staff/providers talked with them about resources/services that might help them.

In community conversations, **Outreach and Prevention were the second most commonly identified need (179 comments),** defined as any stakeholder related to the BHSD's current outreach and prevention services, as well as any comment about communities in need of for targeted outreach/prevention. Within this category, the primary areas for need were:

"more education on what mental health is … many of us in our culture… we don't even know what mental health is"

- General stakeholder requests for prevention/outreach

- Reduce community mental health stigma
- More school-based outreach
- More ethnic-specific outreach

"Do they ever do commercials? Like commercials where we could see black folk getting services where they can see that it's okay... that would be nice to see…"

"You'd have to approach the priests [or other religious leaders] first, they could bring up [mental health]…"

Specifically, stakeholders noted a primary need to decrease community stigma, specifically in parents, youth, and immigrants; stakeholders recommended that BHSD coordinate with religious/spiritual leaders/organizations to facilitate this change. Stakeholders also noted the need to increase general community awareness of mental health and substance use, with a number of participants stating that many people in Santa Clara County have limited knowledge on these topics.

Example consumer stakeholder quotes within this area of need included the following:

"Training a little bit more people in the community on how to support [those with Mental Health & Substance Use problems]"

"Informational campaigns are needed for emerging drugs like fentanyl and xylazine"

Stakeholders suggested enhanced ethnic-specific outreach/prevention, such as anti-discrimination trainings in schools and other County venues, outreach and TV commercials to reach African American communities, and additional resources (e.g., CCWP team, wellness center) for the Middle Eastern community; see appendix for additional suggestions.

"…when I was in high school in the county I didn't know that there was a county…I didn't understand that there was something out there that could do something to help…And I think a lot of high school students don't.. it would be great for them."

"I have used [college counseling services], and it's a wonderful service. … I feel like a lot of [the college counselors], they're not aware of additional services that the county can offer. So I was never redirected elsewhere for any of the… other services outside of just what [college counseling] offered…"

Community members noted the need for additional outreach to public schools (e.g., primary and secondary schools) as well as local colleges (e.g., college campuses generally as well as the college campus counseling clinics). Additional comments spoke to the need to train community members to recognize symptoms and refer to BHSD (e.g., Mental Health First Aid, Be Sensitive, Be Brave), as well as the need to outreach to those who are unhoused, include more events in BHSD outreach

services, enhance substance use prevention, and facilitate outreach to religious/spiritual organizations.

Access & Unplanned Services: Greater and More Varied Treatment Options

The **third most commonly identified Access and Unplanned Services need (38 comments)** was *More Treatment Services.* This theme can be broken into three main sections. First, stakeholders noted the need to continue and expand LGBTQ+ programming (e.g., additional clinical services, greater efforts to be a TGI+ Sanctuary County, and expansions to the much-celebrated Gender Health Center).

Second, stakeholders noted the need to enhance crisis services, which largely revolved around comments that crisis services should have an option to help without bringing police officers to a scene. Stakeholders noted that police, while sometimes very helpful, can at other times bring alternative priorities (e.g., carrying out an active warrant) or can agitate consumers in crisis by their very presence. Additional comments about crisis care included a request for additional emergency services after 5pm and more mobile crisis teams.

> "having [crisis] services that don't require involvement by law enforcement, particularly … clients that may have active warrants. What is happening, everybody is showing up with a different goal in mind… the specific example … was having requested mobile crisis for a client who is in crisis and law enforcement showing up and because there's an active warrant - rather than serving the mental health crisis, they are immediately arrested…this is not an isolated incident"

> "mental health services, I understand that they need to close at a certain time, but what happens after 5 o'clock… What do we do [if we] have a mental break down at 5 or 6 o'clock… who do we call?"
>
> "need to add more [mobile crisis] coverage to all of Santa Clara County…"

Third, stakeholders noted the need to establish pre-crisis services for individuals with serious mental illness who tend to decline treatment. Specifically, stakeholders noted the need for innovative efforts to engage TAY-aged adults who are unable to recognize the need for mental health. Stakeholders noted a pattern of concerned family members reaching out to the County for help with 18-22-year-olds who often live in the home with deteriorating mental health

> "…my son is 20 even when he was younger it was still hard to get him treatment if he didn't want it, they would say No, if he doesn't want to. There's nothing we can do about it, and that's frustrating being a mother and going through this this process…we just don't have rights."

presentations without support from the County due to the consumer declining treatment. While legal considerations should be considered, this need presents an opportunity for BHSD to innovatively meet the needs of these individuals (e.g., a specific outreach program, specific family support materials, specific family coaching, a method of expedited access if the consumer verbally accepts treatment at any point).

> "When I call these emergency crisis lines for mental health, they always tell me she has to be in manic mode in order for us to come out. Manic mode, what when she kills me or kills herself or somebody else…why does it have to be so severe for them to come out? Why can't somebody have mental health issues and somebody that loves them call up and [they] do an evaluation on my friend?"

Access & Unplanned Services: Workforce, Education, and Training

> "[we need] more individuals out there who are from the same culture, who can do the education [and] visit the families at home [and] explain that…this is something that is treatable..."

The **fourth most commonly identified Access/Unplanned Services need (54 comments)** was *Workforce, Education, and Training*. Specifically, consumers/family members expressed wanting more access to culturally matched staff, such as African immigrant women, Spanish-speaking, LGBTQ+, Middle Easter, South Asian, and refugee individuals.

In addition, stakeholders noted the need for additional LGBQPA2S+ and TGI+ training for BHSD clinical staff).

Stakeholders also noted the critical need to hire additional clinical staff (e.g., case managers, therapists/counselors, and rehabilitation counselors), the importance of retaining current clinical staff (e.g., create a welcoming work environment by adding gender pronouns on Teams and all County staff forms, increase burnout prevention for staff with lived mental health experience), and the need to increase pay for clinical staff.

> "individuals, if they're already struggling with mental health and substance, addiction, addiction, they … really need like a case manager to help them navigate… in that [situation] is when a case manager would really be important…"
>
> "the cost of living, relative to having student loans from grad school and trying to survive here with this housing market where you're competing even just to rent a small apartment with people in the tech sector"

Stakeholders suggested specific strategies to recruit LGBTQ+ staff, such as recruiting from outside the general BHSD applicant pool in order to reach more qualified LGBTQ+ potential staff members, adding LGBTQ+ specific interview items, focusing on recruitment of LGBTQ+ bilingual staff, and being flexible with education requirements.

"[We need] specialized recruitment…these positions get filled just [internally] by county [and] the county hiring system is so outdated…the folks who are who have lived, experience, expertise, related to supporting LGBTQ+ folks have to compete with folks who don't, for these specialized programs."

Access & Unplanned Services: Collaborative & Integrative Care

The **fifth most commonly identified Access and Unplanned Services need (19 comments)** was *Collaboration and Integrative Care*, especially regarding collaboration between BHSD and other County services. Specifically, stakeholders consumers/family members clearly expressed the need for a single EMR to facilitate integrative care across County services, a need for greater collaboration with medical/PCP services and, and the need for additional Mental Health & Substance Use training for police officers.

"[I'm] serving sex workers and people who use drugs— but I'm in the infectious disease unit… would love to see more collaboration between us…"

"LGBTQ+ programs get siloed a lot… [need] more department communication with other programs so they know where to refer folx"

ACCESS & UNPLANNED SERVICES: RELEVANT FINDINGS FROM THE COMMUNITY SAMPLE

Survey data from the full community sample (n = 667) have implications for the Access & Unplanned Services. Of the 307 community members who stated that they have had a mental health or substance use problem in the last 12 months, 70.2% stated that they did seek help, leaving 29.1% of these individuals without mental health and/or substance use treatment.

"Due to the pandemic it seems like the services are very well needed in the community… and they shouldn't be taken out, they should continue providing the services"

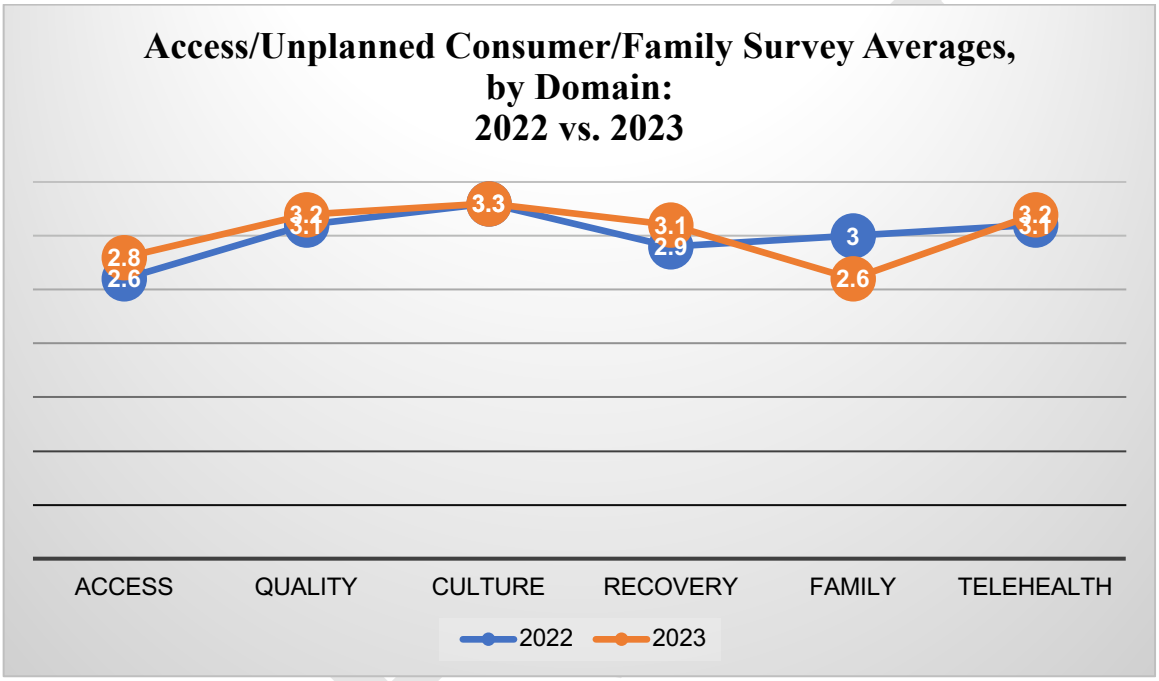
When analyzing only the subset of individuals who *did* report a problem but *did not* seek help, 87 community members answered a follow-up question about *why* they did not seek help ("What were the reasons why you did not seek help for mental health, nervous, emotional, drug or alcohol problems?"). Reported reasons for not seeking help are listed below in the Appendix; the top three reasons were the following:

Top 3 Reasons for Not Seeking Help

1. "There aren't enough services."
2. "My problems aren't serious enough."
3. "There is a lack of help in my language."

Access & Unplanned Services-Level Scores and Changes in MHSA-Related Survey Domains

Survey data from all Access & Unplanned Services consumers/family members are detailed here. Access & Unplanned survey domain averages are listed in the Appendix. Access & Unplanned clients/consumers/family members were generally satisfied within each survey domain: Access to Care, Quality of Care, Recovery, Cultural Considerations, Family Inclusion, and Telehealth. Compared to last year's survey findings (see Chart below), this year's results indicate broad stability across each of the six domains. Specifically, for both 2022 and 2023, the domain averages continued to indicate general satisfaction with all 6 MHSA domains, with no notable differences year-over-year.



Full data from each Community Conversation (themes, sub-themes, frequencies) are available in the Appendix. The paragraphs below provide summaries of each community conversation.

TGI+ Community (n = 9)

Eleven (11) strengths were mentioned: LGBTQ+ Services (n = 8), Outreach/Prevention (n = 2), and Youth/School Services (n = 1). In terms of current needs/changes, the **primary identified need** during this conversation was *Workforce, Education, and Training*; specifically, stakeholders noted the need to hire culturally-matched staff and to provide more LGBTQ+ training for BHSD staff members. The **second identified need** was *Treatment Services;* stakeholders noted a need for expanded LGBTQ+ services. For further information, see the community conversation data table in the Appendix.

LGBQPA2S+ Community (n = 7)

Three (3) strengths were mentioned: CBOs/Programs (n = 1) and LGBTQ+ Services (n = 2). In terms of current needs/changes, the **primary identified need** during this conversation was *Workforce, Education, and Training*; specifically, stakeholders noted the need for additional staff training on LGBTQ+ matters and the need to hire more culturally-matched providers. The **second identified need** was *Treatment Services;* stakeholders noted a need for: additional LGBTQ+ services and more harm reduction approaches. For further information, see the community conversation data table in the Appendix.

EXECUTIVE SUMMARY

Based on community stakeholder feedback, the **core strengths** of recent Workforce, Education, and Training efforts include: inflation adjustments, cost-of-living adjustments, internship stipends, loan forgiveness grants, and efforts to recruit additional staff (specifically case managers and peer support staff). These strengths, along with areas for growth identified by consumers in the community survey and community conversations, yielded the following recommendations.

Workforce, Education, & Training: Recommendations *(mapped onto Department-level Goals)*

The below recommendations mirror the department-level recommendations from the BHSD department-level analysis of the current report, constituting seven (7) Workforce, Education, and Training recommendations:

Corresponding Department Goal #	Description of Recommendation
4 WET	**1. Increase staff positions / hires.** Given that the top need across all community conversations was "More Treatment Services," it is recommended that BHSD continue innovative methods of hiring staff members and filling open vacancies, particularly peer support, therapists, case managers, diversion services staff, and youth-focused staff.
4 WET	**2. Culturally matched staff**. Consumer stakeholders requested hiring staff members who are matched on demographic characteristics like LGBTQ+, marginalized, and racial and ethnic minority (e.g., Middle Eastern, African immigrant women, Spanish-speaking) identities.
4 WET	**3. Consider essential strategies to retain staff and enhance the work environment**, such as enhancing staff benefits (e.g., childcare, reinstating COVID-19 sick pay, support for further trainings/education), preventing burnout (e.g., vicarious trauma resources, support for permanent supporting staff and anti-LGBTQ+ workplace aggression), and reducing workload (e.g., smaller clinical caseloads, reduced requirements for permanent supportive housing staff).
4 WET	**4. More trainings for staff, particularly cultural and LGBTQ+ trainings.** Suggestions for cultural-focused trainings included: LGBTQ+ psychology, Black culture, Middle Eastern culture, and DEI approaches. Stakeholders also suggested a variety of other topics such as AB1424, trauma-informed care, harm reduction and others.
4 WET	**5. Increase staff pay.** Stakeholders suggested increasing pay for all clinical staff, and ensuring pay is adjusted for Bay Area cost-of-living. Other suggestions for increased compensation focused on: Permanent

	Supportive Housing staff, paraprofessionals, CBO staff, and psychiatrists.
4 WET	6. **Consider innovations in the recruitment pipeline** such as increasing intern stipends, working with colleges to educate and recruit graduates, shifting more responsibilities to paraprofessionals, focused efforts for LGBTQ+ staff, and exploring exceptions for individuals applying with credentials from outside the US.
4 WET	7. **Widely market job openings and provide application support**, to address barriers to obtaining applicants for BHSD positions. Though 193 survey respondents expressed interest in BHSD employment, mismatching education background, not knowing where to find job openings, and needing application support were listed as top reasons for not applying for BHSD positions.

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WORKFORCE, EDUCATION, & TRAINING: CONSUMER STAKEHOLDER PARTICIPANTS

All 667 survey respondents were asked items specific to Workforce, Education, and Training (see the Participants section of this report for demographic information). When asked about their perception of a BHSD workforce shortage, 382 individuals responded; on average, they stated that they "somewhat agree" that there is a shortage of behavioral health staff and providers available to them.

WET-level Data

193 stakeholders interested in a mental health or substance use position

58 stakeholders have applied for a mental health substance use position within the past year

All survey respondents (n = 667) were asked if they are interested in working in a mental health or substance use (Mental Health & Substance Use) program. Of those who responded to the item (n = 452), 193 (42.7%) stated that they are interested in working for a Mental Health & Substance Use program, while 259 denied having interest (57.3%).

Those who said they *are* interested (n = 193) tended to be adults aged 25-59 (78.9%); however, it is notable that this group of potential employment candidates includes 20 individuals aged 16-24 and 22 individuals aged 60+. The most common race/ethnicity was White (n = 48), followed by Asian or Asian American (n = 38), and Hispanic/Latin/o/a/e (n = 34). These potential employment candidates tended to be cisgender women/girls (n = 97) and cisgender men/boys (n = 37); however, TGI+ individuals (n = 12) expressed interest. These potential employment candidates were largely heterosexual (n = 137), but there were 31 LGBQPA2s+-identified individuals who expressed interest. The most common language preference was English (n = 145); however, there was interest amongst people whose preferred language is Vietnamese (n = 15), Spanish (n = 8), and Mandarin (n = 1). A majority of these individuals did not identify as having a disability (n = 111), but about one-third did identify as having a disability (n = 66). These individuals largely reported being stably housed over the past 12 months (n = 168), although a sizable portion reported that they have not been stably housed over the past month (n = 22). These individuals largely live in San Jose (n = 125), although 15 individuals reported living in South County (Gilroy = 8, Morgan Hill = 7).

Of those who said they *are* interested (n = 193), they were asked to identify the areas in which they would be interested in working. The most common response was peer support (n = 119); see the table below for full results.

Areas of Interest for Employment in Mental Health & Substance Use	n
Peer Support	119
Counseling	99
Substance Use Treatment	56
Clinician	51
Psychiatrist	34

All survey respondents (n = 667) were asked if they have applied for a position in a mental health or substance use program within the last 12 months. Of the 428 individuals who responded, 58

(13.6%) stated that they have applied for a Mental Health & Substance Use position; 370 (86.4%) stated that they had not applied within the last 12 months. Of those who *had* applied within the last year, they were asked whether there were any challenges in their application process. Of these 58 individuals, 23 (40%) reported that they were no challenges. The top challenges noted were worries about benefits being reduced/impacted (n = 12, 20.6%), followed by worries about employment gap (n = 10, 17.2%), and the need for support in the application process (e.g., resume, interviewing; n = 8, 13.8%).

Challenges in Applying for a Mental Health / Substance Use Position	n
"I was worried about my benefits being reduced or impacted."	12
"I was worried about my employment gap / years out of the workforce."	10
"I needed support to start the employment process (resume, filling out application, interviewing, etc.).	8

All survey respondents (n = 667) were asked what stopped them from applying for a position in a mental health or substance use program item. Of the 206 responses received, the most common responses were lacking the educational requirements (n = 89, 43.2%) and not knowing where to find job openings (n = 88, 42.7%). See the table below for full results.

Reasons for Not Applying for a Mental Health or Substance Use Position	n
"My educational background didn't match what was needed for the job."	89
"I don't know where to find job openings."	88
"I needed support to start the employment process (resume, filling out application, interviewing, etc.)."	45
"Worried about my employment gap / years out of the workforce."	41
"Worried about my benefits being reduced or impacted."	36
"Concerns about my legal status or history."	33
"There aren't' enough disability accommodations."	25

WORKFORCE, EDUCATION, & TRAINING: STRENGTHS

Based on community stakeholder feedback about WET (n=6), the **core strengths** of recent Workforce, Education, and Training efforts include: inflation adjustments, cost-of-living adjustments, internship stipends, loan forgiveness grants, and efforts to recruit additional staff (specifically case managers and peer support staff). Overall, these stakeholders recognized recent efforts to increase and retain clinical staff members. These strengths (and quotes) are listed in the table below.

"Wrap around Care case manager…that's something that I'm really grateful for."

"Continued rate increases to meet inflation and cost of living"

"Having [discussions about retention and cost of living] more … has been helpful"

"So I think the Peer support model is just like awesome."

"Continue to do the internship stipends"

"[Continue] loan forgiveness grants"

WORKFORCE, EDUCATION, & TRAINING: AREAS OF NEED

Workforce, Education, & Training: Hire More Clinical Staff

The **most frequently mentioned Workforce, Education, and Training need** was *Hire More Clinical Staff* (82 comments), defined as any stakeholder comment about the need to increase the number of clinical staff. The most common comment was general in nature (e.g., "hire more clinicians"). However, stakeholders also offered guidance on the specific types of clinical staff that they saw a need to hire. Specifically, the most common request was for more paraprofessionals (e.g., peer support staff).

Stakeholders noted a need for more therapists/counselors to increase capacity for individual therapy, with a noted need for therapists in the South County. They also noted a need for more case managers and case workers throughout the BHSD system, noting that case managers are uniquely situated to help people navigate the BHSD system, access housing services, and facilitate step-down care.

Stakeholders identified the need for additional youth-focused clinical staff, such as additional licensed therapists for youth, additional youth counselors embedded within school buildings, and more youth peer support workers. There was also agreement on the need for more criminal justice clinical staff members, with specific mention of additional assessors for Collaborative Courts. Other comments included the need for more psychiatrists, more addiction specialists, and more staff to serve the African immigrant community.

"Individuals, if they're already struggling with mental health and substance addiction, they don't need to have to figure out who to call … they really need like a case manager to help them navigate in that setting."

"Often patients need assistance with navigating the Behavioral Health Center and become discouraged with the process.

"Not enough practitioners equals far too long between appointments."

"One thing that I think would really be good is, have peers be in…the courts."

"[The] queer community also suffers a disproportionate amount of substance abuse issues so having rehab counselor would be [an] investment to addressing those needs."

Workforce, Education, & Training: Hiring Suggestions

The **second most commonly identified Workforce, Education, and Training need** was *Hiring Suggestions* (59 comments). This need included any stakeholder comments for BHSD to consider in the process of filling vacant staff positions (e.g., cultural considerations, process suggestions).

A vast majority of these comments (60%) revolved around requests that BHSD fill vacant positions with clinical staff who are culturally-matched to the communities they serve. Specific suggestions included hiring staff who are LGBTQ+, Middle Eastern, Spanish-speaking, TGI+, South Asian, TAY-aged, Muslim, women, and individuals who have a history of sex work (particularly when serving sex workers). There were suggestions to implement specialized recruitment for open LGBTQ+ staff positions, such that BHSD should consider recruiting outside of the standardized application portal (e.g., recruitment from within the LGBTQ+ community). It was recommended to favor women when filling positions for African immigrant outreach based on cultural norms of mental health.

"We need to focus on campaigns to promote our profession… the work that we do is very admirable, but not so many people know about it … often they associate us with like taking kids away, but we do so much more than that, we support the community, we're actually alternatives to policing and detaining people into jails."

"[for] interview questions, having something kind of standard related to [LGBTQ+] equity, racial equity…"

"there is a limit in diversity in regards to like who you can consult to [is] a really big issue… one of the problems that a lot of my friends face is the deterioration of their mental health because of their family situation and a lot of the factors that contribute to that are cultural differences"

Additional hiring considerations from community stakeholders included suggestions to increasing intern stipends, working with colleges to recruit interns and build the BHSD workforce, using paraprofessionals to fill the workforce gap, and making hiring exceptions for community members whose credentials come from outside of the U.S. There were also a few comments suggesting that BHSD should invest in public marketing campaigns to promote the public perception of mental health careers, to hire LGBTQ+ staff who are bilingual, to add an LGBTQ+-focused interview question when filling open LGBTQ+-related positions, to reduce barriers for hiring TGI+ applicants (e.g., loosening formalized education requirements), and to reduce hiring barriers of considering a history of sex work as work experience.

Workforce, Education, & Training: Staff Retention

"providing better mental health services for our staff… everyone has an EAP, but the folks in these EAP programs, our staff are more skilled than those folks, so they're not getting the level of care [they need]"

The **third most commonly identified Workforce, Education, and Training need** was *Staff Retention* (51 comments). This theme can be broken

into three main sections. First, stakeholders noted the need to **increase employee benefits**, such as providing/subsidizing childcare for BHSD employees, reinstating Covid-19 sick pay for employees, financially supporting clinical staff in getting advanced trainings (e.g., EMDR, DBT) or going back to school. Second, stakeholders expressed the need to address clinician burnout, noting the need to address vicarious trauma, to better support LGBTQ+ employees after workplace discrimination experiences, and to address the political pressure placed on PSH staff due to the housing crisis.

Third, stakeholders noted the need to reduce staff workload by reducing caseloads and reducing documentation/training/productivity requirements for PSH staff. Additional recommendations included the need to make BHSD an affirming environment for LGBTQ+ staff by adding pronouns to all County forms (including internal forms and HR forms), as well as ensuring that Teams displays gender pronouns (as is done in systems such as the VA).

Workforce, Education, & Training: Staff Training

"I have a mother-in-law who was inpatient for some time… it's very hard to get somebody who is culturally appropriate in that sector"

"[we need] greater capacity for [LGBTQ+] education trainings"

The **fourth most commonly identified Workforce, Education, and Training need** was Staff Training (43 comments). Specifically, consumers/family members expressed indicated the need for additional cultural competency training for BHSD staff, with specific requests including training on LGBTQ+ topics, DEI approaches, Middle Eastern culture, ad Black & African Descended culture. In addition to cultural trainings, stakeholders noted the need for more staff training on AB1424, trauma-informed care, the HIMS system (beyond pre-recorded videos), harm reduction, psychiatric emergency services, and "soft skills" (customer service)

Workforce, Education, & Training: Increase Staff Pay

"Staffing is a huge problem… the pay, people cannot support themselves here… the County has to pay more, or you're not gonna get people… how can you rent an apartment here …"

"There are a lot of doctors that are like 'I'm getting paid more at Kaiser, so I'm leaving the [County] clinic"

The **fifth most commonly identified Workforce, Education, and Training need (31 comments)** was *Increase Staff Pay*. These comments were most often broad in nature, with general recommendations to increase pay for clinical staff. However, there was also mention of the need to continue making cost-of-living adjustments for BHSD clinicians and to increase Permanent Supportive Housing staff [illegible] (BHSD standards and Office of Supportive Housing [illegible] need to increase pay for paraprofessionals, CBO staff, psychiatrists, social workers, and therapists/counselors.

EXECUTIVE SUMMARY

Based on community stakeholder feedback, the **core strength** of AOA services was its current CBO partners (e.g., AACI, Gardner, Goodwill) and County clinics/programs (e.g., Evans Lane), which stood out above all other strengths. Additional strengths included: access procedures, expanded outpatient treatment, and criminal justice services. These strengths, along with areas of need identified by consumer stakeholders in the community survey and community conversations, yielded the following recommendations.

AOA System of Care Recommendations *(mapped onto Department-level Goals)*

The below recommendations should be implemented within the larger context of the department-level recommendations from the BHSD department-level analysis of the current report. Several of the 5 BHSD priorities were mirrored or called out in the AOA-focused data. These corresponding BHSD priorities have been noted below, with the addition and integration of AOA-related comments / data. Together, they constitute 13 AOA System of Care recommendations:

Corresponding Department Goal #	Description of Recommendation
3 Emerging Needs	**1. Keep AOA Outpatient Treatment Services Flexible with Expanded Offerings to Meet the Changing Needs of the Community**. The most frequently mentioned outpatient service needs included: services to reduce isolation, supported employment, services in client's homes, support groups, step-down treatment services after hospitalization, and longer-term treatment.
3 Emerging Needs	**2. Expand Criminal Justice Services.** AOA stakeholders requested expansion of and improvements to Reentry services (e.g., verifying felon-friendly employers, increased capacity at Reentry Vocational centers), expansion of Diversion services (e.g., additional levels of case management, more outpatient care, longer-term treatment), more emphasis on *treatment over incarceration*, expanded Mental Health & Substance Use services within prisons, and the need to train AOA providers to service criminal justice clients.
3 Emerging Needs	**3. Expand AOA Housing-Related Treatment Services.** AOA stakeholders noted the need to expand services for <u>those not currently involved in a BHSD-related housing program</u>; specific requests include: more case management during the housing application process, an FSP-like program specific for those who are chronically unhoused, and more clinicians to visit the unhoused wherever they can be found. Stakeholders also noted the need to expand services for <u>those currently involved in a BHSD-related housing program</u>, such as additional resources for

	scattered-site PSH, psychiatry/therapy at all PSH sites, and Mental Health & Substance Use treatment within temporary/transitional housing sites.
3 Emerging Needs	**4. Expand AOA Substance Use Treatment Service (SUTS).** Consider expanding SUTS, especially: dual diagnosis treatment, harm reduction approaches, medical detox capacity, and residential treatment programs.
3 Emerging Needs	**5. Increase AOA Capacity for Residential & Inpatient Beds.** AOA consumers expressed a need for increased bed capacity, specifically: crisis residential beds, inpatient beds, residential beds, Board & Care capacity, and beds for those released from prison/jail.
3 Emerging Needs	**6. Enhance Services for Immigrants & Refugees** to support acculturation challenges in the immigration and relocation process, services for those without legal status or documentation, LGBTQ+ education, and employment support.
4 WET	**7. WET.** AOA should continue, and ideally enhance, efforts to recruit and retain clinical providers who culturally match the communities they serve. *Note: Refer to the WET subreport for a more detailed set of recommendations that may be relevant for the AOA system of care.*
5 Integrated Systems / Policy	**8. Improve AOA's Collaboration With Other Santa Clara County Departments.** Based on stakeholder comments, AOA should further collaborate and/or integrate with SCC medical services and the SCC Office of Supportive Housing.
5 Integrated Systems / Policy	**9. Enhance AOA's Collaboration and Integration With Other BHSD Programs/Clinics/CBOs.** AOA stakeholders are calling for increased collaboration between AOA and Diversion services, as well as increased collaboration between inpatient staff and Permanent Supportive Housing staff members when consumers discharge from BHSD hospitals.
Not Listed	**10. Decrease Barriers to Accessing AOA Services.** Specifically, AOA stakeholders highlight the need to facilitate access to services by improving the availability of language/translation services and increasing transportation support. *Note: Please refer to the Access portion of the Access & Unplanned subreport for a more detailed set of recommendations that may be relevant for the AOA system of care.*
1 Timely Access	**11. Improve Processes/Procedures for Accessing AOA Services.** Specifically, AOA stakeholders requested more assistance navigating the BHSD system, less paperwork and fewer admission requirements for accessing services; improvements to the Call Center screening tool; and, avenues for accessing care without using the Call Center.
2 Housing	**12. Increase Housing Availability for AOA Consumers.** AOA stakeholders noted the need for increased housing capacity, with specific requests for LGBTQ+-specific housing, more flex funds, housing options for those in wheelchairs, and housing options for Criminal Justice consumers.
Not Listed	**13. Improve AOA Outreach/Prevention Efforts.** AOA consumers requested more general outreach to increase psychoeducation and

	decrease stigma, with suggestions for outreach at religious/spiritual venues.
Not Listed	**14. Ensure Good Quality of Care.** AOA stakeholders spoke to the need for reducing anti-LGBTQ+ discrimination within BHSD housing services and improving quality of care from AOA providers in a variety of settings (e.g., therapists, psychiatrists, orientation to residential programs, planfulness around the 90 days of initial re-entry services).

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AOA System of Care Consumer Stakeholder Participants

AOA-Level Participants

- **18 Community Conversations**
- **310 stakeholders in Community Conversations**
- **614 stakeholder comments**
- **133 consumers or family members on the survey**

In total, participant data for the Community Planning Process from the Adult & Older Adult (AOA) system of care came from 310 stakeholders who participated in 18 community conversations, yielding 614 stakeholder comments, combined with 133 consumers or family members on the consumer survey.

Of the 133 total survey respondents, 82.7% (n = 110) identified as clients/consumers and 17.3% (n = 23) identified as family members. These survey participants reported receiving services from the following programs: Mental Health & Substance Use Services 25-59 (n = 51), Mental Health & Substance Use Services 60+ (n = 12), Criminal Justice Services (n = 6).

The AOA survey consumers/family members were 37.0% White, 27.7% Hispanic/Latino/a/e, 25.7% Asian, 19.3% Black, 10.1% Native American, American Indian, Alaskan Native, 2.5% Middle Eastern or North African, and 1.7% Pacific Islander. With regards to gender identity, 58.2% identified as cisgender women, 37.8% as cisgender men/boys, and 4.1% as TGI+. They were primarily adults aged 25-59 (77.5%), with 17.1% ages 60+, and 7.0% ages 16-24. A vast majority (87.0%) identified as heterosexual, and 11.3% identified as (LGBQAP2S+). Primary city of residence was San Jose (67.2%), followed by Santa Clara (6.9%) and Gilroy (5.3%). When asked about housing status, 11.5% reported they have not been stably housed. When asked about disability status, 50.0% endorsed having a disability.

Data analysis revealed 614 Adult & Older Adult service comments from two combined sources: the 18 AOA focused community conversations (310 stakeholders spanning 3 regional groups, 7 cultural communities, 2 justice-involved groups, 3 housing groups, 2 AOA provider groups, and 1 general AOA group), as well as any AOA comments from qualitative items on the consumer survey. Within these 614 comments, 7 primary areas of need arose, which are listed in the AOA-level Appendix tables alongside the number of comments in each primary area of need. Each primary area of need is listed alongside its secondary themes that clarify community feedback and organize recommendations.

Together, these qualitative and quantitative data from the survey and community conversations informed the AOA System of Care recommendations described in subsequent sections.

AOA System of Care Strengths

Top 3 AOA strengths identified in community conversations:
- CBOs/clinics/programs
-Criminal Justice services
- Housing treatment programs

The greatest AOA system of care strengths identified by stakeholders were: CBOs/clinics/programs (e.g., Goodwill, Evans Lane), access procedures (e.g., general satisfaction with access processes, services being offered in the evenings, 988), and criminal justice services (e.g., Strive program, Diversion services). Additional strengths included: telehealth availability;

housing services; outreach & prevention efforts; WET efforts; collaboration & integrative care; and quality of care.

AOA System of Care: Areas of Need

AOA: Greater Number and Variety of Treatment Services

The **most frequently mentioned stakeholder need** identified in AOA community conversations was the **need for a greater number and variety of treatment services** (198 comments). For the best understanding of the full scope of all 198 stakeholder comments, see the AOA Community-Identified Needs table in the Appendix. The following section focuses on the top five treatment needs (criminal justice services; housing-related services; substance use treatment services; expanded outpatient treatment; residential/inpatient beds).

Highest AOA need from community conversations:
Greater number & variety of treatment services
(particularly criminal justice services; housing-related services; substance use treatment services; expanded outpatient treatment; residential/inpatient beds)

"My problems were kind of put down a little… I talked to someone in high school about how I was having suicide thoughts, and they didn't do anything about it besides create a safety plan for me, and that felt very demoralizing, and I felt like I wasn't struggling enough for these people. And I think there's the sense that you need to be at your very, very worst to get help, and I think we need to be able to give people resources before they attempt, or before they get to the crisis point. There are people who, myself included, I know when I'm about to go into a really big depressive episode or a suicide episode, and I can sense it coming. And I can reach out beforehand, but sometimes, even if I reach out the services that are provided for me are not enough, because I am not at the crisis point. And sometimes certain mental health services will only admit you if you're at a crisis point, and that is like really disheartening."

"I should have had some wrap around [services] for my son when he came out [of prison], I had nobody, matter of fact, I picked him up by myself…"

"90 days [of reentry services] is beautiful but it's not even enough…. You got some individuals that have been incarcerated all their life, been on the streets all their life…"

"the people I do know who [have lost their allegedly felon-friendly job], have literally been working at this job collecting their paycheck and then all of a sudden this other background check comes out and they end up getting fired."

The most commonly requested treatment need was **more criminal justice services**. It should be noted that criminal justice services were the third most-mentioned strength for all of AOA services. In discussing suggestions for improvement, a majority of stakeholder comments centered on Reentry/Vocational services, with stakeholders noting the need to: update/verify the list of felon-friendly business to prevent unstable employment; increase the capacity at reentry vocational centers; add a transitional arm to reentry services for support of longer-term recovery; and, to extend the length of reentry services beyond 90 days. When discussing Diversion services, stakeholder requested additional

capacity for outpatient therapy/counseling; longer-term program participation; and, the establishment of an additional level of support between residential care and FSP case management. Additional stakeholder comments included the need to stop using jails as the County's response to the public mental health and substance use crisis; the need to expand criminal justice competencies beyond Criminal Justice services (e.g., training AOA providers to serve these clients in some capacity); and, additional services for consumers upon release from prison.

"On the [AOA] side, they're just not used to working with our criminal justice clients, so there's a deficit there… there are some special [considerations for] criminal justice… [AOA] providers [do not provide that]"

The second most commonly requested treatment need was **more housing-related services**. Again, it is worth noting that Housing services were listed as the fifth most-mentioned strength for all of AOA services. When asked for improvements and suggestions, stakeholder comments fell into two categories: services for *those who are not currently admitted* to a BHSD-related housing program, and services for *those who are currently participating in* a BHSD-related housing program. For *those who are not currently admitted* to a BHSD-related housing program (representing 75% of the housing comments), community stakeholders primarily spoke to the need for additional case management for those who are actively unhoused (those not staying in temporary, transitional, or stable housing), to provide additional BHSD support (general), and the need for an FSP-like program for those who have been chronically unhoused. Additional comments included: recommendations for licensed therapists to go out into the places where those who are unhoused tend to congregate; more individual therapy for those seeking housing; and, more community education on housing programs/requirements. While stakeholders commented positively about current BHSD-related housing efforts (e.g., PSH), recommendations include: additional resources for scattered-site Permanent Supportive Housing (as additional resources are needed for those in scattered-site programs vs. those who are at site-based programs); ensuring psychiatry/therapy resources are available at every PSH site; and, further incorporating Mental Health & Substance Use treatment into transitional/temporary housing (e.g., shelters).

"there should be FSP focused programs for people experiencing chronic homelessness that ARE housing programs (with the money for housing)"

"our [PSH] clients need psychiatry… some of these site-based programs… are just purely housing, they don't have access to psychiatry and therapy…"

"what has really worked well with [those who are unhoused] is having therapists go out and meet people where they are"

The third most commonly requested treatment need was **more substance use treatment services (SUTS)**. Specifically, stakeholders noted the need to better incorporate harm reduction strategies within SUTS, the need for a medical detox program, and the need for more residential substance use treatment programs. Additional comments pointed to the need for affordable vaping

"Inpatient drug rehabilitation for individuals who really need the help… it's very difficult to find"

"There needs to be a higher capacity for justice-involved clients to access SUTS when they are ready and willing"

cessation options, more Fentanyl interventions, more individual therapy within SUTS, SUTS programs that can accommodate those with intellectual disabilities, the need for response housing, same-day access for SUTS, and more SUTS focus on normalizing relapse (as opposed to shaming/punishing relapse).

The fourth most commonly requested treatment need was **expanded outpatient services**. This theme was coded as a synthesis of needs that matched BHSD's recent efforts to expand services (Goal #3). Specific comments included the need for more individual therapy capacity, more treatment aimed at serving the Mental Health & Substance Use needs of sex workers (as opposed to focusing on preventing sex work), an FSP-like program with lower entry requirements, more consistent group offerings, and more thorough psychological assessment. There were further comments highlighting the need to expand treatment in the following areas: gambling addiction, domestic violence, job loss, group therapy, life skills workshops. There was also a comment about needing additional services for adults with severe mental illness who need treatment but decline services.

"I'm in a [BHSD] program right now and there's a 2 year wait list for therapists"

"I have some friends who were victims of domestic violence, but what our community teaches and parent say is 'it's okay, just tolerate it."

The fifth commonly requested treatment need was **greater residential/inpatient bed capacity**. Specifically, stakeholders noted the need for more crisis residential capacity, more residential treatment, more psychiatric hospital beds, more beds for those discharging from jail/prison, more Board & Care beds, more residential treatment for those in Reentry programming, and the need to separate TAY residential treatment from adult/older adult residential treatment.

Beyond these top five treatment needs, additional needs included: services for immigrants and refugees (11 comments); more dual diagnosis treatment (10 comments), more services to reduce isolation (8 comments), more supported employment programs (8 comments), improvements to BHSD-CBO contracts (7), more BHSD services in clients' homes (7 comments), more support groups (7 comments), more step-down treatment services (6), more capacity for longer-term treatment (6 comments), more Covid-19-adjacent services (6 comments), more hybrid treatment models (4 comments), more services for those with co-morbid cognitive challenges (4 comments), more injectable antipsychotic treatment for those with psychosis, and more adjunctive services (3 comments).

"[We need immigrant] education about accepting LGBT. When these refugees come, it's little bit harder because the parents are not already. The children were opening the door for them, but the parents are not ready to listen to these things, or to accept them or understand them."

"When they talk about dual diagnosis, I don't know how many facilities I called; they said, 'Yeah, we do dual diagnosis. You know we do the drug rehab.' 'Okay, what about mental health services?' 'Well, we don't do that; we don't offer a psychiatrist.' And I go 'But then how can you call yourself a dual diagnosis facility if you do not offer it?' So it's just the frustration…"

"Support groups… we should make them at our gurudwaras… we are much more comfortable talking about this with our own communities…"

"[We need an] automatic step down program, so going from inpatient to outpatient so that folks ca have support during the transition… really structured 24/7 care…"

"I think people do want in-person interaction… [yet] it's a lot easier [for the client] to continue those visits through Zoom"

"One thing that we really just don't have any access … is people suffering from dementia or other neuro cognitive problems. It's coming up a lot …, and we get to a point where it's very clear that's the main problem."

"[For] serious thought disorders, the first line treatment should be injectable medication…there's the expense of the injection, but it's a lot more expensive in the long run to pay for hospitalizations and jail, homelessness…"

AOA: Workforce, Education, and Training

The **second most commonly identified need (167 comments)** was **Workforce, Education, and Training.** First and foremost, AOA consumers/family members called for **greater staff retention**, noting the need to (a) recognize and prevent burnout (e.g., resources to help staff deal with vicarious trauma, more resources for staff members with lived experience, more burnout prevention for the unique pressures of PSH) and (b) increase staff benefits (e.g., childcare); and (c) reduce staff workload (e.g., reduce documentation /productivity requirements for PSH staff positions).

"I'm not just talking about someone that can speak the language but also understand the culture background of these clients."

"Collaborative Court staff are overwhelmed with assessments. We need additional staffing."

"Our [permanent supportive housing] folks that are providing these services… they work together cohesively as a team… but trying to get your case manager, who has been working in support of housing to learn, and understand, and daily do medical billing, that's hard, and that has directly impacted our retention over the last several years. "It's hard to keep people."

Comments also highlighted the importance of **hiring staff members who are culturally-matched** to the communities they serve (e.g., Middle Eastern-identified staff members, LGBTQ+-identified staff members), as well as the need to increase intern stipends and work with colleges to train and recruit the next generation of BHSD staff members.

Community stakeholders pointed to the need for **additional clinical staff** (specifically Criminal Justice providers, more case managers, and more therapists). They requested **additional provider training** on topics such as: cultural competency (generally), LGBTQ+ training, and provider training on AB1424. Finally, stakeholders noted the need to **increase staff pay** given the cost-of-living in the Bay Area and the unique demands on certain staff (e.g., PSH).

AOA: Collaborative & Integrative Care

The **third most commonly identified AOA need (50 comments)** was **Collaborative & Integrative Care**. These needs are best understood as internal BHSD collaboration and external collaboration. Comments about external collaboration (e.g., collaboration between BHSD and other County agencies such as OSH and SCCOE) centered on the need for more collaboration with SCC medical services (e.g., Infections Disease department, primary care, ER staff), as well as the need for additional consideration of the need to re-evaluate the relationship between BHSD and OSH. Comments about internal BHSD collaboration (e.g., collaboration between BHSD programs, clinics, CBOs) highlighted the need for more collaboration between AOA services and Criminal Justice services and the need for better collaboration between hospitals and PSH staff during discharge planning.

"[We need] integrated medical and substance use treatment… clients who have substance use history, or may current use, are typically like disqualified to get medical stabilization at hospitals, and folks who have medical issues with substance use often have challenges finding substance use residential services, because they need to medically stabilize. And what results is our clients just get released in the community and they're just on their own"

"Is it that we need to pour more resources into making experts of everyone across the board [for PSH staff]? Or is it that these really are 2 separate things - supportive housing and behavioral health - and they need to all be provided, but does it need to be the same providers?"

AOA: Access to Care

"if the clients cannot talk for themselves because of language barriers or the County does not have the right staff with the right language skill to help them, we are not helping our clients at all"

"[more language services] particularly in South County specific to the Spanish-speaking, indigenous communities"

"we call the client, but they have to bring their own translator"

The **fourth most commonly identified AOA need (49 comments)** was **Access to Care**. Of these comments, over 50% represent stakeholders' sense that the biggest barrier to AOA services is logistical barriers. The top barrier to accessing AOA services is language/translation support (Spanish, Vietnamese, Middle Eastern languages, Dari, Pashtu), and the need for ESL classes. Additionally, stakeholders noted that they are unable to access AOA services without transportation support.

Stakeholders also spoke to specific BHSD access processes/procedures which could benefit from improvement. Specifically, stakeholders stated that it should be "easier" to access AOA services (e.g., less paperwork, fewer requirements for entry). They requested improvements to the Call Center integrated screening process (e.g., assessing prior BHSD usage, using technology to better match consumers with programs that offer a good fit), and they also requested options for accessing care without using the Call Center (e.g., direct referrals between agencies). Stakeholders further noted that it would be very helpful to have more assistance navigating the BHSD system, to have increased community awareness of BHSD services, and to provide childcare for adults accessing BHSD appointments.

AOA: Housing

The **fifth most commonly identified AOA need (35 comments)** was **housing**, which largely consisted of requests for increased housing capacity. Additional comments included requests for: LGBTQ+-specific housing, flex funds to help secure consumer housing, beds for Criminal Justice Services, housing for those in wheelchairs, temporary housing, and transitional housing.

"Anything that has to do with housing would be major. People really need the housing. It's something that I see a lot in the field that people are looking for"

"It's just so important to have the housing options, the flex funds"

AOA: Outreach & Prevention

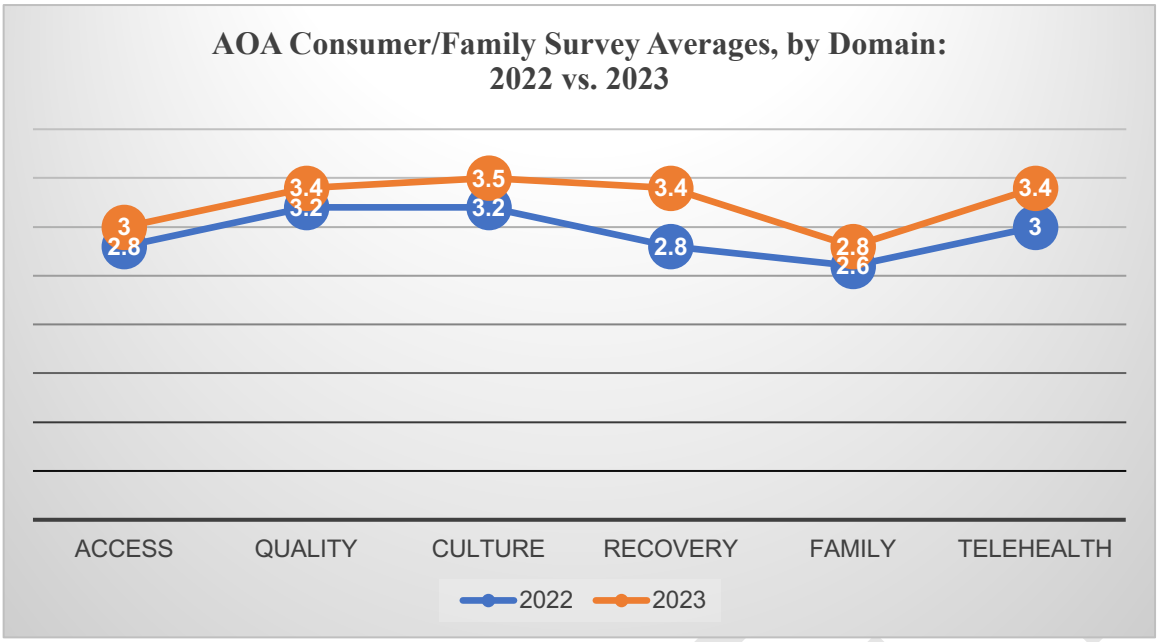
The **sixth most commonly identified AOA need (24 comments)** was **outreach & prevention services**, which focused on need for more outreach (generally), increased efforts to reduce community stigma (potentially by partnering with religious/spiritual organizations), increase community awareness of Mental Health & Substance Use, and additional ethnic-specific outreach.

AOA: Improved Quality of Care

The **final identified AOA need (17 comments)** was **improved quality of care**, which generally consisted of a need to reduce anti-LGBTQ+ discrimination within BHSD housing services and general comments about care quality (e.g., "staff should better explain their professional limits, need higher quality psychiatrists, residential staff should be more engaged with clients).

AOA Scores and Changes in MHSA-Related Survey Domains

AOA survey domain averages are listed in the Appendix. AOA clients/consumers/family members were generally satisfied within each survey domain: Access to Care, Quality of Care, Recovery, Cultural Considerations, Family Inclusion, and Telehealth. Results were notably static year-over-year, as all domain averages stayed in the "moderately satisfied" range. However, increases in Culture ($t_{(145)} = -2.24$, $p<.05$), Recovery ($t_{(159)}=-4.00$, $p<.001$), and Telehealth ($t_{(108)}=-3.50$, $p<.001$) domain scores from 2022 to 2023 were statistically significant.



South County Analyses

Summary: South County Analyses

- Qualitative data highlighted the **need for more mental health and substance use services in South County in the areas of behavioral health support for unhoused individuals, youth, substance use services**, and treatment in Spanish.
- Quantitative data analysis did not show significant differences between South County respondents with North County or other respondents on knowing where to go or who to call to get services, or getting help when needed.

There were a total of 41 comments from community conversations relevant to South County consumers and family members. For a full characterization of South County needs, please see the community conversation data tables listed in the appendix. Overall, the primary South County-specific needs mentioned by South County consumer stakeholders was Treatment Services (compromising 23 out of 41, or 56% of all South County comments), with specific needs related to housing support services such as case management or therapy provided in locations where the unhoused individuals can be found, for individuals not currently in a BHSD-related housing program. Example quotes include: ""The people that need the help the most are the ones that are not getting housed, because the program was designed to come with case management. There's not an enough managers. So … they're not gonna get help…" and "I'm part of the homeless community. I stay in our area, and I know all around here. And [BHSD] actually needs a big change for us, and how they come out."

Youth services such as substance use prevention and parent psychoeducation ("[We need] more therapy for youth"), as well as substance use services, were also mentioned by South County stakeholders.

South County stakeholders also mentioned the need for more BHSD treatment services in Spanish as a need to facilitate access to services in the Latinx community (i.e., "More support for the Latino community, especially because a lot of them don't speak English, and there's also indigenous languages").

Given the qualitative comments indicating a need for more treatment services (and thus access to treatment services), quantitative analyses were run to examine differences between South County (N=9-14) compared to North County (N=6-17) and all other cities (N=85-141) respondents on service access questions. Results showed no significant differences between South County vs. North County vs. other cities on access to care survey questions.

For example, when comparing clients/consumers/family members based on region (North County vs. South County vs. all other cities), there were no statistically significant differences on the access domain (South County = 2.7, North County = 2.8, all other cities = 2.9). Clients/consumers/family members from North County vs. South County vs. all other cities did not differ on knowing where to go to access services (South County = 2.5, North County = 2.7, all other cities = 2.9). There were also no region-based differences on consumers knowing who to call to access services (South County = 2.6, North County = 2.8, all other cities = 2.9). Finally, when comparing clients/consumers/family members based on region (North County vs. South County vs. all other cities), there were no statistically significant differences on the following item: "My mental health or substance use treatment team provides as much help as I need when I need it" (South County = 3.0 North County = 2.7, all other cities = 3.1).

Full data from each Community Conversation (themes, sub-themes, frequencies) are available in the Appendix. The paragraphs below provide summaries of each community conversation.

North County Community (n = 32)

30 strengths were mentioned: Access (n = 2), CBOs/Programs (n = 1), Collaboration (n = 3), Criminal Justice Services (n = 0), Crisis Services (n = 4), Expanded Outpatient Treatment (n = 0), Housing (n = 1), LGBTQ+ Services (n = 2), Outreach/Prevention (n = 5), Quality of Care (n = 0), Telehealth (n = 0), WET (n = 2), Youth/School Services (n = 10). In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need for Youth Mental Health & Substance Use Treatment (Youth Substance Use Prevention, Parent Psychoeducation). The **second identified need** was *Outreach & Prevention;* stakeholders noted a need for: Decreasing Mental Health & Substance Use Stigma in the Community, more Early Prevention). For further information, see the community conversation data table in the Appendix.

South County Older Adults (n = 3)

In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need for Treatment Services (Mental Health & Substance Use treatment for those who are Unhoused and not currently in a BHSD-related housing program) The **second identified need** was *Access;* stakeholders noted a need for: increased help navigating the BHSD system and more community awareness of BHSD services. For further information, see the community conversation data table in the Appendix.

South County Spanish & English Speaking, including some who are Unhoused (n = 42)

Three (3) strengths were mentioned: Access (n = 2) and Housing (n = 1). In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need for BHSD services for those who are unhoused and NOT in a BHSD-related treatment program (e.g., more case management support for those applying for housing; more clinicians to out and see those who are unhoused where they congregate). The **second identified need** was *Access;* stakeholders noted a need for: more BHSD service accessibility for those who speak Spanish. For further information, see the community conversation data table in the Appendix.

Spanish-Speaking Adults (n = 6)

Five (5) strengths were mentioned: Access (n = 3), CBOs/Programs (n = 1), and Telehealth (n = 1). In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need for longer-term treatment, services for those without US citizenship, and youth mental health care The **second identified need** was *Access;* stakeholders noted a need for: better Call Center user experience and more Spanish language support. For further information, see the community conversation data table in the Appendix.

Spanish Speaking LGBTQ+ Adults (n = 19)

Four strengths were mentioned: CBOs/Programs (n = 1) and LGBTQ+ Services (n = 3). In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need for expanded LGBTQ+ services The **second**

identified need was *Workforce, Education, and Training;* stakeholders noted a need for: more case managers, more bilingual LGBTQ+ staff, and more TGI+ employees. For further information, see the community conversation data table in the Appendix.

African Immigrant Community (n = 15)

Two (2) strengths were mentioned: Access (n = 1) and CBOs/Programs (n = 1). In terms of current needs/changes, the **primary identified need** during this conversation was *Outreach & Prevention*; specifically, stakeholders noted the need for in-person outreach, ethnic-specific outreach, outreach via religious/spiritual organizations, and additional trainings for community referrers (e.g., Mental Health First Aid; Be Sensitive, Be Brave). The **second identified need** was *Workforce, Education, and Training;* stakeholders noted a need for to hire culturally-matched staff (e.g., hiring African women to serve the African immigrant community). For further information, see the community conversation data table in the Appendix.

South Asian (Punjabi) Community (n = 27)

In terms of current needs/changes, the **primary identified need** during this conversation was *Outreach/Prevention*; specifically, stakeholders noted the need to reduce Mental Health & Substance Use stigma in the community, increase community awareness of Mental Health & Substance Use, and train community members to recognize/refer others to BHSD. The **second identified need** was *Access;* stakeholders noted a need for transportation support, translation/language services, and increasing community awareness of BHSD services. For further information, see the community conversation data table in the Appendix.

African American Community (n = 3)

Six (6) strengths were mentioned: CBOs/Programs (n = 1), Crisis Services (n = 1), Expanded Outpatient Treatment (n = 1), Outreach/Prevention (n = 1), WET (n = 1), and Youth/School Services (n = 1). In terms of current needs/changes, the **primary identified need** during this conversation was *Workforce, Education, and Training*; specifically, stakeholders noted the need for staff training on Black & African Descendant culture as well as DEI training, as well as additional therapists and psychiatrists. The **second identified need** was *Outreach & Prevention;* stakeholders noted a need for: ethnic-specific outreach and stigma reduction in the community. For further information, see the community conversation data table in the Appendix.

Vietnamese Community (n = 27)

In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need for more youth Mental Health & Substance Use services and expanded outpatient treatment services. The **second identified need** was *Outreach & Prevention;* stakeholders noted a need for: more youth mental health treatment (e.g., youth support groups, family integration therapy). Additionally, stakeholders noted the need for school-based outreach, event-based outreach, and substance use prevention. For further information, see the community conversation data table in the Appendix.

Middle Eastern Community (n = 7)

In terms of current needs/changes, the **primary identified need** during this conversation was *Outreach & Prevention*; specifically, stakeholders noted the need for ethnic-specific outreach, stigma reduction in the community, and outreach via collaboration with spiritual/religious organizations. The second **identified need** was *Access*; specifically, stakeholders noted the need

for increased community awareness of BHSD services. For further information, see the community conversation data table in the Appendix.

Providers Serving Refugee (n = 14)

Eight (8) strengths were mentioned: Access (n = 2), Collaboration (n = 1), Crisis Services (n = 1), Expanded Outpatient Treatment (n = 4). In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need for more youth Mental Health & Substance Use treatment, more refugee services (e.g., cultural assimilation classes), and more in-home BHSD services. The **second identified need** was *Access;* stakeholders noted a need for: additional transportation support and additional language/translation support. For further information, see the community conversation data table in the Appendix.

Providers: Adult & Older Adult Services (n = 24

Nine (9) strengths were mentioned: Access (n = 1), CBOs/Programs (n = 1), Crisis Services (n = 1), Expanded Outpatient Treatment (n = 1), Quality of Care (n = 1), Telehealth (n = 2), and WET (n = 2). In terms of current needs/changes, a **primary identified need** during this conversation was *Access*; specifically, stakeholders noted the need to improve the Call Center integrated screening tool by collecting additional targeted information. Another **primary identified need** was *Workforce, Education, and Training;* stakeholders noted a need to retain staff by increasing staff benefits (e.g., childcare during the workday). For further information, see the community conversation data table in the Appendix.

Consumers/Clients, General (n = 4)

Two strengths were mentioned: CBOs/Programs (n = 1) and Youth/School Services (n = 1). In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need for additional step-down care, additional criminal justice services, and additional residential/inpatient beds. The **second identified need** was *Access;* stakeholders noted a need to increase community awareness of BHSD services. For further information, see the community conversation data table in the Appendix.

Diversion Community (n = 65)

Fourteen (14) strengths were mentioned: Access (n = 2), CBOs/Programs (n = 1), Collaboration (n = 1), Criminal Justice Services (n = 4), Crisis Services (n = 0), Expanded Outpatient Treatment (n = 1), Housing (n = 1), LGBTQ+ Services (n = 0), Outreach/Prevention (n = 0), Quality of Care (n = 0), Telehealth (n = 3), WET (n = 0), Youth/School Services (n = 1). In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need to expand criminal justice competency outside of MH Court and to expand Diversion-focused services. The **second identified need** was *Workforce, Education, and Training;* stakeholders noted a need for: additional Diversion providers (assessors in Collaborative Courts). For further information, see the community conversation data table in the Appendix.

Reentry Community (n = 18)

Fifteen (15) strengths were mentioned: CBOs/Programs (n = 11) and Criminal Justice Services (n = 4). In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need to verify/update the list of felon-friendly businesses, to expand the length/capacity for reentry services, and to expand supported

employment programs. The **second identified need** was *Outreach & Prevention;* stakeholders highlighted the need for outreach to those who are unhoused. For further information, see the community conversation data table in the Appendix.

Adults in Residential/Transitional Housing (Unhoused) (n = 4)

Two (2) strengths were mentioned: Access (n = 1) and Quality of Care (n = 1). In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need for longer-term treatment, youth mental health care, and supported employment programs. The **second identified need** was *Housing;* stakeholders noted a need for: additional supportive housing capacity. For further information, see the community conversation data table in the Appendix.

Providers: Housing-Related Services (n = 13)

Seven (7) strengths were mentioned: Crisis Services (n = 1), Housing (n = 5), and Telehealth (n = 1). In terms of current needs/changes, the **primary identified need** during this conversation was *Collaborative & Integrated Care*; specifically, stakeholders noted the need for better collaboration between BHSD and OSH, as well as the need to re-evaluate the current integration of housing and Mental Health & Substance Use responsibilities within the same staff members The **second identified need** was *Workforce, Education, and Training;* stakeholders noted a need for: burnout recognition/prevention and reduced staff workload. For further information, see the community conversation data table in the Appendix.

East San Jose (n = 1)

Three (3) strengths were mentioned: CBOs/Programs (n = 1), Expanded Outpatient Treatment (n = 1), and WET (n =1). In terms of current needs/changes, the **primary identified need** during this conversation was *Treatment Services*; specifically, stakeholders noted the need for additional BHSD services embedded in jails, SUTS that don't punish relapses, and additional supported employment programs. For further information, see the community conversation data table in the Appendix.

EXECUTIVE SUMMARY

Based on community stakeholder feedback, the **core strengths** of BHSD housing services were current housing programs, access processes/procedures, CBOs/programs, telehealth, expanded outpatient services, and quality of care. These strengths, along with areas of need identified by consumer stakeholders in the community survey and community conversations, yielded the following recommendations.

Housing Recommendations *(mapped onto Department-level Goals)*

The below recommendations should be implemented within the larger context of the department-level recommendations from the BHSD department-level analysis of the current report. Several of the 5 BHSD priorities were mirrored or called out in the housing-focused data. These corresponding BHSD priorities have been noted below, with the addition and integration of housing-related comments / data. Together, they constitute 8 Housing recommendations:

Corresponding Department Goal #	Description of Recommendation
2 Housing	**10. Increase Housing Availability.** BHSD stakeholders noted the need for increased housing capacity, with specific requests for LGBTQ+-specific housing, more flex funds, housing options for those in wheelchairs, and housing options for Criminal Justice consumers.
3 Emerging Needs	**11. Expand Housing-Related Treatment Services.** AOA stakeholders noted the need to expand services for <u>those not currently involved in a BHSD-related housing program</u>. Specific requests include: more case management during the housing application process, an FSP-like program specific for those who are chronically unhoused, and more clinicians to visit the unhoused wherever they can be found. Stakeholders also noted the need to expand services for <u>those currently involved in a BHSD-related housing program</u>, such as additional resources for scattered-site PSH, psychiatry/therapy at all PSH sites, and Mental Health & Substance Use treatment within temporary/transitional housing sites.
5	**12. Enhance Collaboration and Integration Between BHSD/Housing Sites with Inpatient Discharge.** It is recommended that BHSD seek ways to improve collaboration between hospital staff and PSH staff when PSH consumers are discharged from psychiatric hospitalizations.
5	**13. Improve AOA's Collaboration With Office of Supportive Housing.** Based on stakeholder comments, BHSD should consider improving the collaboration with Office of Supportive Housing, especially as the collaboration affects PSH staff and programming.
3 Emerging Needs	**14. Improve BHSD-CBO Contracts.** Consider improving contract flexibility for permanent supportive housing (PSH) agencies for activities

	such as burnout prevention, client advocacy, time spent traveling to clients, and Mental Health & Substance Use training.
4 WET	**15. Consider Innovative Ways to Retain Clinical Staff Who Support Housing Programs,** such as reducing staff productivity requirements and reducing burnout with innovative approaches to supporting staff who experience vicarious trauma. Consider increasing PSH staff pay to compensate for their dual skillsets in therapy and housing.
1 Timely Access	**16. Increase Unhoused Access to Care Through Potential Options for Direct Agency Referral.** Based on stakeholder comments, BHSD should consider facilitating direct agency referrals for those who are unhoused.
Not Listed	**4. Quality of Care: Increase cultural safety of LGBTQ+ housing programs.** BHSD was affirmed in its efforts at LGBTQ+-specific housing, but it became clear that these spaces are not always safe for LGBTQ+ (especially TGI+) consumers; it is recommended that BHSD consider efforts to increase the cultural safety of these programs. For example, facilitate additional LGBTQ+ training for staff at transitional & temporary housing sites to address issues of anti-LGBTQ+ prejudice, and ensure that consumers know the proper avenues of reporting anti-LGBTQ+ discrimination so that BHSD can respond appropriately.

NAVIGATION MENU OF EXECUTIVE SUMMARIES *(click to navigate to page)*

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Executive Summary: BHSD Department-Level Analysis (page 29)

Children, Youth, and Family (CYF) Services (page 58)

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Workforce, Education, & Training (page 84)

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Unhoused Stakeholder Participants

In total, unhoused stakeholder participant data for the Community Planning Process came from 5 specific unhoused-related community conversations, encompassing 26 unhoused stakeholders. Across all community conversations, there were 134 stakeholder comments, combined with 69 unstably housed consumers or family members on the survey.

Unstably housed survey respondents were identified by their Yes / No responses to the following question: "In the past two months, have you been living in stable housing that you own, rent, or stay in as part of a household?" Of the 69 total unstably housed survey respondents, 32% (n = 22) identified as clients/consumers, 10% identified as family members, and 45% did not answer items to determine if they were consumers versus family members.

Unhoused or Unstably Housed Participants

5 Unhoused-related Community Conversations

26 Unhoused stakeholders in Community Conversations

134 stakeholder comments about housing

On the Survey: 69 individuals who not stably housed
22 were BHSD clients
7 were family members
31 did not answer items to determine if they were consumers/family members

Of the 69 unhoused survey respondents, 63 reported their race/ethnicity: 33 Hispanic/Latin//a/e (52.3%), 25 White (39.7%), 9 Black (14.3%), 9 Native American, American Indian, Alaskan Native (14.3%), 7 Asian (11.1%), 2 Middle Eastern or North African (3.2%), and 1 Pacific Islander (1.6%). Gender identity was reported by 46 individuals; 30 identified as men/boys (65.2%), 9 identified as women/girls (20.0%), and 7 identified as TGI+ (15.2%). They were primarily adults aged 25-59 (92.6%), with 4.4% ages 60+, and 2.9% ages 16-24. A vast majority (82.1%) identified as heterosexual, and 17.9%% identified as LGBQAP2S+. Primary city of residence was San Jose (n = 45), followed by Santa Clara (n = 5), Morgan Hill (n = 4), and Mountain View (n = 4). When asked about disability status, 50.9% endorsed having a disability.

When comparing the demographics of those who are unhoused (n = 69) to the general community sample (n = 667), it is important to note the following:

- TGI+ individuals make up represent 7.1% of the community sample, but they represent 15.2% of those who are unhoused.
- Cisgender men/boys represent 33.8% of the community sample, but they represent 65.2% of those who are unhoused.

Unhoused sample: Higher proportion of TGI+ and cisgender men / boys than the overall sample

These data suggested a higher proportion (over-representation) of men and TGI+ individuals in the survey subsample who are unhoused.

See below for a chart detailing the insurance status of those who are unhoused (n = 59 responses).

Insurance Status, Those Who are Unstably Housed	n
Medi-Cal	42
Medicare	7
No Insurance	4
Private Insurance	2

Survey Data for Unstably Housed Stakeholders

44.3% of the Unhoused respondents reported it's been hard to access or afford Mental Health & Substance Use services

44.3% of respondents who are unhoused reported that it has been hard for them to access or afford Mental Health & Substance Use services. When asked about accessing care, respondents on average stated it is "mostly true" that they know where to go to access services (2.92) and that it is "mostly true" that they know who to call to access services (3.09).

When asked, 70.2% of those who are unhoused stated they have had a mental health or substance use problem in the last 12 months. Of note, 19.2% of responses suggested co-occurring mental health and substance use (dual diagnosis) problems. Of those who reported a Mental Health & Substance Use problem, 48.7% reported that they did not receive or seek treatment over the past 12 months. When these individuals were asked why they did not seek or receive services, their top reason was "There aren't enough services" (55%), followed by "There is a lack of help in my language" (26.3%), and "I don't think providers don't understand my needs" (21.1%).

Unhoused sample: 48.7% didn't receive treatment in the past year
Overall sample: 29.3% didn't receive treatment in the past year

Results from Those who are Unhoused and were Consumers of BHSD Services:

Of the 69 survey respondents who are unhoused, 22 were consumers /family members who received BHSD services of the past year (21 consumers; 1 family member of a consumer). Specifically, unhoused consumers/family members reported using the following services over the past year:

Programs Used by Those Who are Unhoused, Last 12 Months	n
Mental Health & Substance Use Services for Children, Youth, and Families	-
Mental Health & Substance Use Services for Transitional Age Youth (TAY)	3
Mental Health & Substance Use Services, 26-59	8
Mental Health & Substance Use Services, 60+	-
Criminal Justice	1
Behavioral Health Call Center Access Line	2
988	1
EPS	3
Drop-in or Walk-in service options	-
Mental Health Urgent Care	1
Suicide/Crisis Hotline	-
Mobile Crisis Response Team	-
Substance Use Services Access Line	-
LGBTQ+ Services	-
Children's Mobile Crisis Response Team (Pacific Clinics)	-
Crisis Text Line	-
Peer Navigator Program	-

Responses on the six MHSA survey domains (access, quality of care, family inclusion, cultural considerations, recovery orientation, telehealth) were compared between housed vs. unhoused consumers/family members. There were no statistically significant differences, although there were higher ratings for family inclusion by those who were housed (2.8, SD = 0.98) versus those who were unhoused (2.4, S.D. = 1.2). Over half (53.3%) of unhoused consumers were asked if they want their family to be included in their Mental Health & Substance Use treatment.

Referral by other providers was the most common way that unhoused consumers initially learned about Mental Health & Substance Use

Consumers/family members who are unhoused (n = 22) were asked how they initially learned about Mental Health & Substance Use services; the most common answer was from other providers. For full results, see the chart below.

How Did you First Learn About Mental Health & Substance Use Services?	n
Provider	8
Word of Mouth	5
Call Center	4
Internet	2
Walk-In	2
Called Clinic	1
988	1

Unhoused consumers/family members were also asked if they had at any point interacted with the Call Center or the Access Line; a vast majority (78.6%, n = 11) stated that they had not interacted with the Call Center or Access Line, and only 21.4% (n = 3) of consumers who are unhoused had interacted with the Call Center or Access Line. The average number of weeks for unhoused consumers to get connected was 3.7 weeks (range: 0 weeks – 12 weeks).

21.4% of unhoused consumers interacted with the Call Center or Access Line

Average service connection time: 3.7 weeks

Of the 16 unhoused consumers who responded to an item about telehealth, about two-thirds (62.5%) stated that they had not received telehealth services within the last year; 25% stated they had received 1-3 telehealth sessions; 6.3% reported receiving 7-11 telehealth sessions; 6.3% reported receiving 12-19 telehealth sessions.

When asked about the accomplishments of the BHSD system, 16 unhoused consumers responded, as follows:

1) "Services are helpful" (n = 11)
2) "My mental health and substance use treatment providers talk to each other and coordinate services with other agencies" (n = 8)
3) "Services are focused on patient-centered recovery" (n = 8)

When asked about the most important needs of the BHSD system, 14 unhoused consumers responded, as follows:

1) "Disability accommodations need to be improved" (n = 4)
2) "Services should be helpful" (n = 4)
3) "Services should employ more peer support staff (i.e., people with similar experiences)" (n = 4)
4) "Service providers should talk to each other and coordinate services with other agencies" (n = 4)

Strengths in Unhoused Services from Community Conversations

Ten comments from stakeholders in community conversations spoke to strengths related to unhoused services in the county. The most commonly reported strength was in relation to the department's recent investment in permanent supportive housing, along with supportive

"The system has evolved and in many ways grown better to look at things like multidisciplinary teams versus…a case manager [only]…I would say the direction [that] things are going, in many ways, is very good."

"Good job on…[investing] a lot in site based permanent support of housing and providing services to sites."

services for permanent supportive housing.

Examples of these strength in services include a focus on multidisciplinary teams, a focus on the housing needs of transitional-aged youth, the provision of strong case management services, as well as a whole person approach to incorporating trauma in unhoused supportive services. Stakeholders also mentioned benefits to the use of housing flex funds to get immediate housing access consumers right after they are released from custody. Finally, one comment discussed strengths in these services offered by East Valley homeless clinic.

"…including housing flex funding within the FDR programs as this allows our providers to secure immediate housing for individuals being released from custody."

"…case management are doing a lot to get information that we receive out to our clients"

"…after someone has housing is stabilized…there are layers of issues that must be addressed with someone who is chronically [experiencing] trauma…I love the way that they look at that approach [as a whole person with multiple layers of the process]… I think that's very innovative."

Areas of Need in Unhoused Services from Community Conversations

"People really need the housing. It's something that I see a lot in the field that people are looking for, and even myself, when I was trying to help people. The resources are scarce…"

"There is no excuse for the number of people living in tents on the side of the freeway. They need a small basic room, bed, shower, sink and toilet. Local garbage pick-up. Nothing fancy. Just something to get out of the rain and the cold."

The most commonly mentioned area of need related to housing, was for **more access to housing, and stabilization of housing options for consumers**. In addition to many comments about the need overall for more housing (including temporary housing, transitional housing, and permanent supportive housing), specific suggestions included more LGBTQ+ specific housing, flex funds to secure housing, more housing options for South County, housing beds specific to criminal justice, and more housing options for those in wheelchairs.

The second most commonly mentioned area of need related to community, was the need for **more treatment services related to housing support**. Twenty-three comments discussed a need for services for unhoused stakeholders who are not currently in a BHSD related housing program.
Commonly discussed was a need for more case management for those applying for housing, given the complexities of the process and paperwork. Some suggested a full service partnership

like programs specifically for those who are chronically unhoused, as well as services provided directly to the unhoused wherever they are found.

"The people that need the help, the most are the ones that are not getting housed, because the program was designed to come with case management. There's not enough managers. So if you can't find your [help] by yourself, and you can't fill out the application, … you don't have a car, you don't have money, credit… [you're] not gonna get help."

"If anyone reached out and…provided support around other housing options. Not…just advice…someone to do research and help you figure that next step out"

"We need more of…having therapists go out and meet [unhoused] people where they are..."

S
already currently engaged in BHSD-related housing programs, such as more contract flexibility for non-billable client advocacy efforts. Stakeholders pointed to a specific need for more resources and support for scattered site permanent supportive housing, defined as services that are not located in one consolidated site, but rather are scattered in different locations (as was created years ago but are still in existence). Staff supporting scattered site PSH programs may need more contract time for home visits.

"There's been this investment in site-based housing and the County has sort of forgotten about the initial [scattered site PSH] programs that that we serve in the community."

"How it used to happen is there was a behavioral healthcare team that that folks in housing could call upon, but they weren't really accessible that it doesn't really work. If they're not actually on site and supporting it like in in a sort of a housing setting."

Stakeholders also discussed a need for **more mental health and substance use treatment**, outpatient services within housing shelters and programs, increased capacity for residential and inpatient beds, more crisis and step-down care, and dual diagnosis services.

"Our clients need psychiatry…some of these site based programs … are just purely housing. They don't have access to psychiatry and therapy [that] they still really need…how do we maximize the strengths that are already in the county?"

"Having 2 data sources…and 2 audits and double documentation and double billing is really challenging. And there's no change to their expectation or staffing expectation. So our staff are doing double the work, but they're required to have the same amount of productivity, and that's all because of the way the contracts written, the agency wishes we could have more flexibility. But the way the contracts are written it's really challenging to make that work."

Many unhoused stakeholders spoke to the need for **more collaboration and integrative care, specifically between BHSD and the Office of Supportive Housing (OSH).** Consumers pointed to pain points in in lack of communication and coordination between BHSD and OSH requirements, expectations, and paperwork, creating increased workload, extra stress, and problems with retention for permanent supportive housing staff.

Other areas for increased collaboration were in relation to **discharge of unhoused consumers from inpatient crisis care.** Permanent supportive housing staff called for better coordination and communication, and standardized approaches so that unhoused stakeholders are not prematurely discharged without connection to resources and other mental health options at their housing sites.

"[There's] no standardized response for handoff.. when we…present ourselves as the outpatient providers, what usually tends to happen is [that] there seems to be [push-back]…from certain providers [and they just say]…these are doctors' orders…it really depends who the attending…provider is in that moment."

"[For good service connection for the unhoused], it's just about [inpatient providers] being patient, waiting for bed to be open and then making that step down. And oftentimes they're looking to discharge people so quickly that they don't have the opportunity to use those resources."

Twenty comments spoke to Workforce, Education, and Training needs to specifically **retain staff by addressing potential burnout** related to vicarious trauma experiences and the multiple pressures of balancing the differing needs and expectations of OSH and BHSD. Consumers suggested reducing staff workload, including for scattered site PSH staff, and by reducing documentation and the productivity requirements. Staff training and increasing staff pay for PSH staff were also mentioned as ways to retain staff.

Comments also spoke to the need to **decrease LGBTQ+ discrimination in BHSD housing programs**, and ensuring that consumers have an avenue to report anti-LGBTQ+ discrimination so that BHSD can respond appropriately.

Six comments pointed to the need for **non-Call center access options (i.e. direct referrals) for unhoused consumers**. Finally, three comments mentioned the need to outreach to unhoused individuals specifically where they are, including for the increased number of college students who live in their cars on campus.

The following section represents general community-level recommendations from the community conversations and data from Santa Clara County residents who responded to the Mental Health and Substance Use Community Survey (including consumers, family members, general community residents, and other stakeholders). These analyses were conducted with the aim of understanding the mental health and substance needs of community respondents. It is important to note that 2023 recruitment and survey distribution efforts (for the FY25 annual update) were focused on garnering responses from consumers and family members, as opposed to 2022 outreach (for the FY2024-26 3-year community planning process) which included a mass physical mailing to household addresses across the County. Given these differences in sampling, comparability between community samples should be interpreted with caution.

Many of the 2023 survey marketing efforts were posted in spaces that would be viewed by general community members/residents of Santa Clara County (e.g., online marketing throughout the County, targeted cultural community outreach, distribution throughout County clinics and locations, and community partners whose network penetration was county-wide), and thus still included 481 general community respondents. These survey respondents who self-selected/volunteered to participate may not be representative of a random sample of all SCC residents, and data results should be interpreted with appropriate caution with regards to potential limits to generalizability.

EXECUTIVE SUMMARY: COMMUNITY NEEDS

When analyzing data from the general community survey respondents (regardless of whether they have engaged with BHSD services), 471 individuals responded to the question: "In the past 12 months, have you or another person (relative, friend, neighbor, minister, priest or other) thought you had a mental health, nervous, emotional, drug or alcohol problem?" Of these 471 individuals, 65.2% stated that they had a mental health or substance use problem, and 34.8% stated that they did not. When asked to describe the severity of their problem, the average respondent rated their problem as moderately serious and that their problem makes it mildly difficult to carry out daily activities.

65.2% stated that they had a mental health or substance use problem

"The connection piece is especially important because of the Covid pandemic… there's increased isolation… I can only imagine the isolation people feel, and that exacerbates everything."

Of those who stated that they had a mental health or substance use problem, 29.3% stated that they did not seek help. Together, these data indicate that about one-third of community-level survey respondents living with a moderately serious and somewhat impairing mental health or substance use problem did not receive treatment services.

Additionally, community survey respondents in the current sample reported that the COVID-19 pandemic has left them with additional issues in need of assistance from mental health or substance use services, including: decreased self-care activities (e.g., sleep, exercise), additional mental health problems, increased difficulty with work/life balance, increased isolation, and more physical health problems.

Community-level Recommendations

Two community-wide recommendations emerged from the community needs survey and community conversations:

1. Untreated mental health and substance use struggles: Of the 65.2% of community survey respondents who are living with a mental health or substance use issue, almost one-third of them (28.3%) are not receiving treatment.

> **Recommendation: Continue or expand current BHSD services to ameliorate untreated mental health need in the community.** The current assessment further supports the County Board of Supervisors' April 2022 declaration of mental health to be a public health emergency. Notably, among those in the community sample who did not receive treatment, their top reason why was "There aren't enough services." The primary recommendation for ameliorating this untreated mental health need is to continue or expand current BHSD services.

2. Increase service access & awareness while maintaining privacy: Of the 29.3% of people with a mental health or substance use problem who did not seek help, the second most common reason was "My problems are not serious enough," indicating a potential perception that County services are only available to those in crisis or with very serious behavioral health struggles.

> **Recommendation:** It is recommended that the County engage in additional community education and in-person outreach to community organizations and religious/spiritual centers.

"Offer more services"

A flow chart detailing responses to survey questions assessing mental health burden and help-seeking/service connection within the general community sample is shown on the following page. Of the 667 community members who completed the survey, 471 individuals responded to a question about the presence of mental health or substance use problems in their own lives. Of these 471 individuals, 307 (65.2%) stated that they (or another person) thought that they had a mental health or substance use problem over the previous 12 months in response to the following question: "In the past 12 months, have you or another person (relative, friend, neighbor, minister, priest or other) thought you had a mental health, nervous, emotional, drug or alcohol problem?"

When asked about the severity of their mental health and/or substance use problem, community members stated that their problems were moderately serious (2.8), on average. Further, when asked about functional impairment, community members stated that their mental health and/or substance use problem made it somewhat difficult (2.4) to carry out their normal daily activities, on average. **In summary**, almost two-thirds of community survey respondents stated that they have a somewhat serious mental health or substance use issue that makes it somewhat difficult to complete their daily tasks.

Of those who stated that they have had a mental health or substance use problem in the last 12 months, 70.2% stated that they did seek help, leaving 29.1% of these individuals without mental health and/or substance use treatment.

29.1% of individuals with a mental health or substance use problem did not receive help or treatment

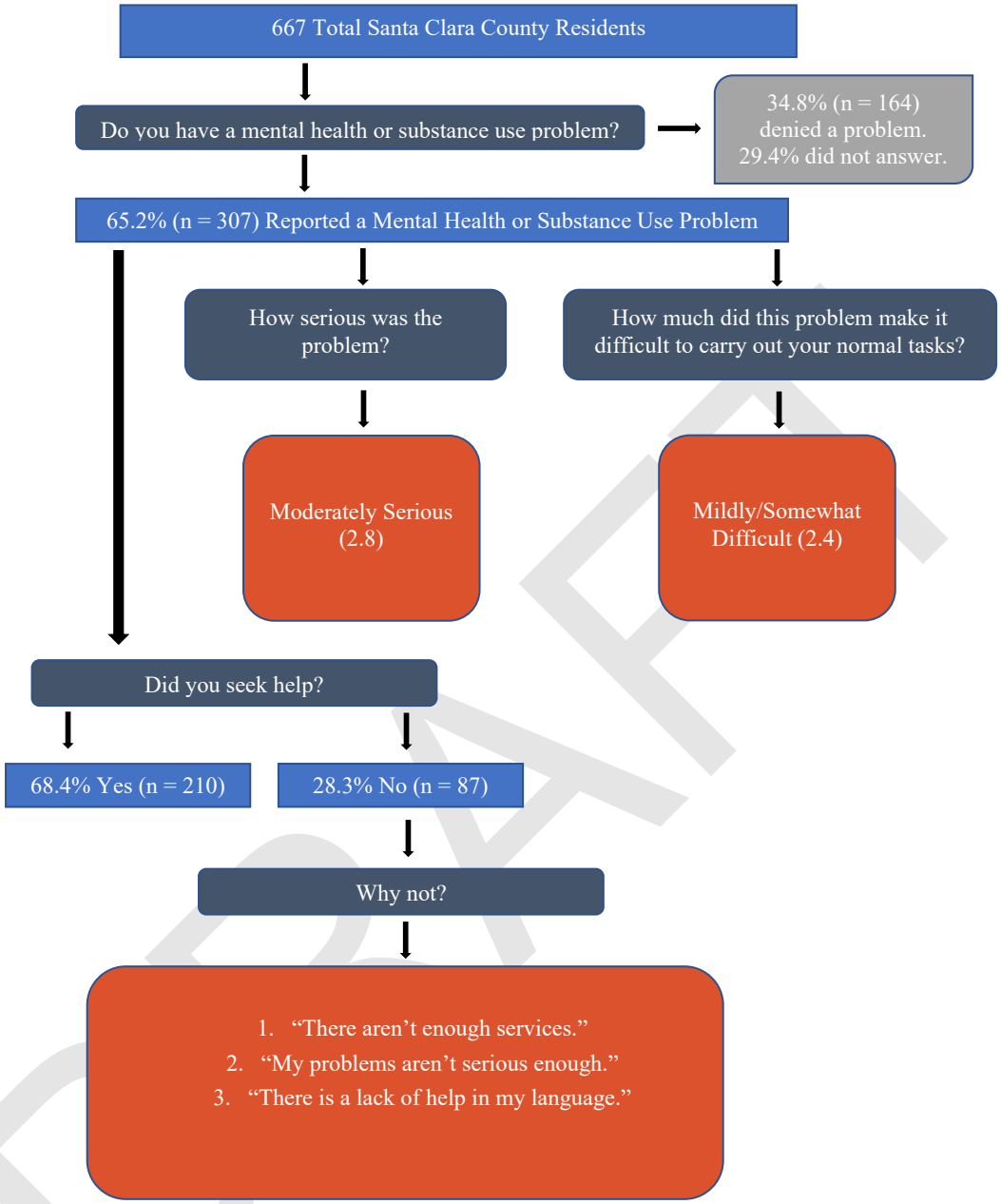
"Due to the pandemic it seems like the services are very well needed in the community… and they shouldn't be taken out, they should continue providing the services"

When analyzing only the subset of individuals who *did* report a problem but *did not* seek help, 87 community members answered a follow-up question about *why* they did not seek help ("What were the reasons why you did not seek help for mental health, nervous, emotional, drug or alcohol problems?"). Reported reasons for not seeking help are listed below in the Appendix; the top three reasons were the following:

Top 3 Reasons for Not Seeking Help

4. "There aren't enough services."
5. "My problems aren't serious enough."
6. "There is a lack of help in my language."

Flow Chart of Mental Health & Substance Use Burden and Help-seeking Responses



Note: Numbers may not add up to totals because of missing responses / skipped items.

Community Access to Mental Health & Substance Use Services

All 667 community survey respondents were asked whether they knew where to access mental health and substance use services, and if they knew who to call for mental health and substance use services. On average, community members stated it was mostly true (2.9) that they know where to go to get mental health and substance use services. They also reported that it was, on average, mostly true (3.0) that they knew who to call to get mental health and substance use services.

Strength: "Love the easy access through the Call Center"

All community respondents (n = 667) were asked about their insurance status; of those, 534 individuals responded to the item. The most common responses were: private insurance (n = 231, 43.3%) and MediCal (n = 209, 39.1%); see table below for full data.

What kind of insurance (if any) do you have?	
Private	231
MediCal	209
Medi-Medi	46
Medicare	36
No Insurance	12

All survey respondents (n = 667) were asked if they were unable to access or afford mental health and substance use services over the past 12 months regardless of insurance status. 520 individuals responded to the item; of those, 36% endorsed difficulties accessing/affording services (n = 187) and 64% denied difficulties accessing/affording services (n = 333).

Pandemic-Related Needs

All 667 community members were asked about their mental health and substance use needs as the pandemic improves and they transition back to school, work, and other activities, and 329 individuals responded. The most frequently reported needs were the following:

Top Pandemic-Related Needs

1. I am experiencing more problems with sleep, diet, or exercise.
2. I am experiencing more mental health problems.
3. I am experiencing a hard time with work/life balance.
4. I am more lonely or more isolated.
5. I am experiencing more physical health problems.

Of note, 138 out of 329, or 41.9% of community survey respondents, reported that they are experiencing more pandemic-related mental health problems. See the Appendix for a full list of data reported about pandemic transition-related needs.

“Post-Covid, I think, particularly in the schools, that there’s a lot of work that can be done around grief”

Department Stakeholder Identified Needs from Community Conversations, Aggregate

Primary Areas of Need	Number of comments
Increase Treatment Services	498
Workforce Education and Training	265
Access	235
Increase & Expand Prevention/Outreach	179
Collaborative & Integrated Care	93
Housing	61
Improve the Quality of BHSD Services	33
Miscellaneous	70

Department-level Stakeholder Identified Needs from Community Conversations, Aggregate, with Sub-Themes

Primary Need	Sub-Themes	Corresponding Department Goal #
Treatment Services (498 Comments)	Youth Mental Health & Substance Use Treatment Services – 138	3 [3.CYF]
	School Services – 26	3 [3.CYF]
	Youth Substance Use Prevention – 21	3 [3.CYF]
	Youth Parent Services – 18	3 [3.CYF]
	Family Therapy Services – 16	3 [3.CYF]
	More Telehealth for Youth – 10	3 [3.CYF]
	Youth Substance Use Treatment – 8	3 [3.CYF]
	Detox Services – 38	3 [3.1]
	Criminal Justice Services – 30	3 [3.4]
	More Residential/Inpatient Beds – 23	3 [3.AOA]
	LGBTQ+ Services – 23	3 [3.AOA]
	Treatment for those who are Unhoused – 16	3 [3.3]
	Dual Diagnosis Treatment – 16	3 [3.AOA]
	Services for Immigrants & Refugees – 16	Not listed
	Reduce Isolation – 16	Not listed
	Crisis Care – 15	3 [3.AOA]
	Longer-Term Treatment – 14	3 [3.AOA]
	Treatment for those Seeking Housing – 13	3 [3.3]
	Services for those who Decline Treatment – 13	3 [3.AOA]
	Support Groups – 12	3 [3.AOA]
	Step-Down Residential Treatment – 10	3 [3.AOA]
	Support Obtaining Benefits for Those Who are Unhoused - 10	Not listed
	Improvements to BHSD-CBO Contracts – 8	3 [3.4]
	Services for Women – 3	3 [3.AOA]
	Other Treatment Services – 104	Not listed
Workforce, Education, and Training (265 comments)	More Clinical Staff (total) – 77	4
	More Clinicians (non-specific) – 23	4
	More Peer Support – 13	4
	More Case Managers – 11	4
	More Therapists/Counselors – 10	4
	Greater Pay for Treatment Staff – 11	4
	More Psychiatrists – 9	4
	More Therapists – 8	4
	More CIT Staff – 5	4
	Hiring Considerations (e.g., culturally-matched staff) – 64	4

	Reduce Staff Turnover – 51	4
	More Staff Training (e.g., DEI, LGBTQ+) – 43	4
	Increase Staff Pay – 31	4
Access (235 comments)	Improve Community Awareness of BHSD Services – 56	Not listed
	More Language/Translation Services – 47	Not listed
	*Easier/Faster Access to Treatment Services – 45	1
	Increase Transportation Support – 28	Not listed
	*Improve Call Center integrated screening processes – 25	1.2
	*More non-Call Center access options – 15	1.5
	*Improve Call Center Response Times – 8	1.2
	Improve Call Center User Experience – 6	Not listed
	*More Assistance Navigating BHSD System– 5	1.4
	Need Childcare Services During BHSD Appointments – 4	Not listed
	Increase Youth Awareness of BHSD Services – 4	Not listed
	Direct access to SUTS for those who are Unhoused – 1	Not listed
Prevention / Outreach (179 comments)	General Outreach – 49	Not listed
	Reduce Community Stigma – 32	Not listed
	Increase Community Awareness of Mental Health & Substance Use – 29	Not listed
	School-based Outreach – 16	Not listed
	Ethnic-Specific Outreach – 10	Not listed
	College Student Outreach – 10	Not listed
	Train the Community to Help & Refer – 7	Not listed
	Substance Use Prevention – 6	Not listed
	In-person Outreach – 4	Not listed
	Community/Event-based Outreach – 4	Not listed
	Outreach to those who are Unhoused – 3	2 [2.3c]
	Outreach via Religious/Spiritual Venues – 3	Not listed
Collaboration & Integrated Care (93 comments)	More External Collaboration/Integration (e.g., OSH, OOE) – 67	5
	More Internal Collaboration Within BHSD – 21	5
	Other Collaboration – 6	5
Housing (61 comments)	More Housing (General) – 55	2 [2.1]
	More Temporary Housing – 3	2 [2.4]
	More Permanent Supportive Housing – 4	2 [2.3]
	More Transitional Housing – 1	2 [2.2]
Improve Quality (33 comments)	General Care Quality Improvement – 29	Not listed
	More Clarity about the Time Limits of Care – 4	Not listed

Note: *"Not listed" means that the area of need is not listed in the description of the current 5 BHSD goals*

BHSD Department-Level Analysis Tables

BHSD Strengths Identified by Survey Respondents	n
Services are helpful.	66
My mental health and substance use treatment providers talk to each other and coordinate services with other agencies.	56
Services are focused on patient-centered recovery.	41
Service providers understand my needs.	39
Services are provided by people who understand or share my culture and/or speak my language.	32
Services help me accomplish my goals.	31
Services are available in a crisis.	26
Services are consumer and family driven (families and clients have a primary decision-making role in their services).	23
Services are accessible (e.g., easy to get appointments, good locations/times).	21
The availability of telehealth	17
Help is available from peers, people who have similar experiences.	16
The availability of culturally-specific community programs.	12
One point of access to services through the 988 number	10
Services are accessible for individuals with disabilities	5

BHSD Strengths Identified in Community Conversations, ranked	n
Quality of Care (e.g., "staff are kind and nice")	31
Youth/School Services (School Wellness Centers, San Jose Youth Wellness Center, Family therapy in juvenile prison)	28
Community Based Organizations (e.g., Goodwill, Gardner, Allcove, AACI)	23
Access (e.g., "easy to access BHSD services," 988, mobile mental health trucks/vans)	19
LGBTQ+ Services (Q Corner, LGBTQ+ space, current Gender Affirming Clinic)	16
Expanded Outpatient Treatment (immigration/refugee services)	15
County Clinics/Programs (e.g., Evans Lane, Elmwood, New Haven)	15
Outreach & Prevention	12
Criminal Justice Services	11
Telehealth Options	11
Housing Services	9
Crisis Services (e.g., Mobile crisis teams)	8
Workforce, Education, and Training (e.g., case managers, peer support, internship stipends)	7

Collaborative Care	3

BHSD Areas of Need Identified by Survey Respondents	n
Services providers should talk to each other and coordinate services with other agencies.	44
Services should be focused on patient-centered recovery.	41
There aren't enough services.	39
We need different types of services.	30
Services and referrals should be helpful	30
Service should employ more peer support staff (i.e. people with similar experiences).	25
More service providers should go out into the community to deliver services.	23
Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours).	22
Services should be provided by people who understand or share my culture.	22
Services should be available in my preferred language.	21
Services providers should understand my needs.	19
Disability accommodations need to be improved.	10

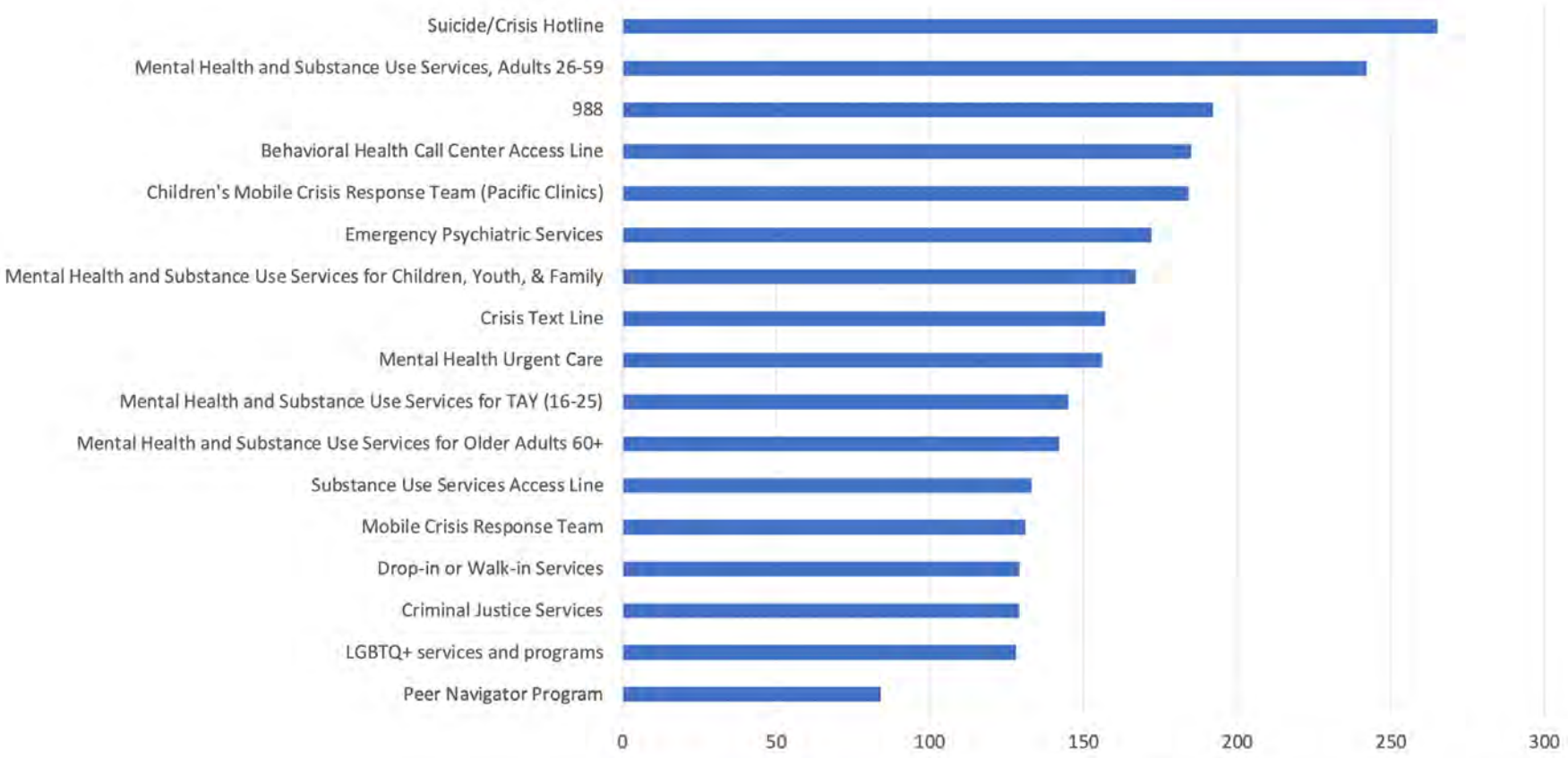
BHSD Needs Identified in Community Conversations	Number of comments
Treatment Services	497
Workforce, Education, and Training (WET)	265
Access	256
Outreach & Prevention	160
Collaborative & Integrated Care	93
Housing	61
Quality of Care	33

Note: The n represents the number of times a particular theme was mentioned in any community conversation, typically by different people. Total number of mentions was 1635..

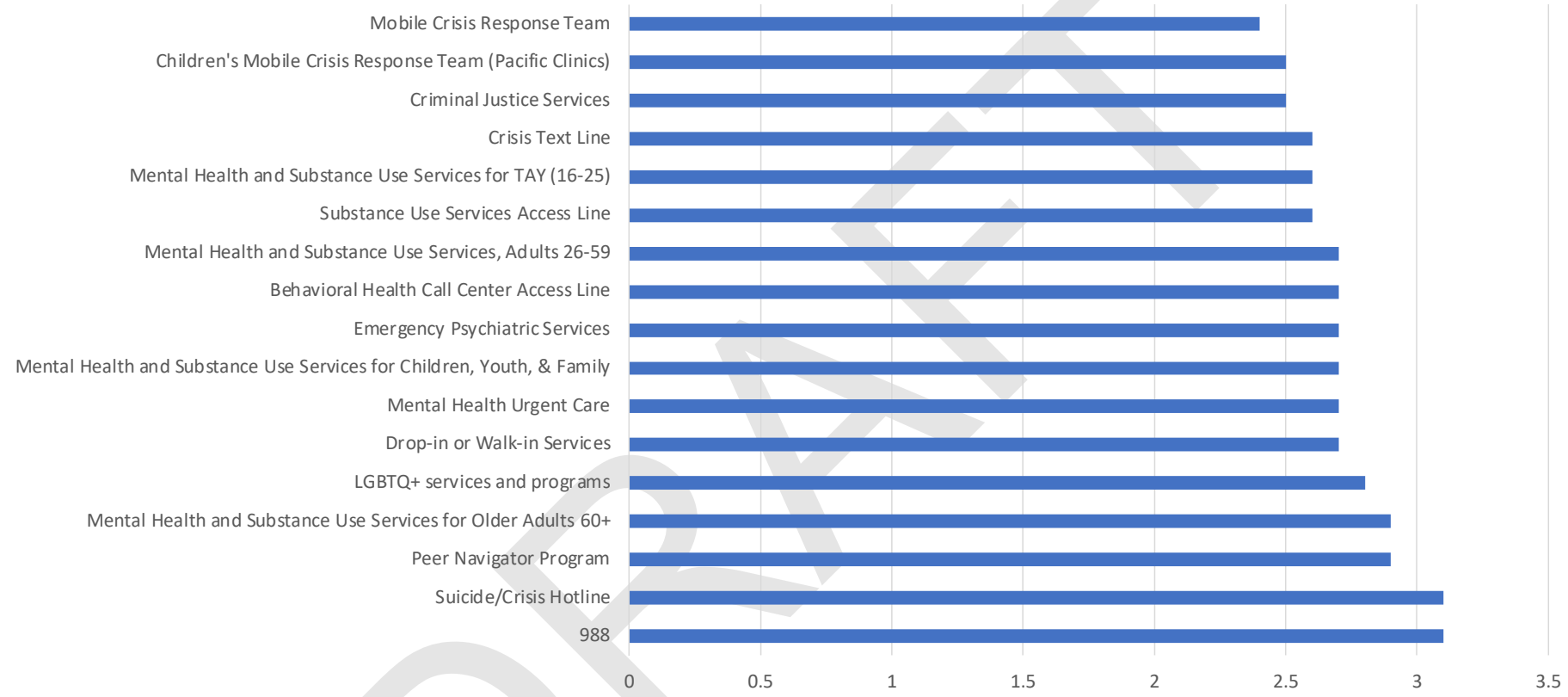
Quality of Care, by item	Mean Score
Provider created a safe and respectful space	3.3
Good communication with my provider	3.3
BHSD staff acted professionally	3.4
Satisfied with my BHSD services	3.2
Quality of Care Average Score	3.3

Note: Items were rated on a Likert scale of 1 = Not at all true, 2 = A little bit true, 3 = Mostly true, and 4 = Very true.

Community Survey Responses to the question: "Are you aware of any of the following services?



Community Survey Responses to the question: "How easy was it to access the following services?



Note: 1 = Very Difficult, 2 = Somewhat Difficult, 3 = Somewhat Easy, 4 = Very Easy

Access to Care, Item-by-Item Scores	Mean Score
I know where to go	2.8
I know who to call	2.9
Providers informed me about services/resources	3.0
It's not hard to get connected to my provider	2.6
My BHSD team provides care when I need it	3.1
Access to Care Average Score	2.9

Note: Items were rated on a Likert scale from 1=Not at all true to 4=Very true, or 1=Not at all hard to 4=Very hard.

Method of Connecting to Provider	n (%)
Referred from other providers	57 (44.2%)
BHSD Call Center Access Line (MH or SU)	36 (27.9%)
Word of Mouth	39 (30.2%)
Internet Search, Brochure, or Flier	30 (23.3%)
Called the Provider/Clinic Directly	16 (12.4%)
By directly dropping in to a "walk-in" clinic	18 (14.0%)
By calling 988	4 (3.1%)

**Note: Percentages were calculated using 166 as the denominator*

Survey Data, Recovery Orientation, by Item	Mean Score
I have choice/options in my care	2.9
Services are focused on my goals/needs	2.9
Recovery Orientation Average Score	2.9

Note: Items were rated on a Likert scale from 1=Not at all true to 4=Very true, or 1=Not at all hard to 4=Very hard.

Family Inclusion, by Item	Mean Score
Offered to include family in treatment	2.9
Services helped family members better understand them	2.5
Family members support my recovery	3.0
Family Inclusion Average Score	2.8

Note: Items were rated on a Likert scale from 1=Not at all true to 4=Very true, or 1=Not at all hard to 4=Very hard.

Cultural Considerations, by Item	Mean Score
Provider understands my culture	3.2
Provider respects my cultural identities	3.4
Services are available in my language	3.7
Cultural Considerations Average Score	3.4

Telehealth, by Item	Mean Score
Satisfied with telehealth services	3.2
Few challenges accessing telehealth	3.1
Important to continue telehealth	3.6
Telehealth Average Score	3.3

Children, Youth, and Family System of Care-Level Analysis Tables

Community Survey Data from CYF Consumers (updated4.15)

CYF Survey Data Category	Average Response (Consumers & Family, n = 25)
Access to Care	2.6
Quality of Care	3.1
Cultural Considerations	3.3
Recovery Orientation	2.9
Family Inclusion	3.0
Telehealth	3.1

CYF Themes from Community Conversations, Aggregate Data

Strengths (What should stay the same?)	Number of Comments
- Student Wellness centers – 9 - Satisfaction with quality of BHSD services – 8 - Therapy options (e.g., early childhood services, Strengthening Families workshops, TAY services, family systems services) – 7 - Mental Health & Substance Use treatment in juvenile jail – 6 - Downtown San Jose Youth Center – 5 - CBOs (AACI, New Haven, Goodwill, Q Corner) – 4 - Outreach/Prevention services – 3 - Access to BHSD services – 2 - School -based services – 2 - TAY housing services – 2 - Mental health mobile clinics – 2 - Community planning events – 1 - Flexible County processes – 1 - Peer leader training – 1 - Training School Staff on Mental Health & Substance Use – 1	54

CYF Stakeholder Identified Needs from Community Conversations, Aggregate, with Sub-Themes and Quotes

Primary Themes	Sub-Themes	Corresponding Department Goal #	Quotes
Treatment Services (186 Comments)	School Services – 29 • Major youth concern: parents' access to therapy records – 7 • Expand sex education to prevent sexual assault – 4 • More school services for sexual assault – 4 • More peer training in schools – 2 • Establish school mental health peer referral system – 2 • Other School Service Suggestions – 10	3 [3.CYF]	"[NAMI] came over to our school and did a presentation… that was really cool" "There's a lot of hesitancy on our school campus because of the confidentiality fear that it's going to get reported back to them [parents]" "a mental referral form where we can refer yourself or your friends"
	Youth Substance Use Prevention - 21 • More MH education in schools to prevent SU – 10 • More youth substance use prevention focused on mental health and education – 5 • More MH treatment to prevent development of SU problems – 1 • More youth-led prevention efforts – 1 • General support for additional youth substance use prevention – 4	3 [3.CYF]	"educating kids… more about shame, resilience…" "let's talk about being well… being happy and feeling better without using…"
	Youth Substance Use Treatment Services - 18 • More dual diagnosis treatment for youth – 5 • More detox services – 5 • Need youth-focused AA/NA options – 1 • Suboxone program – 1 • More programs for vaping cessation – 1 • General comments on youth substance use treatment – 5	3 [3.CYF]	"It's really important to address how substance abuse and mental health, they're interconnected… they're very much related… and so I feel like in general, the broad umbrella of substance use can be used as an unhealthy coping mechanism" – CYF consumer
	Youth Parent Services - 17 [2: CYF+] • Parent Psychoeducation on Mental Health & Substance Use – 15 • Establish a parent peer program – 1 • General support for parent psychoeducation – 2	3 [3.CYF]	"making sure parents [in a setting] where they're going to pay attention, they can actually know what mental health services are"

	Support attaining benefits -10 • More help determining if eligible for benefits – 3 • More case management to help with the benefits application process – 7	3 [3.CYF]	"support for County CalFresh and General Assistance… it was difficult to get that going… I didn't really find that there was somebody that could help me with it…"
	More Therapy for youth (General) - 8 [2: CYF+] • More long-term therapy options – 2 • Counseling services for youth (general) – 6	3 [3.CYF]	"with the current stressors… after working through those, will you actually get down on a deeper level… if you only get those first few therapy sessions… that's kind of just a vicious cycle…" – CYF client
	More telehealth for youth (General) - 7 [2: CYF+] • Telehealth allows youth to have time and access services – 4 • Telehealth helps circumvent parent stigma – 3	3 [3.CYF]	"I feel like having services online can help because if there's a lot of parent stigma…"
	Services for those who Decline Treatment - 7 [2: CYF+] • Services for adult youth who are pre-crisis and decline treatment when they need it – 5 • Need a multi-service team to assist with the conservatorship process – 1 • Need more parent support for adult youth who need treatment but consistently decline it – 1	3 [3.CYF]	"when you call the line and you can't get your loved one to agree to treatment, they just stop right there and there was nothing… I don't know what the answer is, but if we could have started receiving services sooner, I think that we'd be so much further along right now" – family member
	More Residential/Inpatient Beds - 6 [2: CYF+] • More options for inpatient adolescent stays – 3 • More residential treatment for youth – 1 • More rehabilitation beds for youth – 1 • More respite care – 1	3 [3.CYF]	"The County needs more options for inpatient stays for adolescents"
	Services for Immigrants & Refugees - 5 [2: CYF+] • More acculturation services for immigrant and refugee families (e.g., on LGBTQ+ culture) – 2 • Trauma-focused care – 1 • More family services targeting inter-generational cultural divide – 1 • General need to invest into refugee and immigrant needs – 1	3 [3.CYF]	"Children are having some conflict… they want to accept what the teacher says, but that's not what's happening at home…" " When the youth arrive here, there's a lot of assimilation acculturation that can actually increase the substance use…"

	Longer-Term Treatment - 5 [2: CYF+] • Longer-term outpatient treatment – 3 • Longer-term treatment for those in transitional housing – 2	3 [3.CYF]	"a more robust after care apparatus for people who will not thrive on their own without some levels of touches from the system…"
	Treatment for those Seeking Housing - 5 [2.3] • General support for those in the process of seeking housing – 5	3 [3.3]	"if anyone reached out and kind of provided support around other housing options… just someone to do research and help you figure that next step out"
	Reduce Isolation - 4 • Services for youth affected by the social isolation of the pandemic – 3 • Services to decrease isolation for those who are immunocompromised – 1	3 [3.CYF]	Services for "youth affected by the disruptions/prolonged social isolation of the pandemic"
	Support Groups - 4 [2: CYF+] • Support groups in inpatient settings – 1 • Youth support groups (general) – 1	3 [3.CYF]	
	Services to Bridge Intergenerational Divide - 4 [2: CYF+] • Services for youth, parents, and families struggling with inter-generational cultural conflicts – 4	3 [3.CYF]	"having 2 cultures, the child is in school for 8 hours at least, and then the home environment, home culture… and there's a constant clash between them…"
	More Physical Locations for Youth Drop-in Services - 3[2: CYF+] • General need for more physical locations for youth treatment – 3	3 [3.CYF]	"So the thing with Allcove is that before they had 2 sites, but now there's only one site in Palo Alto…"
	Criminal Justice Services - 2 [2.4] • Need more private locations for Mental Health & Substance Use treatment in jails – 1 • Should stop requiring Mental Health & Substance Use treatment in jails for youth – 1	3 [3.4]	"It's sometimes hard to get a place to meet though"
	LGBTQ+ Services - 2 [2: CYF+] • Need counselors for the Gender Affirming Clinic – 1 • Need more LGBTQ+-specific physical spaces for youth – 1	3 [3.CYF]	"Youth Space… the drop-in center has been a core component of that program since they started in 2008, and they lost a physical space during the lockdown and still do not have one"
	Services for Women - 2 [2: CYF+] • Perinatal Mental Health & Substance Use services – 1	3 [3.CYF]	"Behavioral services dedicated to the perinatal population, so either new moms

	• Female detox center – 1		or even dads… clinicians to work with parents…"
	Other Treatment Services - 24 [2: CYF+]	3 [3.CYF]	
Workforce, Education, and Training (62 comments)	<u>More Clinical Staff (by profession)</u> - 15 [4] • More youth peer support – 5 • More therapists in schools – 3 • More clinical staff focused on youth – 2 • More case managers – 1 • Non-specific recommendations for more clinical staff – 4	4	"[youth] probably need, the younger minds, to kind of understand what they need and provide help" - a parent participant "specialized recruitment… a lot of times these positions get filled just by the County hiring system… so outdated… and these are the folx who have lived experience, expertise, supporting LGBQ+ folx…" "The limit in diversity in regards to who you can consult to... is a big issue, one of the problems that a lot of my friends face is ... the deterioration of their mental health because of their family situation and a lot of the factors that contribute are because of cultural factors…" – a TAY participant "the counselor we have is shared with another school, and they're not licensed… [we need to] make sure that a lot of services that are offered in schools are verified" - a TAY participant
	<u>Hiring Considerations</u> - 20 [4] • Hire culturally-matched staff: o LGBTQ+ identified staff – 7 o School therapists from marginalized backgrounds – 3 o Middle Eastern providers – 1 o General desire for culturally-matched staff – 1 • Recruit from college students – 4 • More licensed staff – 2 • Collaborate with colleges to build the workforce – 1 • Use more paraprofessionals – 1	4	
	<u>Reduce Staff Turnover</u> - 10 [4] • Re-instate Covid-19 sick pay policies – 3 • Need a space for pronouns on all County documents – 2 • Tuition assistance for current staff members who want to go back to school – 1 • More prevention burnout for staff with lived experiences – 1 • Reduce clinician caseloads – 1 • Reduce clinician burnout (general) – 2	4	
	<u>Increase Staff Pay (general) - 9</u> [4]	4	
	<u>Staff Trainings</u> - 8 [4] • Staff training on LGBTQ+ issues – 5 • Staff training for school counselors – 1 • Staff training on Middle Eastern culture – 1	4	

	• More cultural competency training – 1		
Outreach & Prevention (38 comments)	<u>Reduce Mental Health & Substance Use stigma in the community</u> - 10 • Reduce stigma in parents – 7 • Reduce stigma in youth – 2 • Reduce stigma in youth who have recently immigrated – 1	Not listed	"Just more on outreach specifically because … I'm coming to school at [a university] in Santa Clara County, and… I just haven't heard about these services…" "putting funding into marketing and promoting such resources to students would be great" "prevention for the middle schools, for the elementary schools, for the kids to know these topics" "different activities that they can do… because I remember at times youth are like we wanna go bowling, we wanna go here…" "when it comes to mental health, at least like my parents specifically, they're not very receptive" "there are a lot of [youth] who say 'Oh I don't need it, yeah, it's bad, but I don't need that… for them, it seems like a hassle…'"
	<u>Need more outreach to the college campuses</u> - 7 • Increase college students' awareness of BHSD services – 2 • Coordinate with college professors to spread awareness of BHSD services – 1 • Outreach through the college counseling centers – 2 • General Outreach – 2	Not listed	
	<u>Need more Mental Health & Substance Use education in the schools</u> - 5 • Increase access to Mental Health & Substance Use information – 2 • General Mental Health & Substance Use education in schools – 3	Not listed	
	<u>Activities-Based Prevention</u> - 3 • General suggestion to include activities to increase engagement – 3	Not listed	
	<u>Vaping Prevention</u> - 3 • General suggestion to focus on preventing youth vaping – 3	Not listed	
	<u>Ethnic-specific outreach</u> - 3 • Middle Eastern – 1 • African immigrant youth – 1 • Immigrants – 1	Not listed	
	<u>School Prevention & Outreach - 3</u> • Suggestion to increase outreach to elementary school students – 1 • General suggestions to coordinate with schools – 2	Not listed	
	<u>Expand Drop-In Centers</u> - 2 • Expand Drop-in Hours – 1	Not listed	

	• Add more drop-in centers – 1		
	In-person outreach - 1 • Suggestion to increase in-person outreach efforts for youth – 1	Not listed	
	Discrimination Prevention - 1 • More activities to reduce anti-immigrant bias – 1	Not listed	
Access (29 comments)	More Non-Call Center Access Opportunities - 7 [1.5] • Need option for referrals without Call Center involvement – 3 • Need option or direct referrals for those who are unhoused – 2 • Need option for agencies to refer directly to each other – 1 • General Walk-In – 1	1.5	"mental health and the Wellness centers is known, but its services are not really as publicized… our teachers don't really talk about it at all during class… it's just something you hear on the announcements, and I mean honestly, what student listens to the announcements…" "improvement to language services… families often have to wait, or maybe check for another place to go because those services are… not the same as having a person in the room speaking the same language…" "Many parents cannot receive services... because they don't have any means or resources for childcare…"
	Translation/Language Services - 7 • More in-person translation services – 3 • More BHSD services in Spanish – 2 • More BHSD services in Vietnamese – 2	Not listed	
	Increase Youth Awareness of BHSD Services - 4 • Implement Wellness Fairs to all schools – 2 • General Need for Increased Youth Awareness – 2	Not listed	
	Need Childcare Services During BHSD Appointments - 4	Not listed	
	Improve Call Center integrated screening - 4 [1.2] • Need additional assessment items to ensure clients are referred to the correct agency/program – 3	1.2	
	Increase Community Awareness of Mental Health & Substance Use - 2 • More awareness of BHSD services along the continuum of substance recovery – 2	Not listed	
	Increase Transportation Support (General) - 2	Not listed	
Collaboration & Integrative Care (20 comments)	More Collaboration Between BHSD & Other County Agencies - 20 • Need more collaboration with medical services – 10 • Need a single EMR for all County services – 7 • Need a better bridge to college counseling sites – 1	5	"You have to wait 30 days so they can find a primary doctor…" "30 days and that's if it runs smoothly"

	• Need more collaboration with schools' independent therapists – 1 • Need more teacher training on Mental Health & Substance Use – 1		"And even after 30 days the wait to see a doctor is 3 months…"
Housing (15 comments)	More Housing (General) – 11 [3.1]	2.1	"Especially with the families too… single mom with two kids… you don't call every day and you lose your spot…"
	More Temporary Housing – 2 [3.4]	2.4	
	More Permanent Supportive Housing – 2 [3.3]	2.3	
Improve Quality (8 comments)	General Care Quality Improvement - 8 • Need a system for reporting of anti-LGBTQ+ aggressions by staff in housing centers – 7 • More recovery orientation – 1	Not listed	"even in [LGBTQ+ specific] housing, there's been complaints… and that's just unacceptable…"

Note: *"Not listed" means that the area of need is not listed in the description of the current 5 BHSD goals*

Access & Unplanned Services System of Care-Level Analysis Tables

Access & Unplanned Services: Consumer/Client/Family Data

Survey Domain	Average Consumers/Family Response (n = 90)
Access to Care	2.8
Quality of Care	3.2
Cultural Considerations	3.3
Recovery Orientation	3.1
Family Inclusion	2.6
Telehealth	3.2

Access & Unplanned Services: Strengths from Community Conversations

BHSD Strengths Identified in Community Conversations, ranked
<u>Access – 19</u> • Access to BHSD services (5) • 988 (2) • Mobile mental health trucks/vans (2) • Offering services throughout the day (e.g., night-time classes) (2) • Navigator program (2) • Offering services in multiple locations (1) • Language services in call center (1) • Self-help centers (1) • Connecting consumers to County resources (1) • Informational brochures (1) • Flexibility in how clients are opened (1)
<u>LGBTQ+ Services – 16</u> • Current LGBTQIA+ services (7) • Q Corner (4) • LGBTQ wellness Center (2) • Access to gender-affirming garments (1) • LGBTQ space (1) • Latinx Diversa group (1)
<u>Outreach & Prevention – 12</u> • Communication from BHSD MHSA & SP team (2) • Community education efforts (2) • Overdose prevention programming (2) • Prevention services (2) • Community outreach (1) • Community-based work (1) • Suboxone program (1) • Suicide prevention (1)
<u>Crisis Services – 9</u> • Mobile Crisis Teams (7) • Crisis response services (1) • Police intervention in mental health crises (1)

Access & Unplanned Services: Stakeholder Identified Needs from Community Conversations, Aggregate, with Sub-Themes and Quotes

Primary Theme	Sub-Themes	Corresponding Department Goal #	Quotes
Access (235 Comments)	<u>Increase Community Awareness of BHSD Services – 56</u> • Community needs more awareness (general) – 32 • Need a single list of all BHSD Services – 9 • More advertising – 7 • Increase community understanding of the process for accessing BHSD services – 3 • Need a physical location where people can go to get BHSD resources and information – 1 • More communication from city communications and supervisor newsletter – 1 • Collaborate with Public Health to market BHSD services – 1 • Market to Medical beneficiaries at PCP offices, hospitals, libraries, and DMV – 1 • Need a place where people can go to complete paperwork and gain knowledge about BHSD services – 1	Not Listed	"From the County, if you can provide a resource cheat sheet that would be great that we can share with kids as well." "I don't know what services the county provides." "if the clients cannot talk for themselves because of language barriers or the County does not have the right staff with the right language skill to help them, we are not helping our clients at all" "[more language services] particularly in South County specific to the Spanish-speaking, indigenous communities" "we call the client, but they have to bring their own translator" "In Gilroy I see it so much… psychiatrist wait time is 6 to 8 weeks…" "getting these services out in a timely manner because sometimes you lose people int eh cracks because they're waiting and… these processes can be so heinous for them…"

	<u>More Language/Translation Services – 47</u>
	• Spanish – 14
	  o Treatment services in Spanish (11)
	  o BHSD forms in Spanish (2)
	  o Spanish language services in South County (1)
	• ESL classes – 5
	• More Vietnamese language services – 4
	• Punjabi – 3
	  o MH resources in Punjabi (2)
	  o Punjabi language option on 988 (1)
	• In-person translation services – 2
	• More translation services for Middle Eastern languages – 2
		Not Listed	

	• More services in African languages – 1 • More ASL services – 1 • More services in Dari – 1 • More services in Pashtu – 1 • More services in Russian – 1 • Easier access to translation services – 1 • Language services within SUTS – 1 • More translation in outreach/prevention materials – 1 • Language (general) – 9		"as someone who has been in the emergency room waiting to be admitted in a psychiatric hospital… the process of getting admitted was… traumatic honestly…" "[one of my clients], she wants programs, she wants to enroll her children, she doesn't have money, she doesn't have a car, and doesn't know how to drive" "Call Center screenings… I think they've been saying we have to get these done quick, flip them – and they read like it… like they just completed miss that part [about symptoms and history]… asking some very specific questions about psychosis level, about level of acuity… do you want meds or do you want therapy?" "There is a lot of anxiety that comes from calling the calling line, I wish there were ways to request support in written format such as email or online forms. I don't mind in there is a longer wait to get a response…" "the Call Centers don't work, so you're sitting there waiting for hours…" "I have [called the Call Center] and they have decided the programs that I have to go to… it was not because I wanted to…"
	<u>Easier/Faster Access to Treatment Services – 45</u> • Should be "easier" to access BHSD services (too many barriers, too many requirements for program entry, too much paperwork) – 21 • Need shorter wait for BHSD services – 12 • Should be easier to understand the process for accessing BHSD services (e.g., "what are the steps ") – 10 • More information on who to contact for services – 1 • Reduce barriers to detox services – 1	1	
	<u>Increase Transportation Support – 28</u> • General Comments about Transportation as a Barrier to Accessing BHSD Services – 25 • Need to teach people to drive – 1 • Orientation on how to use public transportation – 1 • More rideshare vouchers for BHSD services – 1	Not Listed	
	<u>Improve Call Center Integrated Screening Processes – 25</u> • Need better diagnostic screening/assessment (e.g., psychotic symptoms, suicidality, history of hospitalization, eating disorders, types of symptoms) – 10 • Need to ensure that clients are only sent for levels of care that are appropriate for the client – 3 • Call Center should evaluate previous BHSD services history to reduce redundancy of services – 2	1 [1.2]	

	• Call Center should be staffed by clinicians – 2 • Need to clearly assess client's desire for therapy versus medication – 1 • Should use technology to help pair consumers with therapists who will be a good fit for them – 1 • Should be more streamlined – 1 • Need uniform screening for MH and SU – 1 • General calls to improve screening through the Call Center – 4		"Make flyers, like step by steps. First step you know go to this website. Second step put this information and send that, third step if you need help come to me the person who gave you this flyer… I feel like that would be really useful a lot." "Many parents cannot receive services whether they are support groups, psycho education groups, process groups or anything is that because they don't have any means or resources for childcare…"
	<u>More non-Call Center access options – 15</u> • Need an option for direct referrals (e.g., walk-ins) without using the Call Center – 9 • Need an option for direct referrals between BHSD agencies/providers – 3 • Need an option for direct referrals for those who are unhoused – 2 • Need a method of initiating care access through an online form or chat portal – 1	1 [1.5]	
	<u>Improve Call Center Response Times – 8</u> • Decrease wait time for the Call Center – 8	1 [1.2]	
	<u>Improve Call Center User Experience – 6</u> • Better training for call handlers – 1 • Increase cultural sensitivity when asking about citizenship status – 1 • General – 1 • More cultural sensitivity – 1 • Better explanation of limits to confidentiality, especially re: child abuse – 1 • Improve client voice in treatment planning process – 1	1	
	<u>More Assistance Navigating BHSD System – 5</u> • Help consumers navigate the process of accessing BHSD services (e.g., how to start, what to expect, what to ask for) – 5	1 [1.4]	
	<u>Need Childcare Services During BHSD Appointments – 4</u>	Not Listed	

	• Facilitate parents accessing BHSD services by providing childcare – 4		
	<u>Increase Youth Awareness of BHSD Services – 4</u> • Increase youth knowledge of BHSD services for which they are eligible, through: o wellness fairs (2) o wellness center marketing (1) o school advertising (1)	3	
	<u>Direct access to SUTS for those who are Unhoused – 1</u> • Faster treatment access for those who are unhoused with Mental Health & Substance Use problems – 1	3	
Prevention & Outreach (179 comments)	<u>General Outreach – 49</u>	Not Listed	"stigma… keeps people away, especially those who do not speak English as a first language… I think it would be helpful for prominent older people of all races do some PSAs… this would be effective for cultures who particularly respect their elders…" "more education on what mental health is because if you ask me, many [people] don't even know what mental health is…" "Do they ever do commercials? Like commercials where we could see black folk getting services where they can see that it's okay... that would be nice to see…" "…when I was in high school in the county I didn't know that there was a county…I didn't understand that there was something out there that could do something to help…And I
	<u>Reduce Community Stigma – 32</u> • General calls to reduce community stigma – 16 • Reduce Mental Health & Substance Use stigma in parents – 7 • Reduce community stigma via collaboration with religious/spiritual leaders – 5 • Reduce stigma in recent immigrants – 2 Reduce stigma in youth – 2	Not Listed	
	<u>Increase Community Awareness of Mental Health & Substance Use – 29</u> • General need to increase community awareness of Mental Health & Substance Use – 20 • Through social media (e.g., Instagram, Facebook) – 2 • Specifically the Hispanic/Latino/a/e community (e.g., through commercials) – 1 • Specifically for serious mental illness – 1 • Specifically regarding emerging substances – 1 • Specifically regarding Covid-19 – 1 • Specifically regarding child abuse – 1 • Specifically regarding substance use – 1 • Specifically the Sikh community – 1	Not Listed	

	Ethnic-Specific Outreach/Prevention – 18 • More racial/ethnic anti-discrimination efforts to prevent Mental Health & Substance Use problems for stigmatized communities (anti-Muslim discrimination, anti-South Asian discrimination) – 4 • Use TV commercials to reach African American community – 2 • More prevention for recent immigrants – 2 • Need a CCWP team focused on Middle Eastern community – 1 • Need a wellness center for Middle Eastern community – 1 • More Middle Eastern outreach – 1 • More outreach to African American community – 1 • More outreach to African immigrant youth – 1 • More targeted outreach using the terminology of the ethnic community (e.g., Hmong) – 1 • More outreach resources in Punjabi – 1 • Need to promote 988 in Punjabi spaces – 1 • More ethnic-specific outreach (general) – 2	Not Listed	think a lot of high school students don't.. it would be great for them." "I have used [college counseling services], and it's a wonderful service. … I feel like a lot of [the college counselors], they're not aware of additional services that the county can offer. So I was never redirected elsewhere for any of the… other services outside of just what [college counseling] offered…" "I want to learn how to get people to talk? For other communities, how has the County taken steps to bring them forward? So, if the Sikh community is at step 0 and there is some community that is at step 5 - how did they get there? That's what I want to learn. So that we can move our community in the right direction" "The number of cars that are overnight there at the South Garage [on campus] has been more in comparison to the previous semesters… is anybody going out there to check on them, or offering these services … because I … myself was homeless at some point, and it's really hard to get help, to look for those services…" "More discussions about fentanyl overdoses."
	School-Based Outreach – 15 • More outreach to public schools – 6 • More prevention in public schools – 3 • More school education on Mental Health & Substance Use – 5 • School wellness centers should be open outside of class lessons – 1	Not Listed	
	College Student Outreach – 7 • More outreach to college campuses – 5 • More outreach to the college counseling centers – 2	Not Listed	
	Train the Community to Help & Refer – 7 • Need more trainings for community members to learn how to recognize Mental Health & Substance Use problems and effectively refer people for help – 7	Not Listed	
	Substance Use Prevention - 6 • More Vaping Prevention – 3 • More Substance Use Prevention (Generally) – 3	Not Listed	

	<u>Event-Focused Outreach – 5</u> • More event-focused outreach (e.g., biking, hiking) – 4 • More events at wellness centers – 1	Not Listed	"you'd have to approach the priests [or other religious leaders] first, they could bring up [mental health]…
	<u>Outreach to Religious/Spiritual Venues – 4</u> • More outreach through religious organizations and houses of worship – 3 • Outreach to the Middle Eastern community through religious organizations – 1	Not Listed	
	<u>Outreach to Those who are Unhoused – 3</u> • Outreach efforts to those without stable housing - 2 • Outreach efforts to college students living in their cars on campus – 1	3 [3.3c]	
More Treatment Services (88 comments)	<u>LGBTQ+ Services – 23</u> • Expand clinical services for LGBTQ+ community – 11 o Need more LGBTQ+-affirming physical spaces (2) o Need more services for disabled LGBTQ+ individuals – (1) o Need more support for the older adult LGBTQ+ community – (1) o Need a bilingual SUTS group for LGBTQ+ folx – (1) o Need a consultation program for providers serving TGI+ folx (1) o Need a group for Spanish-speaking trans women (1) o Need more activities within the [existing] Latinx LGBTQ+ group (1) o Need LGBTQ+-specific sober living environment (1) o Need more LGBTQ+ services in South County (1) o Need additional LGBTQ+-focused facilities (1) • Santa Clara County should do more to be a TGI+ sanctuary County – 9 o Need a County-wide "living document" with guidelines for SOGI data collection (2)	3	"You know the drop in center of [LGBTQ+] Youth Space, has been a core component of that program since they started in 2008, and they lost [their] physical space during the lockdown because of COVID-19, and still do not have one" "I want to see Santa Clara County raise its voice… and really cue that we are here to support rans and non-binary folx of all ages…" "maybe some kind of consulting groups for people who are working with transgender diverse and intersex clients, even on a drop-in bases… just to be able to get good quality informed, culturally-relevant consultation… maybe you work in a hospital and someone's on your unit who's trans and who do you go to talk to[if] nobody else

	o Need more advocacy interventions for trans women/girls (1) o Need an intersectional lens for supporting/resourcing TGI+ folx (1) o Need more residential aftercare post gender affirmation surgery (1) o Need more funding to support TGI+-led organizations who are already serving the TGI+ community (1) o Need more gender affirmation in legal settings (e.g., remove binary jail settings) (1) o General calls for additional programming to actualize SCC's declaration to be a TGI+ sanctuary (2) • Expand the Gender Health Center – 3 o Need an additional Gender Health Center: one for adults and one for children (1) o Need more services in the Gender Health Center (1) o Need a rehabilitation counselor for the Gender Health Center (1)		who works in your unit as a ton of expertise…" "having [crisis] services that don't require involvement by law enforcement, particularly … clients that may have active warrants. What is happening, everybody is showing up with a different goal in mind… the specific example … was having requested mobile crisis for a client who is in crisis and law enforcement showing up and because there's an active warrant - rather than serving the mental health crisis, they are immediately arrested…this is not an isolated incident" "mental health services, I understand that they need to close at a certain time, but what happens after 5 o'clock… What do we do [if we] have a mental break down at 5 or 6 o'clock… who do we call?" "need to add more [mobile crisis] coverage to all of Santa Clara County…" "…my son is 20 even when he was younger it was still hard to get him treatment if he didn't want it, they would say No, if he doesn't want to. There's nothing we can do about it, and that's frustrating being a mother and going through this this process…we just don't have rights." "When I call these emergency crisis lines for mental health, they always
	<u>Crisis care – 15</u> • Need an option for crisis care that does not include police accompaniment – 7 • Need more emergency services available after 5pm – 3 • Need more mobile crisis teams – 3 • Expand the TRUST program – 1 • Need more services for those presenting with high-acuity mental health challenges – 1	Not listed	
	<u>Services for Treatment-Declining Individuals – 13</u> • Need more services aimed at connecting with TAY-aged adults with SMI presentations who don't think they need treatment – 7 • Need more resources for involuntary non-emergency care (e.g., someone stops taking their medication and begins to decompensate but is not yet in crisis) – 2	Not listed	

	• Need a multi-service team meeting to facilitate conservatorship for those who need it – 2 • Need broader training and implementation of Laura's Law to initiate treatment access for those who need it most – 1 • Need to fully implement the CARES act to facilitate access to Mental Health & Substance Use treatment – 1		tell me she has to be in manic mode in order for us to come out. Manic mode, what when she kills me or kills herself or somebody else…why does it have to be so severe for them to come out? Why can't somebody have mental health issues and somebody that loves them call up and [they] do an evaluation on my friend?"
Workforce, Education, & Training (54 comments)	<u>Hiring Considerations – 23</u> • Hire More Culturally-Matched Staff – 17 o Need specialized recruitment for LGBTQ+ positions (e.g., stop recruiting for LGBTQ+ positions from the general BHSD applicant pool) – 4 o Hire women for outreach to the African immigrant community – 3 o Hire more Spanish-speaking staff members – 2 o Hire more TGI+ employees – 2 o Need more LGBTQ+-identified staff members – 2 o Hire more Middle Eastern providers – 1 o Hire more South Asian providers – 1 o Hire refugees as translators – 1 o Need more case managers who are age-matched – 1 • LGBTQ+ Considerations – 3 o Add an interview item on LGBTQ+ considerations when interviewing for LGBTQ+ Service positions o Need more bilingual LGBTQ+ therapists o Need to reduce barriers to hiring LGBTQ+ peer support (e.g., educational requirements) • Other Considerations – 2 o Hiring more paraprofessional - 1 o Need to consider sex work as formal work experience when evaluating applicants - 1	4 [4.5]	"[we need] more individuals out there who are from the same culture, who can do the education [and] visit the families at home [and] explain that…this is something that is treatable..." "[We need] specialized recruitment…these positions get filled just [internally] by county [and] the county hiring system is so outdated…the folks who are who have lived, experience, expertise, related to supporting LGBTQ+ folks have to compete with folks who don't, for these specialized programs." "There is a need to be more familiar with the [Middle Eastern] culture, and things that even may look weird, crazy in America are not… something that came to my mind [is] our elders wear suits everywhere… so that's a simple example of how important it is that to understand… and not to label them as crazy…"
	<u>Staff Training – 12</u>	4	

	• More LGBQPA2S+ and TGI+ training for BHSD clinical staff – 7 • More cultural competency training (general) for BHSD clinical staff – 2 • Need a better method for disseminating TGI+ training to staff who need it but don't volunteer – 1 • Need more TGI+ and LGBTQ+ training for BHSD caregivers – 1 • More Middle Eastern cultural competency trainings for clinical staff – 1		"…acknowledging that we get burnt out… because we're supporting folks that are members of this population… you get burnt out from both sides because you're also part of the community." "the cost of living, relative to having student loans from grad school and trying to survive here with this housing market where you're competing even just to rent a small apartment with people in the tech sector" "individuals, if they're already struggling with mental health and substance, addiction, addiction, they … really need like a case manager to help them navigate… in that [situation] is when a case manager would really be important…" "This case manager is very consistent, and he is also on the same age as my son. So they have a lot of things to talk about in common, and I think that makes a big difference"
	<u>Hire More Clinical Staff – 7</u> • Case Managers – 2 • Therapists/Counselors – 1 • Rehabilitation Counselor for Gender Health Center – 1 • Hire more Clinical Staff (general) – 3	4	
	<u>Improve Retention of Clinical Staff – 6</u> • Need to add a space for pronouns on all County forms – 2 • Need ability to add pronouns on Teams profiles – 1 • Include LGBTQ+ staff representatives when determining BHSD decisions on LGBTQ+ programming – 1 • More burnout prevention for staff with lived experiences – 1 • Reduce staff burnout (general) – 1	4	
	<u>Increase Pay for Clinical Staff – 6</u> [1.2] • Increase pay for CBO staff – 3 • Increase pay for paraprofessionals – 1 • Increase staff pay (general) – 2	4	
Collaboration & Integrative Care (19 comments)	<u>More Collaboration Between BHSD & Other County Agencies – 18</u> • Need a single EMR for all County services – 8 • Need easier collaboration & referrals to SCC medical services (e.g., PCP) – 5 • Need more police training on Mental Health & Substance Use – 4 • Collaborate with Public Health Department for outreach programming – 1	5	"Advertising and spreading the message about all of the services in SCC. I am a health care provider caring for chronic diseases in the county and even I didn't know about many of these services" "[I'm] serving sex workers and people who use drugs— but I'm in the infectious disease unit… would
	<u>More Collaboration Within BHSD Services/Agencies – 1</u>	5	

	• More marketing of LGBTQ+ programming to other BHSD programs, clinics and CBOs		love to see more collaboration between us…" "LGBTQ+ programs get siloed a lot… [need] more department communication with other programs so they know where to refer folx"
Improve Quality (1 comment)	Improve Quality of Care from Call Center Staff – 1	1	"one of [our consumers] was in crisis so … we're explaining the situation to the 988 person… and we're trying to ask for resources and places where this person can go to because they're homeless and they have animals… the 988 person wasn't willing to help us with resources, they just totally shut us down…"
Housing (1 comment)	Facilitate easier access for those who are unhoused seeking BHSD services – 1	3	"especially when working with homeless populations, being able to take direct referrals is huge…"

Note: *"Not listed" means that the area of need is not listed in the description of the current 5 BHSD goals*

Workforce, Education, and Training: Stakeholder Identified Needs from Community Conversations, Aggregate, with Sub-Themes and Quotes

Primary Theme	Sub-Themes	Corresponding Department Goal #	Quotes
Workforce, Education, & Training (265 Comments)	<u>Increase Number of Clinical Staff – 82</u> • More Clinical Staff (General) – 20 • More Paraprofessionals – 13 o More peer support workers (12) o More paraprofessionals (general) (1) • More Therapists – 11 o More therapists (general) (9) o More therapists for South County (2) • More Case Managers – 11 • More Diversion Services Staff – 9 o More assessors in Collaborative Courts (6) o More Diversion staff (general) (3) • More Youth-Focused Staff – 9 o More youth-focused clinical staff (3) o More licensed therapists for youth (2) o More therapists in schools (2) o More youth peer support staff (1) o More youth-focused counselors in schools (1) • More Psychiatrists – 4 • More Addiction Specialists – 3 • More Staff to Serve the African Immigrant Community – 2	4	"they certainly are not enough psychiatrists to meet with people once a month, which I require." "Collaborative Court staff are overwhelmed with assessments. We need additional staffing. BHSD staff have been working as hard as we can but more staffing resources are need to meet the client need." "The queer community also suffers a disproportionate amount of substance abuse issues and so, having rehab counselor would be [a] specific … investment to addressing those needs."
	<u>Specific Hiring Suggestions – 58</u> • Hire Culturally-Matched Staff – 35 o Hire staff who are culturally-matched to the community they serve (general) (7) o Hire school therapists who are culturally matched (5) ▪ From marginalized backgrounds, 2 ▪ LGBTQ+-identified, 2	Not Listed	"Something that I've heard from providers in Gilroy is that there's just not enough [therapists] … and this is something that's been going on for years. … I just really wanna ask for help with down here."

	▪ General, 1 o Implement specialized recruitment for LGBTQ+ staff positions (4) o Hire Middle Eastern individuals to serve the community (3) o Hire women for outreach to the African immigrant community (3) o Hire Spanish-speaking staff members (2) o Hire TGI+ individuals to serve the community (2) o Hire culturally-matched peer support workers (1) o Hire Hispanic/Latino/a/e staff to serve the community (1) o Hire South Asian staff to serve the community (1) o Hire refugees as translators (1) o Hire young counselors/therapists to serve TAY-aged individuals (1) o Hire case managers who are age-matched, especially for TAY-aged individuals (1) o Hire LGBTQ+-identified individuals to serve the community (1) o Hire Muslim-identified individuals to serve the community (1) o Hire more women employees (1) • Recruit college graduates - 9 o Recruit College Students Looking for Internships – 3 o Collaborate with Colleges to Educate and Build the Workforce – 3 o Recruit from new graduates – 3 • Increase Intern Stipends – 4 • Shift More Responsibilities to Paraprofessionals – 3 • LGBTQ+ Specific Hiring Considerations – 3 o Hire LGBTQ+ therapists who are bilingual – 1 o Add an interview question about LGBTQ+ topics when hiring for LGBTQ+-focused positions – 1		"for discrimination, … whether it's against someone for the gender, their race, whether it's because they're part of the LGBT community or anything like that… if the therapist is like not from that demographic, they may not understand." "I'm not just talking about someone that can speak the language but also understand the culture background of these clients" "We need to start earlier, having better conversations with graduate schools, because no one teaches them what community mental health looks like." "as a student, there are difficulties affording [living expenses]… there are stipends and things like that, but even with those stipends it's still difficult to really live in the Santa Clara County…" "Take into account for jobs, people that come from other countries and are professionals in mental health."

	○ Reduce barriers to hiring TGI+ applicants (e.g., formal education requirements) – 1 • More Exceptions for Those Applying with Credentials from Outside the U.S. – 2 • Use Ad Campaigns to Promote the Field of Mental Health (e.g., billboards highlighting how fulfilling it is) – 1 • Reduce Barriers to Hiring Individuals With a History of Sex Work (e.g., formal education requirements) (1) • Consider Sex Work as Work Experience in the Hiring Process, Especially for BHSD Positions That Serve Sex Workers – 1		"[We need] paraprofessionals just throughout all of [our programs and to understand] how they can partner with therapist to provide a lot of support"
	<u>Retain Clinical Staff – 51</u> • Increase Staff Benefits – 15 ○ Providing/subsidizing childcare for BHSD employees (5) ○ Reinstate Covid-19 sick pay for employees who are sick (4) ○ Financial support for BHSD staff to attain additional education (2) ○ More funding for staff to attain advanced clinical trainings, such as EMDR and DBT (2) ○ More Mental Health & Substance Use services for BHSD staff (1) ○ More student loan forgiveness for BHSD staff (1) • Burnout Needs/Recommendations – 12 ○ Reduce provider burnout (general) (4) ○ More burnout resources focused on vicarious trauma (3) ○ More burnout resources for staff with lived experience (e.g., peer support) (1) ○ More HR/BHSD support for LGBTQ+ staff after anti-LGBTQ+ aggressions in the workplace (1) ○ Reduce PSH staff burnout caused by the political pressure of the housing crisis (1) ○ Reduce PSH staff burnout caused by the need to interact with a large number of community partners (1)	1	"just being trans and having barriers getting education and training and having the employment history, and all of the experience of discrimination and stigma throughout the process, and then all of that creates lots of problems… I think we need to really take employment into account in a very out of the box way." "Behavioral health, they have a lot of, they have full caseloads sometimes, or they have to see a lot of people during the day" "Our [permanent supportive housing] folks that are providing these services… they work together cohesively as a team… but trying to get your case manager, who has been working in support of housing to learn, and understand, and daily do medical billing, that's hard, and that has directly impacted our

	○ Reduce burnout by setting aside funding and contract time for team building (1) • Reduce Staff Workload – 10 ○ Reduce clinician caseloads (2) ○ Reduce documentation/training/productivity requirements for PSH staff, who must meet BHSD and OSH requirements (2) ○ Less case manager responsibilities for Diversion lawyers – (1) ○ Reduce caseloads of therapists in juvenile jails (1) ○ Peer mentors should only do outreach (1) ○ Reduce case manager responsibilities (1) ○ Reduce staff demands (1) ○ Reduce productivity standards for PSH staff serving on-site programs vs. scattered site programs (1) • Retain clinical staff (general) – 5 • Make BHSD an affirming environment for LGBTQ+ staff – 4 ○ Need to add a space for pronouns on all County forms, including internal/staff documents (2) ○ Better incorporate LGBTQ+ staff input when making decisions for LGBTQ+ programs (1) ○ Need to allow pronouns to be displayed on Teams, as is done in other systems, such as the VA (1) • More support for staff (general) – 3 • Reduce BHSD staff strikes – 1 • Reduce programs/clinics "poaching" staff from each other – 1		retention over the last several years. It's hard to keep people." "[There's a] very specific sort of set of skills and experiences that are needed for supportive housing. There's some crossover, but there's not a lot, and it's different folks with different skill sets. And I think that the staffing and the contracts definitely don't reflect that, and that really plays into staff retention because you are hiring folks that think they're coming into one job and show up [and have to learn a whole different job on top of it]" "Some of our employees are like, 'Can we get childcare inside our buildings so that it's just easier?" We can just drop off our kids as we go to work… this keeps coming up because a lot of our staff are mothers."
	<u>Increase Staff Training – 43</u> • Increase Cultural Competency (General) in BHSD Services – 15 • More LGBTQ+ training for clinical staff – 14 • More cultural training for school therapists – 2 • DEI training for all staff and directors – 1 • More staff training on Middle Eastern culture – 1	Not Listed	"[We need] more community workers that are trained to provide culturally sensitive services" "Something that has come up for my friends is getting help/ education/ resources/referrals for their

	• More staff training on Black & African Descendant culture – 1 • More County staff training on AB1424 – 2 • More staff training on trauma-informed care – 2 • More staff training on HIMS – 1 • More staff training on harm reduction – 1 • More staff trained in psychiatric emergency services – 1 • More staff training on "soft skills" (e.g., customer services) – 1 • More staff training on eligibility requirements, specifically at access points such as the Call Center and the Cultural Wellness Centers – 1		families/parents/adults 50+ seeking [services] that are culturally sensitive (immigrant, refugee backgrounds)." "We always talk about investing in therapists and clinicians, and we're really pleased that a lot of providers were able to get rate increases. But I always think about the case managers and the peer partners, and the paraprofessionals who oftentimes don't get looked at in the same way…"
	<u>Increase Staff Pay – 31</u> • Increase Staff Pay (General Comments) – 13 • Staff must be paid based on the living costs of the Bay Area – 4 • Permanent Supportive Housing (PSH) staff should be paid for their dual skillsets (both therapy and housing skills) – 4 • Increase pay for paraprofessionals (e.g., case managers, peer support staff) – 4 • Increase pay for CBO staff – 3 • Increase pay for psychiatrists – 2 • Increase pay for therapists/counselors – 1	4	

<u>Note</u>: *"Not listed" means that the area of need is not listed in the description of the current 5 BHSD goals*

Adult & Older Adult (AOA) System of Care-Level Analysis Tables

Community Survey Data from AOA Consumers

AOA Survey Data Category	Average Response, Consumers & Family
Access to Care	3.0
Quality of Care	3.4
Cultural Considerations	3.5
Recovery Orientation	3.4
Family Inclusion	2.8
Telehealth	3.4

AOA Strengths from Community Conversations, Aggregate Data

AOA Strengths
Community Based Organizations (CBOs) – 12 • Goodwill – 8 • AACI – 1 • Gardner's work serving Black residents – 1 • Seneca program – 1 • Star program – 1
Access Processes – 12 • Access to BHSD services (general) – 2 • Offering services at different times of day (e.g., evenings) – 2 • 988 – 1 • Connecting consumers to County resources – 1 • Covid-19 antigen test support – 1 • Informational brochures – 1 • Navigator program – 1 • Offering services in multiple locations – 1 • Reentry Center – 1 • Valley Homeless Van – 1
Criminal Justice Services – 10 • STRIVE program (Reentry services) – 4 • Diversion services – 3 • Collaboration within Diversion services – 1 • Mental Health Court – 1 • Criminal Justice services (generally) – 1
County Clinics/Programs – 9 • Evans Lane – 4 • African CCWP – 1 • East Valley Homeless Clinic – 1 • Elmwood – 1 • FSP – 1 • New Haven – 1
Telehealth – 9

Housing Services – 7

- Good investment in site-based permanent supportive housing – 2
- Case Managers Educating Those Seeking Housing – 1
- Housing flex funds – 1
- Permanent supported housing – 1
- Permanent Supportive Housing's access to Mental Health & Substance Use treatment resources – 1
- Services for unhoused individuals (generally) – 1

Outreach & Prevention Efforts – 6

- Community education efforts – 2
- Overdose prevention programming – 2
- Community planning events – 1
- Ethnic Wellness Centers – 1

Workforce, Education, & Training – 6

- Continued inflation adjustment – 1
- Internship stipends – 1
- Loan forgiveness grants – 1
- More discussions about cost of living – 1
- Peer Support programs growing – 1
- Wrap-around case managers growing – 1

Collaborative / Integrative Care – 4

- Collaboration between BHSD and the HEARD Alliance – 1
- Collaboration within Diversion programs – 1
- Collaboration with police on Mental Health & Substance Use crisis care – 1
- Interagency collaboration on refugee needs – 1

Quality of Care – 1

- Recognizing diversity and supporting the populations served – 1

AOA Stakeholder Identified Needs from Community Conversations, Aggregate, with Sub-Themes and Quotes

Primary Themes	Sub-Themes	Corresponding Department Goal #	Quotes
Treatment Services (198 comments)	<u>More Criminal Justice Services – 31</u> • Reentry & Vocational Services (14) o Reentry services needs to verify the list of felon-friendly businesses, 5 o Need more reentry vocational centers, 3 o Need to add a transitional component to reentry vocational programs, 3 o Need longer-term Reentry services, 3 • Diversion Services (3) o Diversion clients need another level of care between FSP and residential treatment, 1 o More long-term treatment in Diversion services, 1 o More outpatient therapy through Diversion services, 1 • SCC should stop using jails/prisons in place of Mental Health & Substance Use treatment (4) • Mental Health & Substance Use services in jail (3) o More MH treatment in jails/prisons, 2 o More family integration services for those in jail/prison, 1 • Need to expand criminal justice competency beyond Mental Health Court (3) • Need more services after consumers are released from jail/prison (2) • Need more aftercare services after graduating from Criminal Justice program (1) • More services for justice-involved clients, generally (1)	3.4	"I should have had some wrap around [services] for my son when he came out [of prison], I had nobody, matter of fact, I picked him up by myself…" "A very large portion of the people in jail right now have behavioral health issues, and they try to get them treatment in the jail… I mean, they're doing a great job, they're really trying… but the environment is wrong." "90 days [of reentry services] is beautiful but it's not even enough…. You got some individuals that have been incarcerated all their life, been on the streets all their life…" "the people I do know who [have lost their allegedly felon-friendly job], have literally been working at this job collecting their paycheck and then all of a sudden this other background check comes out and they end up getting fired"
	<u>More Housing-Related Services – 21</u> • Services for those who are unhoused, and NOT in a BHSD-related housing program (17) o More case management for those applying for housing, 6	3.3	"On the [AOA] side, they're just not used to working with our criminal justice clients, so there's a deficit there… there are some

	- More BHSD treatment services for those who are actively unhoused (e.g., those not staying in temporary, transitional, or stable housing), 4 - Need an FSP-like program specifically for those who are chronically unhoused, 3 - More clinicians to go out to visit the unhoused wherever they can be found, 2 - Need more individual therapy for those seeking housing, 1 - More community education on housing programs and requirements, 1 • Services for those who are unhoused, and currently engaged in a BHSD-related housing program (4) - More resources for scattered-site PSH, 2 - Need to ensure psychiatry and therapy services at every PSH site, 1 - Need more Mental Health & Substance Use tx within temporary/transitional housing (e.g., shelters), 1		special [considerations for] criminal justice… [AOA] providers [do not provide that]" "there should be FSP focused programs for people experiencing chronic homelessness that ARE housing programs (with the money for housing)" "our [PSH] clients need psychiatry… some of these site-based programs… are just purely housing, they don't have access to psychiatry and therapy…" "what has really worked well with [those who are unhoused] is having therapists go out and meet people where they are"
	<u>SUTS (including detox) – 19</u> • Need more harm reduction approaches (5) • Need a medical detox program (3) • Need more residential substance use treatment programs (3) • Need more affordable resources for vaping cessation (1) • Need more Fentanyl interventions (1) • Need more individual therapy during SUTS (1) • Need more SUTS, generally (1) • Need more SUTS for those with intellectual disabilities (1) • Need respite house for substance use (1) • Need same-day-access for SUTS (1) • Need SUTS without punishing relapse (1)	3	"Inpatient drug rehabilitation for individuals who really need the help… it's very difficult to find" "There needs to be a higher capacity for justice-involved clients to access SUTS when they are ready and willing" "I'm in a [BHSD] program right now and there's a 2 year wait list for therapists" "I have some friends who were victims of domestic violence, but what our community teaches and parent say is 'it's okay, just tolerate it.'
	<u>Expand Outpatient Treatment, Miscellaneous – 18</u> • More capacity for individual therapy (4) • More pre-crisis intervention services (2)	3	

	• More treatment for sex workers instead of focusing on preventing sex work (2) • Services for gambling addictions (1) • Need an FSP-like program with lower entry requirements (1) • More domestic violence services (1) • More programs to support stress after the loss of employment (1) • Need more consistent group offerings (1) • Need more WRAP plans (1) • More thorough psychological assessment (1) • More workshops on life skills (1) • More capacity for outpatient care (1) • More Services for adults with severe symptoms who need treatment but decline services (1)		"My problems were kind of put down a little… I talked to someone in high school about how I was having suicide thoughts, and they didn't do anything about it besides create a safety plan for me, and that felt very demoralizing, and I felt like I wasn't struggling enough for these people. And I think there's the sense that you need to be at your very, very worst to get help, and I think we need to be able to give people resources before they attempt, or before they get to the crisis point. There are people who, myself included, I know when I'm about to go into a really big depressive episode or a suicide episode, and I can sense it coming. And I can reach out beforehand, but sometimes, even if I reach out the services that are provided for me are not enough, because I am not at the crisis point. And sometimes certain mental health services will only admit you if you're at a crisis point, and that is like really disheartening. "[We need immigrant] education about accepting LGBT. When these refugees come, it's little bit harder because the parents are not already. The children were opening the door for them, but the parents are not ready to listen to
	<u>Greater Residential/Inpatient Bed Capacity – 16</u> • More crisis residential capacity (4) • More residential treatment (3) • More psychiatric hospital beds (3) • Need more beds for those discharging from jail/prison (2) • More Board & Care beds (2) • More residential treatment for those in Reentry programming (>90 days) (1) • Need separate residential treatment for adults and TAY populations (1)	3	
	<u>Services for Immigrants & Refugees – 11</u> • Need more cultural assimilation training for immigrants (8) • Need more cultural assimilation training for refugees (1) • Need to extend length of services for refugees (1) • Need more LGBTQ+ education for immigrant families (1)	Not Listed	
	<u>More Dual Diagnosis Treatment – 10</u> • Need more dual diagnosis treatment programs (9) • Need more long-term residential treatment for dual diagnosis presentations (1)	3	

	More Services to Reduce Isolation – 8	3	these things, or to accept them or understand them." "When they talk about dual diagnosis, I don't know how many facilities I called; they said, 'Yeah, we do dual diagnosis. You know we do the drug rehab.' 'Okay, what about mental health services?' 'Well, we don't do that; we don't offer a psychiatrist.' And I go 'But then how can you call yourself a dual diagnosis facility if you do not offer it?' So it's just the frustration…" "Support groups… we should make them at our gurudwaras… we are much more comfortable talking about this with our own communities…" "Once they're stabilized in the hospital, there is nowhere to step down to." "[We need an] automatic step down program, so going from inpatient to outpatient so that folks ca have support during the transition… really structured 24/7 care…" "Hospitals are letting people go too quickly before they are stabilized, and then they decompensate again, wind up in trouble or on the street, or having a violent episode…"
	More Supported Employment – 8 • More supported employment, generally (7) • More employment support for immigrants (1)	Not Listed	
	Improvements to BHSD-CBO Contracts – 7 • Need more contract flexibility for non-billable tasks (e.g., consumer advocacy, burnout prevention) (3) • Need dedicated contact time for in-depth staff training (2) • Need more reimbursement for SUTS within MH programs (1) • PSH staff need more contract time for home visits (1)	3.2	
	More BHSD Services in Client's Homes – 7	Not Listed	
	More Support Groups – 7 • Need more social support groups for LGBTQ+ individuals (2) • Need a support group at the Punjabi Gurudwara (1) • Need advocacy support group (1) • Need more support groups for non-emergency clinical presentations (1) • Need more support groups for seniors (1) • Need more support groups for long-term Covid cases (1)	3	
	More Step-Down Treatment Services – 6 • Need more aftercare programs after psychiatric hospitalization (2) • Need more dual diagnosis crisis stabilization after psychiatric hospitalization discharge (2) • Need a more flexible continuum of care after psychiatric hospitalization (1) • Need more step-down options after psychiatric hospitalization (1)	3	
	More Longer-Term Treatment – 6 • More long-term outpatient therapy options (4) • More emphasis on long-term substance use recovery programs (e.g., AA, NA, AlAnon) (1) • Psychiatric hospitals should hold people longer for stabilization (1)	3	

	More Covid-19-related Services – 5 • More services focused on Covid-19-related grief (2) • Continue Covid-19 testing resources to facilitate Mental Health & Substance Use treatment programs (2) • More Mental Health & Substance Use treatment related to the long-term effects of Covid-19 (1)	3	"I think people do want in-person interaction… [yet] it's a lot easier [for the client] to continue those visits through Zoom" "One thing that we really just don't have any access … is people suffering from dementia or other neuro cognitive problems. It's coming up a lot …, and we get to a point where it's very clear that's the main problem." "[For] serious thought disorders, the first line treatment should be injectable medication…there's the expense of the injection, but it's a lot more expensive in the long run to pay for hospitalizations and jail, homelessness…"
	More Hybrid Care – 4 • More in-person availability while keeping all current telehealth options (4)	Not Listed	
	More Services for those with Neurocognitive Conditions (e.g., Alzheimer's, cognitive decline, brain injury, neurocognitive deficits) – 4	3	
	More BHSD Services for Those without Citizenship – 4 • More BHSD services for those without U.S. citizenship (2) • Need more BHSD services for older adults without U.S. citizenship (1) • BHSD should plan for expansion of services to all undocumented individuals starting in 2024 (1)	Not Listed	
	More Injectable Antipsychotic for Those with Psychosis – 3	3	
	Adjunctive Services – 3 • Need a method for checking in with provider weekly (2) • Need more resources (general) (1)	Not Listed	
Workforce, Education, and Training (167 comments)	Retain Clinical Staff – 38 • Burnout Needs/Recommendations – 11 o Reduce provider burnout (general) (3) o More burnout resources focused on vicarious trauma (3) o More burnout resources for staff with lived experience (e.g., peer support) (1) o More HR/BHSD support for LGBTQ+ staff after anti-LGBTQ+ aggressions in the workplace (1) o Reduce PSH staff burnout caused by the political pressure of the housing crisis (1)	4	"they certainly are not enough psychiatrists to meet with people once a month, which I require." "Collaborative Court staff are overwhelmed with assessments. We need additional staffing. BHSD staff have been working as hard as we can but more staffing resources are need to meet the client need."

	○ Reduce PSH staff burnout caused by the need to interact with a large number of community partners (1) ○ Reduce burnout by setting aside funding and contract time for team building (1) • Increase Staff Benefits – 10 ○ Providing/subsidizing childcare for BHSD employees (5) ○ Reinstate Covid-19 sick pay for employees who are sick (1) ○ Financial support for BHSD staff to attain additional education (1) ○ More funding for staff to attain advanced clinical trainings, such as EMDR and DBT (1) ○ More Mental Health & Substance Use services for BHSD staff (1) ○ More student loan forgiveness for BHSD staff (1) • Reduce Staff Workload – 8 ○ Reduce documentation/training/productivity requirements for PSH staff, who must meet BHSD and OSH requirements (2) ○ Reduce clinician caseloads (1) ○ Less case manager responsibilities for Diversion lawyers – (1) ○ Peer mentors should only do outreach (1) ○ Reduce case manager responsibilities (1) ○ Reduce staff demands (1) ○ Reduce productivity standards for PSH staff serving on-site programs vs. scattered site programs (1) • Make BHSD an affirming environment for LGBTQ+ staff – 4 ○ Need to add a space for pronouns on all County forms, including internal/staff documents (2) ○ Better incorporate LGBTQ+ staff input when making decisions for LGBTQ+ programs (1) ○ Need to allow pronouns to be displayed on Teams, as is done in other systems, such as the VA (1) • More support for staff (general) – 3 • Reduce BHSD staff strikes – 1		"The queer community also suffers a disproportionate amount of substance abuse issues and so, having rehab counselor would be [a] specific … investment to addressing those needs." "Something that I've heard from providers in Gilroy is that there's just not enough [therapists] … and this is something that's been going on for years. … I just really wanna ask for help with down here." "for discrimination, … whether it's against someone for the gender, their race, whether it's because they're part of the LGBT community or anything like that… if the therapist is like not from that demographic, they may not understand." "I'm not just talking about someone that can speak the language but also understand the culture background of these clients" "We need to start earlier, having better conversations with graduate schools, because no one

	• Reduce programs/clinics "poaching" staff from each other – 1		teaches them what community mental health looks like."
	<u>Specific Hiring Suggestions – 37</u> • Hire Culturally-Matched Staff – 21 o Hire staff who are culturally-matched to the community they serve (general) (5) o Implement specialized recruitment for LGBTQ+ staff positions (4) o Hire Middle Eastern individuals to serve the community (3) o Hire Spanish-speaking staff members (2) o Hire Hispanic/Latino/a/e staff to serve the community (1) o Hire South Asian staff to serve the community (1) o Hire refugees as translators (1) o Hire case managers who are age-matched, especially for TAY-aged individuals (1) o Hire LGBTQ+-identified individuals to serve the community (1) o Hire Muslim-identified individuals to serve the community (1) o Hire more women employees (1) • Increase Intern Stipends – 4 • Collaborate with Colleges to Build the Workforce – 2 • Recruit from New Graduates – 2 • More Exceptions for Those Applying with Credentials from Outside the U.S. – 2 • Use Ad campaigns to promote the field of Mental Health (e.g., billboards highlighting how fulfilling it is) – 1 • Hire LGBTQ+ therapists who are bilingual – 1 • Add an interview question about LGBTQ+ topics when hiring for LGBTQ+-focused positions – 1 • Reduce barriers to hiring TGI+ applicants (e.g., formal education requirements) – 1 • Use Paraprofessionals to Meet Staffing Needs – 1 • Consider sex work as work experience in the hiring process, especially for BHSD positions that serve sex workers – 1	Not Listed	"as a student, there are difficulties affording [living expenses]… there are stipends and things like that, but even with those stipends it's still difficult to really live in the Santa Clara County…" "Take into account for jobs, people that come from other countries and are professionals in mental health." "[We need] paraprofessionals just throughout all of [our programs and to understand] how they can partner with therapist to provide a lot of support" "just being trans and having barriers getting education and training and having the employment history, and all of the experience of discrimination and stigma throughout the process, and then all of that creates lots of problems… I think we need to really take employment into account in a very out of the box way."

	<u>Increase Number of Clinical Staff – 34</u>
	• More Diversion Services Staff – 9
	  o More assessors in Collaborative Courts (6)
	  o More Diversion staff (general) (3)
	• More Case Managers – 6
	• More Clinical Staff (General) – 6
	• More Therapists – 5
	  o More therapists (general) (4)
	  o More therapists for South County (1)
	• More Psychiatrists – 4
	• More Paraprofessionals – 2
	  o More peer support workers (2)
	• More Addiction Specialists – 2
		1	"Our [permanent supportive housing] folks that are providing these services… they work together cohesively as a team… but trying to get your case manager, who has been working in support of housing to learn, and understand, and daily do medical billing, that's hard, and that has directly impacted our retention over the last several years. It's hard to keep people."
			
			"[There's a] very specific sort of set of skills and experiences that are needed for supportive housing. There's some crossover, but there's not a lot, and it's different folks with different skill sets. And I think that the staffing and the contracts definitely don't reflect that, and that really plays into staff retention because you are hiring folks that think they're coming into one job and show up [and have to learn a whole different job on top of it]"
			
			"Some of our employees are like, 'Can we get childcare inside our buildings so that it's just easier?" We can just drop off our kids as we go to work… this keeps coming up because a lot of our staff are mothers."

	<u>Increase Staff Training – 33</u> • Increase Cultural Competency (General) in BHSD Services – 13 • More LGBTQ+ training for clinical staff – 13 • More County staff training on AB1424 – 2 • More staff training on trauma-informed care – 1 • DEI training for all staff and directors – 1 • More staff training on Middle Eastern culture – 1 • More staff training on Black & African Descendant culture – 1 • More staff training on HIMS – 1	Not Listed	
	<u>Increase Staff Pay – 25</u> • Increase Staff Pay (General Comments) – 12 • Staff must be paid based on the living costs of the Bay Area – 4 • Permanent Supportive Housing (PSH) staff should be paid for their dual skillsets (both therapy and housing skills) – 4 • Increase pay for CBO staff – 3 • Increase pay for psychiatrists – 1 • Increase pay for therapists/counselors – 1	4	
	<u>More Collaboration Between BHSD & Other SCC Departments – 29</u> • Need more collaboration with SCC medical services (11)		"[We need] integrated medical and substance use treatment…

Collaboration & Integrative Care (50 comments)	o Need more cross-County collaboration Infections Disease department and BHSD, 4 o Need more integrated medical-Mental Health & Substance Use treatment programs, 3 o More integration between BHSD and primary care, 3 o Need more MH training for PCP/ER staff, 1 • Need more integration between BHSD and Office of Supportive Housing (11) • Need to separate OSH and BHSD and instead have dedicated BHSD staff in-person at PSH locations (6) • Need a single EMR for all County services (2)		clients who have substance use history, or may current use, are typically like disqualified to get medical stabilization at hospitals, and folks who have medical issues with substance use often have challenges finding substance use residential services, because they need to medically stabilize. And what results is our clients just get released in the community and they're just on their own"
	<u>More Collaboration Within BHSD Agencies – 18</u> • Need more collaboration between Diversion and AOA services (6) • Need more collaboration between BHSD programs (6) • Need more collaboration between inpatient care and PSH staff for discharge planning (5) • Need more opportunities for collaboration with Diversion services (1)	5	"Is it that we need to pour more resources into making experts of everyone across the board [for PSH staff]? Or is it that these really are 2 separate things - supportive housing and behavioral health - and they need to all be provided, but does it need to be the same providers?"
	<u>Need more innovative partnerships between BHSD and private entities – 3</u> • Need better information sharing mechanism with Kaiser (2) • Better collaboration with nonprofit organizations and libraries (1)	5	
Access (49 comments)	<u>More Language/Translation Services – 24</u> • Language (general) – 8 • Spanish – 7 o Treatment services in Spanish (6) o BHSD forms in Spanish (1) • ESL classes – 4 • More translation services for Middle Eastern languages – 2 • More Vietnamese language services – 1 • More services in Dari – 1 • More services in Pashtu – 1	Not Listed	"I don't know what services the county provides." "if the clients cannot talk for themselves because of language barriers or the County does not have the right staff with the right language skill to help them, we are not helping our clients at all"
	<u>Increase Transportation Support – 8</u>	Not Listed	

	• General Comments about Transportation as a Barrier to Accessing BHSD Services – 8		"[more language services] particularly in South County specific to the Spanish-speaking, indigenous communities" "we call the client, but they have to bring their own translator" "In Gilroy I see it so much… psychiatrist wait time is 6 to 8 weeks…" "getting these services out in a timely manner because sometimes you lose people in the cracks because they're waiting and… these processes can be so heinous for them…" "[one of my clients], she wants programs, she wants to enroll her children, she doesn't have money, she doesn't have a car, and doesn't know how to drive"
	<u>Easier/Faster Access to Treatment Services – 5</u> • Should be "easier" to access BHSD services (too many barriers, too many requirements for program entry, too much paperwork) – 4 • Need shorter wait for BHSD services – 1		
	<u>Improve Call Center Integrated Screening Processes – 4</u> • Call Center should evaluate previous BHSD services history to reduce redundancy of services – 2 • Should use technology to help pair consumers with therapists who will be a good fit for them – 1 • General calls to improve screening through the Call Center – 1		
	<u>More non-Call Center access options – 4</u> • Need an option for direct referrals (e.g., walk-ins) without using the Call Center – 4		
	<u>More Assistance Navigating BHSD System – 3</u> • Help consumers navigate the process of accessing BHSD services (e.g., how to start, what to expect, what to ask for) – 3		
	<u>Increase Community Awareness of BHSD Services – 3</u> • Need a single list of all BHSD Services – 2 • Community needs more awareness (general) – 1		
	<u>Need Childcare Services During BHSD Appointments – 1</u> • Facilitate parents accessing BHSD services by providing childcare – 1	1	
Housing **(35 comments)**	<u>Housing Stabilization (General Housing Need) – 33</u> • More Housing (general) – 25 • More LGBTQ+-specific housing – 3 • More flex funds to secure housing – 3 • More housing beds specific to Criminal Justice services – 1 • More housing options for those in wheelchairs – 1	3.1	"Anything that has to do with housing would be major. People really need the housing. It's something that I see a lot in the field that people are looking for" "It's just so important to have the housing options, the flex funds"
	<u>More Temporary Housing – 1</u>	3.4	
	<u>More Transitional Housing – 1</u>	3.2	

Outreach & Prevention (24 comments)	General Outreach – 7	Not Listed	"Older adults who are part of the LGBTQ+ community do not know how the mental health system works, and they need support in learning how to navigate the system." "educating people, family members on what to look for… it's the de-stigmatization… trying to get people if they need services to go get services" "Education is prevention." "you'd have to approach the priests [or other religious leaders] first, they could bring up [mental health]…"
	Reduce Community Stigma – 6 • General calls to reduce community stigma – 3 • Reduce community stigma via collaboration with religious/spiritual leaders – 2 • Reduce stigma in recent immigrants – 1	Not Listed	
	Increase Community Awareness of Mental Health & Substance Use – 5 • General need to increase community awareness of Mental Health & Substance Use – 4 • Specifically for serious mental illness – 1	Not Listed	
	Ethnic-Specific Outreach/Prevention – 4 • More racial/ethnic anti-discrimination efforts to prevent Mental Health & Substance Use problems for stigmatized communities (anti-Muslim discrimination, anti-South Asian discrimination) – 2 • Need a CCWP team focused on Middle Eastern community – 1 • Need a wellness center for Middle Eastern community – 1	Not Listed	
	Event-Focused Outreach – 1 • More event-focused outreach (e.g., biking, hiking) – 1	Not Listed	
	Outreach to Religious/Spiritual Venues – 1 • More outreach through religious organizations and houses of worship – 1	Not Listed	
Improve Quality (17 comments)	Decrease LGBTQ+ Discrimination in BHSD Housing Programs – 7	Not Listed	"[A BHSD client] decided to opt out [of therapy] because [the provider] fell asleep." "hit or miss on the quality of the psychiatrists" "Make it very clear these 90 days [in this program] are going to go quick so right… so people can [use the time well]." "more trauma-informed care"
	General Comments About Care Quality – 5 • Should better explain professional limits – 1 • Therapists should not fall asleep during sessions – 1 • Residential treatment staff should be more engaged with clients on a daily basis – 1 • Should have higher consistency in the quality of psychiatrists – 1 • Staff should be kinder and more motivating – 1	Not Listed	
	More Psychoeducation on the Time Limit for Each Episode of Care – 4	Not Listed	

	Treatments Offered should be More Trauma-Informed – 1	Not Listed	

Note: *"Not listed" means that the area of need is not listed in the description of the current 5 BHSD goals*

South County Stakeholder Identified Needs from Community Conversations, Aggregate, with Sub-Themes and Quotes

Primary Themes	Sub-Themes	Corresponding Department Goal #	Quotes
More Treatment Services (23 Comments)	<u>More Housing-Related Services – 11</u> • Services for those who are unhoused, and NOT in a BHSD-related housing program (10) o More BHSD treatment services for those who are actively unhoused (e.g., those not staying in temporary, transitional, or stable housing), 3 o More case management for those applying for housing, 3 o More clinicians to go out to visit the unhoused wherever they can be found, 2 o Need more individual therapy for those seeking housing, 1 o More community education on housing programs and requirements, 1 • Services for those who are unhoused, and currently engaged in a BHSD-related housing program (1) o Need more Mental Health & Substance Use treatment for those who are unhoused, general, 1	3	"[We] need licensed clinical, social workers supporting [those who are unhoused." "The people that need the help the most are the ones that are not getting housed, because the program was designed to come with case management. There's not an enough managers. So … they're not gonna get help…" "I'm part of the homeless community. I stay in our area, and I know all around here. And [BHSD] actually needs a big change for us, and how they come out." "The lack of mental health stability causes the housing instability because individuals are in crisis and are not able to keep up with appointments, requirements, commitments - so they're at risk for losing housing vouchers, leases, [etc.]."
	<u>Youth</u> Mental Health & Substance Use <u>Treatment – 5</u> • Youth Substance Use Prevention (2) o More MH treatment to prevent development of SU problems, 1 o More vaping prevention, 1 • Parent Services (2) o General need for parent psychoeducation, 2 • More Therapy for youth (General) (1) o Counseling services for youth (general), 1	3 [CYF]	"[We need] more therapy for youth." "[We need] for [parents] to know where to call like a confidential number for the teenagers." "teenagers… they're depressed because of boyfriends or things like that. And then they're using substances like marijuana. I think we do a lecture."
	<u>SUTS (Including Detox) – 3</u>	3	

	• Need a medical detox program (1) • Need more residential substance use treatment programs (1) • Need more Fentanyl interventions (1)		"the drug Fentanyl has become an issue within youth up to also adults." "Wait times [are] unacceptable right now, like [being] told that the first available appointment is March first… that is entirely too long for somebody" "[There is] a lot of addiction with different types of drugs and mental health issues.
	<u>Expand Outpatient Treatment, Miscellaneous – 1</u> • More capacity for individual therapy (1)	3	
	<u>More Dual Diagnosis Treatment – 2</u> • Need more dual diagnosis treatment programs (2)	3	
	<u>More BHSD Services for Those without Citizenship – 1</u> • BHSD should plan for expansion of services to all undocumented individuals starting in 2024 (1)	Not Listed	
Access (6 comments)	<u>More Language/Translation Services – 3</u> • More BHSD treatment services in Spanish (3)	Not Listed	"More support for the Latino community, especially because a lot of them don't speak English, and there's also indigenous languages" "In Gilroy I see [long wait times] so much… psychiatrist wait time is 6 to 8 weeks" "[We need a] list of services for these people.. How do people find out about them? [Maybe] a newsletter that they put out… like, if you have substance problems, call this number."
	<u>Increase Community Awareness of BHSD Services – 1</u> • Community needs more awareness (general) – 1	Not Listed	
	<u>Easier/Faster Access to Treatment Services – 1</u> • Should be "easier" to access BHSD services (too many barriers, too many requirements for program entry, too much paperwork) – 1	1	
	<u>More Assistance Navigating BHSD System – 1</u> • Help consumers navigate the process of accessing BHSD services (e.g., how to start, what to expect, what to ask for) – 1	1 [1.4]	
Workforce, Education, and Training (4 comments)	<u>Increase Staff Pay – 2</u> • Increase pay for psychiatrists – 1 • Increase pay for therapists/counselors – 1	4 [4.2]	"The workers at the compassion center, they're great. They love what they do. They work hard. They are not paid enough." "We're not paying therapists enough we're not paying psychiatrists enough"
	<u>Increase Number of Clinical Staff – 1</u> • More psychiatrists – 1	4	
	<u>Increase Staff Training – 1</u> • More staff training on trauma-informed care – 1	4	
Outreach & Prevention (3 comments)	<u>Increase Community Awareness of</u> Mental Health & Substance Use <u>– 2</u> • Through social media (e.g., Instagram, Facebook) (1)	Not Listed / 3	"[We need] prevention for the middle school, for the elementary school, for the kids to know about these topics"

	• Specifically the Hispanic/Latino/a/e community (e.g., through commercials) (1)		"A lot of like Hispanic, they tune in more on TV. And that's where they get their information on from"
	School-Based Outreach – 1 • More prevention in public schools – 1	Not Listed	
Housing **(3 comments)**	Housing Stabilization (General Housing Need) – 3 • More housing (general) – 3	2.1	"[We need] more housing"
Collaboration & Integrative Care **(1 comment)**	Need more innovative partnerships between BHSD and private entities – 1 • Need better information sharing mechanism with Kaiser (1)	5	"Something that I'm hearing from clients specifically with children is that at one time they had Kaiser, and even though they haven't had Kaiser in over 18 months, [BHSD] mental health refuses to see the child until they provide a letter from Kaiser. And when they call, Kaiser's like 'Well, I can't give you this letter,' or it's a joint custody situation. And we're really putting clients in crisis in the position of doing the work that case managers or social workers should be doing. To the point where they're struggling to cash pay or their children are not getting their services.
Improve Quality **(1 comment)**	General Comments About Care Quality – 1 • Therapists should not fall asleep during sessions (1)	Not Listed	"[A BHSD consumer] decided to opt out [of treatment] because the [provider] fell asleep while she was trying to get help."

Housing-Related Analyses Appendix Tables & Figures

Unhoused Services: Strengths from Community Conversations (10 comments)

BHSD Strengths Identified in Community Conversations	Quotes
Strong Permanent Supportive Housing Investment & Services – 4 Use of housing flex funding to get immediate housing post-release from custody – 1 Strong case management services – 1 Whole-person approach incorporating trauma - 1 Focus on multidisciplinary teams – 1 Focus on housing and youth / TAY services – 1 East Valley homeless clinic - 1	"As the system has evolved and in many ways grown better to look at things like multidisciplinary teams versus…a case manager [only]…I would say the direction [that] things are going, in many ways, is very good." "Good job on…[investing] a lot in site based permanent support of housing and providing services to sites." "…including housing flex funding within the FDR programs as this allows our providers to secure immediate housing for individuals being released from custody." "…case management are doing a lot to get information that we receive out to our clients" "…after someone has housing is stabilized…there are layers of issues that must be addressed with someone who is chronically [experiencing] trauma…I love the way that they look at that approach [as a whole person with multiple layers of the process]… I think that's very innovative." "[A great thing] is the focus on both housing and youth services, especially the transitional age youth category just because in terms of prevention work, it's something that if we can catch them early, it's gonna have a less effect down the pipeline. So I think that's a focus that's been really, really good."

Unhoused Stakeholder Identified Needs from Community Conversations, Aggregate, with Sub-Themes and Quotes

Primary Themes	Sub-Themes	Corres-ponding Depart-ment Goal #	Quotes
Housing (62 comments)	Housing Stabilization (General Housing Need) – 56 • More Housing (general) (42) • More LGBTQ+-specific housing (4) • More flex funds to secure housing (3) • More housing options for South County (3) • Easier access to housing (2) • More housing beds specific to Criminal Justice services (1) • More housing options for those in wheelchairs (1)	2.1	"More housing solutions; options for people banned from shelters." "People really need the housing. It's something that I see a lot in the field that people are looking for, and even myself, when I was trying to help people. The resources are scarce." "There is no excuse for the number of people living in tents on the side of the freeway. They need a small basic room, bed, shower, sink and toilet. Local garbage pick-up. Nothing fancy. Just something to get out of the rain and the cold." "[I] hope there will be a lot of immediate access points to housing for all and reduced barriers to being accepted or placed." "[I] think the permanent housing and waiting list is ridiculous. A year long." "…more shelters in general." "…more flexible funding that we can spend directly on the client to secure their housing." "…there's got to be a way to make substance abuse [services] more available to the clients that are not in the collaborative courts…I had a [male] client yesterday that is in a wheelchair with substance abuse, and the only place that is available for a male for substance abuse is in the shelter at Life Moves. And then I got a call this morning from the social worker that has a female and has nowhere to go except for the shelter, because there's no wheelchair accessibility… I think that's something that needs to be looked at early." "Dedicated beds for the BHSD-FDR is key. LA County's Office of Diversion and Reentry have dedicated beds solely for
	More Temporary Housing – 3	2.4	
	More Permanent Supportive Housing (PSH) – 2	2.3	
	More Transitional Housing – 1	2.2	

			their patients, as it is understood that individuals within the criminal justice system have unique barriers to housing." "We do have housing [but] it's temporary, and our clients have voice kind of anxiety about…when their length of stay is coming up…they're not wanting to relapse and go back onto the street…how do we create more permanent housing options for these folks?" "As a client, not knowing when your time…ends is super stressful. Particularly if you don't have a place to go to next, which a lot of people don't have a clear place to go to…"
Treatment Services (50 comments)	<u>More Housing-Related Services – 28</u> • Services for those who are unhoused, and NOT in a BHSD-related housing program (23) o More BHSD treatment services for those who are actively unhoused (e.g., those not staying in temporary, transitional, or stable housing), 8 o More case management for those applying for housing, 7 o Need an FSP-like program specifically for those who are chronically unhoused, 3 o More clinicians to go out to visit the unhoused wherever they can be found, 2 o Need more individual therapy for those seeking housing, 1 o More community education on housing programs and requirements, 1 o Need more services for college students who are unhoused, 1 • Services for those who are unhoused, and currently engaged in a BHSD-related housing program (5) o More resources for scattered-site PSH, 2 o Need to ensure psychiatry and therapy services at every PSH site, 1	3.3	"The people that need the help, the most are the ones that are not getting housed, because the program was designed to come with case management. There's not enough managers. So if you can't find your [help] by yourself, and you can't fill out the application, … you don't have a car, you don't have money, credit… [you're] not gonna get help." "The lack of mental health stability causes the housing instability because individuals are in crisis and are not able to keep up with appointments, requirements, commitments. So they're at risk for losing housing vouchers, leases, and longer." "It is too confusing for people in the program that they're designed for and that's inequity right? A program should be easily understood by who it's designed for, the one using it." "If anyone reached out and…provided support around other housing options. Not…just advice…someone to do research and help you figure that next step out" "There should be FSP focused programs for people experiencing chronic homelessness that ARE also housing programs (with the $$ for housing connected)." "We need more of…having therapists go out and meet [unhoused] people where they are..." "Make sure there aren't perverse incentives that reduce the ability to meet clients in their homes (i.e. travel time, collateral contact time etc.)."

	o Need more Mental Health & Substance Use tx within temporary/transitional housing (e.g., shelters), 1 o Need more Mental Health & Substance Use treatment for those who are unhoused, general, 1		"Support our teams beyond what's happening in the contract…Bill Wilson has come in [and] debriefed our teams when there's been a number of [trauma] incidents…[but] that takes away from the billable activity that we're able to do that day which then pushes our productivity down which…allows us not to recoup our finances, to be able to afford the program."
	<u>Improve BHSD-CBO contracts – 5</u> • Need more contract flexibility for non-billable burnout prevention efforts (1) • Need more contract flexibility for non-billable client advocacy efforts (1) • Need more dedicated contract time to train PSH staff on Mental Health & Substance Use treatment (1) • PSH staff need more contract time for home visits (1) • Improve BHSD-CBO contracts (generally) (1)	3.3a	"New CalAIM requirements that are…by nature not going to be billable activities like picking up the phone and advocating for your client, [such as] about a lease violation. These are things that are expected to be done by our supportive system…They're vital to the health and wellness of the client. However, they're not billable by medical, and then our programs suffer financially." "[It's] a one-way street where we're hiring specialty housing [staff] providers, but they are learning [how to do] mental health…support…[as] a necessity. And that's not being acknowledged. [There's a need for more] resources…for ongoing development of becoming a mental health commissioner…who's informed with the best practices…for healing from trauma." "There's been this investment in site-based housing and the County has sort of forgotten about the initial [scattered site PSH] programs that that we serve in the community." "Scattered site Permanent Supportive Housing - those programs are older. So just for context, when we started the system, it was very much one case manager to 20 clients in scattered site….[and] that's not enough. You're [serving] people anywhere from Gilroy to Palo Alto, and maybe on the same caseload." "Our clients need psychiatry…some of these site based programs … are just purely housing. They don't have access to psychiatry and therapy [that] they still really need…how do we maximize the strengths that are already in the county?" "How it used to happen is there was a behavioral healthcare team that that folks in housing could call upon, but they weren't really accessible that it doesn't really work. If they're
	<u>Expand Outpatient Treatment, Miscellaneous – 4</u> • More case management support for those applying for public benefits (2) • More hybrid care with in-person services, while maintain all current virtual options (2)	3	
	<u>Increase Capacity for Residential/Inpatient Beds – 4</u> • Need a residential crisis stabilization after inpatient hospitalization (2) • Need more beds for those discharging from prison (2)	3	
	<u>More Step-Down Care – 4</u> • Need more dual diagnosis crisis stabilization (2) • Need residential crisis stabilization after psychiatric hospitalization (2)	3	
	<u>More Dual Diagnosis Services – 3</u> • More Dual Diagnosis services (generally) (2) • More residential dual diagnosis care (1)	3	
	<u>Crisis Care – 2</u>	3	

	• More crisis services without police involvement (2)		not actually on site and supporting it like in in a sort of a housing setting."
Collaboration & Integrative Care (22 comments)	<u>More Collaboration Between BHSD & Office of Supportive Housing (OSH) – 17</u> • Need more integration between BHSD and Office of Supportive Housing (11) • Need to separate OSH and BHSD and instead have dedicated BHSD staff in-person at PSH locations (6)	5	"Folks [that work in] permanent supportive housing [deal with silos between OSH and BHSD that impact their ability to work effectively]…The office support of housing is our bread and butter…we know that they make the decisions…[and are] our contract monitors, etc. But a lot of our funding comes through behavioral health. But the two [don't meet] they don't really understand each other at all." "Having 2 data sources…and 2 audits and double documentation and double billing is really challenging. And there's no change to their expectation or staffing expectation. So our staff are doing double the work, but they're required to have the same amount of productivity, and that's all because of the way the contracts written, the agency wishes we could have more flexibility. But the way the contracts are written it's really challenging to make that work." "[Do] we [really] need to pour more resources into making experts of everyone across the board? Are [these really] 2 separate things - supportive housing and behavioral health? Maybe [they] don't combine [well].. [The services] need to all be provided but does it need to be the same providers?" "I question whether we should have any MediCal billing and have typical clinicians in PSH." [with] supportive housing…we tried to fit one piece of [the] diagnostic [picture]…We…have to be able to…stress the importance of taking a mental health approach to the [unhoused] population
	<u>More Collaboration Within BHSD Agencies</u> – 5 • Need more collaboration between inpatient care and PSH staff for discharge planning (5)	5	"[There's] no standardized response for handoff.. when we…present ourselves as the outpatient providers, what usually tends to happen is [that] there seems to be [push-back]…from certain providers [and they just say]…these are doctors' orders…it really depends who the attending…provider is in that moment." "[For good service connection for the unhoused], it's just about [inpatient providers] being patient, waiting for bed to be open and then making that step down. And oftentimes they're

			looking to discharge people so quickly that they don't have the opportunity to use those resources." "[the inpatient providers just] sober our clients up, and [then put them] back out into the community without seeing what other services they may need [or] collaborating with us in outpatient, and so like, if we're lucky enough to hear that they're at EPS then we will advocate and try to support, but that doesn't always happen, because they've already discharged folks."
Workforce, Education, and Training (20 comments)	<u>Retain Clinical Staff – 10</u> • Burnout Needs/Recommendations (6) o Need PSH staff burnout interventions targeted at vicarious trauma, 3 o Reduce PSH staff burnout caused by the political pressure of the housing crisis, 1 o Reduce PSH staff burnout caused by the need to interact with a large number of community partners, 1 o Contracts should support staff burnout activities like team building, 1 • Reduce Staff Workload (4) o Reduce documentation/training/productivity requirements for PSH staff, who must meet BHSD and OSH requirements, 2 o Reduce productivity standards for PSH staff serving on-site programs vs. scattered site programs, 1 • Reduce staff burnout (general), 1	4	"In this quarter's risk management report that covers our entire service area (6 counties), we had 11 deaths (last quarter) mostly in PSH-- in 6 of those cases residents were found deceased by staff." "[We need support for] the level of trauma that we see in our clients, and…the things that our staff are dealing with. [The sites] are all piecemealing ways that we can support our staff and dealing with those things, but [we would benefit from more comprehensive support]." "Because of the political nature of so many of these sites, there's also…an added pressure…elected [officials] are involved, and community meetings and angry neighbors, and [police]. [This] adds to the pressure of onsite staff…[agency] leadership tries to shield…Staff…but it doesn't always work because literally when Pd comes on site, or…council members will just think they have the right to show up and take a tour of the site." "There are so many more relationships…that PSH staff…have to maintain…You have the…property management team,…the OSH team,…the behavioral health team, and…these community partners [and housing specialists] that are all weighing in. And so you have a lot of different stakeholders that are all trying to get what they want out of the situation…Our staff…end up carrying a lot of that weight…They feel like everybody wants them to be doing better, and they are doing the best they can all the time. So it's really, really challenging." "Employee retention is complicated due to contractual demands."
	<u>Increase Staff Pay – 7</u>	4	

	• Permanent Supportive Housing (PSH) staff should be paid for their dual skillsets (both therapy and housing skills) (4) • Increase Staff Pay (General Comments) (3)		"[PSH staff need] skill sets in these 2 worlds that feel very siloed and if we're gonna combine them, they need to be paid accordingly." "Our biggest issue is keeping an administrator for HMIS system, because they're doing program admin stuff that a normal program admin would have to do with avatar and then also focusing on HMIS and sometimes picking up slack for the whole agency with HMIS because we're only housing programs. So that's really challenging." "[I wish the] county had more training available on HMIS that's not just these videos that we have to watch [but instead], really how to navigate housing as a system, the resources that are available." "[We] need licensed clinical, social workers supporting [unhoused] people"
	<u>Increase Staff Training – 2</u> • More staff training on HMIS (1) • More staff training on AB1424 (1)	Not Listed	
	<u>Increase Number of Clinical Staff – 1</u> • More Case Managers to help with benefits attainment and housing processes (1)	4	
Improve Quality (8 comments)	<u>Need to Decrease LGBTQ+ Discrimination in BHSD Housing Programs – 7</u>	Not Listed	"Even [when] it's…slated to be [an] LGBTQ+ shelter, [people] who are not LGBTQ+ have gone in and then that impacts the folks who are trans, or who are not English-speaking and then you see that bias or discrimination occur." "There's been complaints. There's been negative experiences, and that's just…unacceptable."
	<u>Improve Call Center support to those who are Unhoused – 1</u> • 988 call line staff should be more helpful in giving resources for housing in cases of those with pets (1)	1	
Access (6 comments)	<u>More non-Call Center access options – 5</u> • Need an option for direct referrals for those who are unhoused (4) • Easier access for those who are unhoused (1)	1 [1.5]	"Especially when working with homeless populations, being able to take direct referrals is huge because those populations are highly scattered, and to try to get them through the queue. It's a pain so in order. For us to provide more timely supports and resources. Direct referral would be amazing." "[What] would be huge in terms of timely access is direct intakes rather than having basically the call center. I understand the view from the call center because they centralize the data but with homeless, thinking of the whole situation when you're fielding clients that might be outing incomes encampments, the last thing they want to do is call the call center and wait for 30 minutes and get their services that way." "Under some programs and conditions we have [need to have] access to quick detox and permanent support of housing. That is not available to others that are not in those programs, and [we
	<u>Direct access to SUTS for those who are Unhoused – 1</u> • Faster treatment access for those who are unhoused with Mental Health & Substance Use problems (1)		

			need] the ability to quickly get people in that moment and get them access to their appropriate care"
Outreach & Prevention (3 comments)	<u>Outreach to Those who are Unhoused – 3</u> • Outreach efforts to those without stable housing (2) • Outreach efforts to college students living in their cars on campus (1)	3 [3.3c]	"Make the programs that help the homeless, the poor people,…go out there and… really pull them out of the streets not just (wait)…Go find them, go to these encampments and go to these people in RVs and little tents [and sleeping] on sidewalks." "The number of cars that are overnight [at] the South garage [for college students] has been more in comparison to the previous semesters…Is anybody going out there to check on them [and tell them about the] services are available?...I myself was homeless at some point, and it's really hard to get help…it's difficult…to look for those services [i.e. on the internet]."

Community Needs Appendix Tables & Figures

Reasons for Not Seeking Help

Survey responses to the question: "What were the reasons why you did not seek help for mental health, nervous, emotional, drug or alcohol problems?"

Reasons for Not Seeking Help	N = 87
1. There aren't enough services.	36
2. My problems aren't serious enough.	22
3. There is a lack of help in my language.	17
4. I don't have the resources (time, money, transportation, childcare, etc.) to get help.	16
5. I'm not sure where or how to get help.	16
6. I am concerned about privacy.	16
7. Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours).	16
8. Services and referrals aren't as helpful as they should be.	14
9. I've had prior bad experiences getting help for my problems.	14
10. I don't think service providers understand my needs.	14
11. It's too hard to get myself to an agency to receive services.	12
12. Information on how to get help (website, phone numbers, instructions) is hard to find).	11
13. Information on how to get help (website, phone numbers, instructions) is confusing or difficult to understand.	11
14. Mental health / substance use problems are not talked about in my family or community.	8
15. I'm not eligible for publicly funded services, and can't afford other services.	8
16. There aren't enough telehealth options.	7
17. Services don't fit the needs of people who share my culture.	7
18. There aren't enough services focused on patient-centered recovery.	7
19. Services don't have enough peer staff.	7
20. There aren't enough disability accommodations.	5

Pandemic-Related Needs

Survey responses to the question: "As the pandemic improves and we all transition back to work, school, or other activities, do you have any specific issues in need of assistance from mental health or substance use services? (Check all that apply)"

Pandemic-Transition-Related Need	n
I am experiencing more problems with sleep, diet, or exercise.	159
I am experiencing more mental health problems.	138
I am experiencing a hard time with work/life balance.	128
I am more lonely or more isolated.	120
I am experiencing more physical health problems.	98
I have fewer financial resources.	97
I am having a hard time getting mental health care.	84
I am experiencing worry or stress related to COVID-19, the pandemic, or vaccines.	84
I am having a hard time meeting my basic needs (food, clothes, housing, transportation).	68
I am having a hard time getting or keeping a job.	51
I am having a hard time getting medical care.	42
I am having a hard time with childcare.	18
I am having a hard time getting substance use services.	18

Note: A total of 329 individuals responded to this item about pandemic-transition-related needs

Appendices: Data Tables, per Community Conversation

Adults in Residential Treatment (n = 4)		
STRENGTHS: "What Should Stay the Same?"		
Access Processes/Procedures (n = 1)		
Quality of Care (n = 1)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (10 comments)	More Longer-Term Treatment – 2 • More long-term therapy options (2)	3 [AOA]
	Youth: Youth Substance Use Prevention – 2 • More MH education in schools to prevent SU (2)	3 CYF]
	More Support Applying for Benefits – 2 • More support applying with benefits (2)	Not Listed
	More Housing-Related Services – 1 • Services for those who are unhoused, and NOT in a BHSD-related housing program (1) o More case management for those applying for housing, 1	3.3
	Expand Outpatient Treatment, Miscellaneous – 1 • More thorough psychological assessment (1)	3 [AOA]
	More Dual Diagnosis Treatment – 1 • Need more long-term residential treatment for dual diagnosis presentations (1)	3 [AOA]
	Treatment Services, Miscellaneous – 1 • Need more flexibility in types of treatment at residential treatment facilities (1)	Not Listed
Housing (3 comments)	More Temporary Housing – 2	2.3
	Housing Stabilization (General Housing Need) – 1 • More housing, general (1)	2.1

Workforce, Education, and Training (1 comment)	<u>Increase Staff Pay – 1</u> • Increase Staff Pay (General Comments) (1)	4.2
Outreach & Prevention (1 comment)	<u>Increase Community Awareness of Mental Health & Substance Use – 1</u> • General need to increase community awareness of Mental Health & Substance Use (1)	Not Listed

African American Community (n = 3)

STRENGTHS: "What Should Stay the Same?"

CBOs, Clinics, Programs (n = 1)
Crisis Services (n = 1)
Expanded Outpatient Treatment (n = 1)
Outreach & Prevention Services (n = 1)
Workforce, Education, and Training (n = 1)
Youth & School-Based Services (n = 1)

NEEDS: "What Should be Added or Changed?"

Primary Themes	Sub-Themes	Corresponding Department Goal #
Workforce, Education, and Training (8 comments)	Increase Staff Training – 4 • Increase Cultural Competency (General) in BHSD Services (2) • DEI training for all staff and directors (1) • More staff training on Black & African Descendant culture (1)	Not Listed
	Increase Number of Clinical Staff – 3 • More Therapists (2) o More therapists (general), 2 • More Psychiatrists (1)	4.3
	Specific Hiring Suggestions – 1 • Hire Culturally-Matched Staff (1) o Hire staff who are ethnically-matched to the community they serve (general), 1	4.3
Outreach & Prevention (7 comments)	Ethnic-Specific Outreach/Prevention – 3 • Use TV commercials to reach African American community (2) • More outreach to African American community (1)	Not Listed
	Reduce Community Stigma – 2 • General calls to reduce community stigma (2)	Not Listed

	School-Based Outreach – 1 • More outreach to public schools (1)	3 [CYF]
	Event-Focused Outreach – 1 • More event-focused outreach (e.g., biking, hiking) (1)	Not Listed
Treatment Services (6 comments)	Expand Outpatient Treatment, Miscellaneous – 3 • More capacity for individual therapy (2) • More services for women (1)	3 [AOA]
	More Housing-Related Services – 2 • Services for those who are unhoused, and NOT in a BHSD-related housing program (1) o Need an FSP-like program specifically for those who are chronically unhoused, 1 • Services for those who are unhoused, and currently engaged in a BHSD-related housing program (1) o Need more Mental Health & Substance Use tx within temporary/transitional housing (e.g., shelters), 1	3.3
	More Services to Reduce Isolation – 1	3
Housing (2 comments)	Housing Stabilization (General Housing Need) – 2 • More LGBTQ+-specific housing (2)	2.1

African Immigrant Community (n = 15)

STRENGTHS: "What Should Stay the Same?"

Access Processes / Procedures (n = 1)

CBOs, Clinics, Programs (n = 1)

NEEDS: "What Should be Added or Changed?"

Primary Themes	Sub-Themes	Corresponding Department Goal #

Workforce, Education, and Training (8 comments)	Specific Hiring Suggestions – 5
	• Hire Culturally-Matched Staff (5)
	  o Hire women for outreach to the African immigrant community, 3
	  o Hire Muslim-identified individuals to serve the community, 1
	  o Hire more women employees, 1
		4.3

	Increase Staff Training – 2 • Increase Cultural Competency (General) in BHSD Services (2)	Not Listed
	Increase Number of Clinical Staff – 1 • More Clinical Staff (General) (1)	4.3
Outreach & Prevention (8 comments)	More In-Person Outreach – 3 • More in-person wellness outreach events (1) • More in-person community outreach (1) • More in-person outreach at youth events (1)	Not Listed
	General Outreach – 2 • Need specific outreach to women (1) • Need specific outreach to those at risk for a mental health crisis (1)	Not Listed
	Ethnic-Specific Outreach/Prevention – 1 • More outreach to African immigrant youth (1)	Not Listed
	Train the Community to Help & Refer – 1 • Need more trainings for community members to learn how to recognize Mental Health & Substance Use problems and effectively refer people for help (1)	Not Listed

	Outreach to Religious/Spiritual Venues – 1 • More outreach through religious organizations and houses of worship (1)	Not Listed
Treatment Services (7 comments)	Expand Outpatient Treatment, Miscellaneous – 2 • More programs to support stress after the loss of employment (1) • More Services for adults with severe symptoms who need treatment but decline services (1)	3 [AOA]
	Youth: Youth Substance Use Prevention – 1 • More activities to prevent youth substance use (1)	3 [CYF]
	Youth: Youth Substance Use Treatment Services – 1 • More youth SUTS (1)	3 [CYF]
	More Housing-Related Services – 1 • Services for those who are unhoused, and NOT in a BHSD-related housing program (1) o More BHSD treatment services for those who are actively unhoused (e.g., those not staying in temporary, transitional, or stable housing), 1	3.3
	More Services to Reduce Isolation – 1	3 [AOA]
	More Hybrid Care – 1 • More in-person availability while keeping all current telehealth options (1)	Not Listed
Collaboration & Integrative Care (3 comments)	More Collaboration Between BHSD & Other SCC Departments – 3 • Need more police training on Mental Health & Substance Use (3)	5
Housing (1 comment)	Housing Stabilization (General Housing Need) – 1 • More Housing (General) (1)	2.1
Access (1 comment)	More Language/Translation Services – 1 • More translation services for Middle Eastern languages (1)	Not Listed

Consumers/Clients, General (n = 4)		
STRENGTHS: "What Should Stay the Same?"		
CBOs, Clinics, Programs (n = 1)		
Youth & School-Based Services (n = 1)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (16 comments)	More Step-Down Treatment Services – 4 • Need more aftercare programs after psychiatric hospitalization (2) • Need a more flexible continuum of care after psychiatric hospitalization (1) • Need more step-down options after psychiatric hospitalization (1)	3 [AOA]
	Expand Outpatient Treatment, Miscellaneous – 3 • Need a method for checking-in with providers weekly (2) • More capacity for individual therapy (1)	3 [AOA]
	Greater Residential/Inpatient Bed Capacity – 3 • More residential treatment (3)	3 [AOA]
	More Criminal Justice Services – 3 • SCC should stop using jails/prisons in place of Mental Health & Substance Use treatment (3)	3.4
	Improvements to BHSD-CBO Contracts – 1 • Need more contract flexibility for non-billable tasks (e.g., consumer advocacy, burnout prevention) (1)	3.2
	Youth: School Services – 1 • Need therapy services for those needing help with procrastination (1)	3 [CYF]
	More Longer-Term Treatment – 1 • Psychiatric hospitals should hold people longer for stabilization (1)	3 [AOA]
Workforce, Education, and Training (9 comments)	Increase Number of Clinical Staff – 4 • More Case Managers (2) • More Psychiatrists (2)	4.3
	Increase Staff Pay – 2	4.2

	• Increase Staff Pay (General Comments) (1) • Staff must be paid based on the living costs of the Bay Area (1)	
	Specific Hiring Suggestions – 1 • Use Paraprofessionals to Meet Staffing Needs (1)	4.3
	Retain Clinical Staff – 1 • Increase Staff Benefits (1) o More student loan forgiveness for BHSD staff, 1	4.1
	Increase Staff Training – 1 • More County staff training on AB1424 (1)	Not Listed
Access (5 comments)	Increase Community Awareness of BHSD Services – 4 • Community needs more awareness (general) (3) • Need a physical location where people can go to get BHSD resources and information (1)	Not Listed
	Improve Call Center Integrated Screening Processes – 1 • Should use technology to help pair consumers with therapists who will be a good fit for them (1)	1.2
Collaboration & Integrative Care (3 comments)	More Collaboration Between BHSD & Other SCC Departments – 3 • Need more collaboration with SCC medical services (1) o Need more integrated medical-Mental Health & Substance Use treatment programs, 1 • Need a single EMR for all County services (1) • Need more police training on Mental Health & Substance Use (1)	5
Outreach & Prevention (2 comments)	Increase Community Awareness of Mental Health & Substance Use – 1 • Specifically for serious mental illness (1)	Not Listed
	Train the Community to Help & Refer – 1 • Need more trainings for community members to learn how to recognize Mental Health & Substance Use problems and effectively refer people for help (1)	Not Listed
Improve Quality (2 comments)	General Comments About Care Quality – 2 • 988 call line staff should be more helpful in giving resources (1) • Should have higher consistency in the quality of psychiatrists (1)	Not Listed
Housing (1 comment)	Housing Stabilization (General Housing Need) – 1 • More housing (general) (1)	2.1

Diversion (n = 65)

STRENGTHS: "What Should Stay the Same?"

Access Processes / Procedures (n = 2)
CBOs, Clinics, Programs (n = 1)
Collaborative & Integrated Care (n = 1)
Criminal Justice Services (n = 4)
Expanded Outpatient Treatment (n = 1)
Housing (n = 1)
Telehealth (n = 3)
Youth & School-Based Services (n = 1)

NEEDS: "What Should be Added or Changed?"

Primary Themes	Sub-Themes	Corresponding Department Goal #

Treatment Services (31 comments)	More Criminal Justice Services – 9
	• Diversion Services (3)
	  o Diversion clients need another level of care between FSP and residential treatment, 1
	  o More long-term treatment in Diversion services, 1
	  o More outpatient therapy through Diversion services, 1
	• Need to expand criminal justice competency beyond Mental Health Court (3)
	• More family integration services for those in jail/prison (1)
	• Need more services after consumers are released from jail/prison (1)
	• More services for justice-involved clients, generally (1)
		3.4

	SUTS (including detox) – 5 • Need a medical detox program (2) • Need more individual therapy during SUTS (1) • Need respite house for substance use (1) • Need same-day-access for SUTS (1)	3.1

	Expand Outpatient Treatment, Miscellaneous – 4 • More capacity for outpatient programs (4)	3 [AOA]
	Greater Residential/Inpatient Bed Capacity – 4 • More crisis residential capacity (3) • More Board & Care beds (1)	3 [AOA]
	More Dual Diagnosis Treatment – 4 • Need more dual diagnosis treatment programs (3) • Need more long-term residential treatment for dual diagnosis presentations (1)	3 [AOA]
	Youth: Family Therapy – 2 • Need more family services for those in legal system (2)	3 [CYF]
	More Services for those with Neurocognitive Conditions (e.g., Alzheimer's, cognitive decline, brain injury, neurocognitive deficits) – 2	3 [AOA]
	Youth: Need More Resources for TAY Population – 1	3 [CYF]
Workforce, Education, and Training (13 comments)	Increase Number of Clinical Staff – 11 • More Diversion Services Staff (9) o More assessors in Collaborative Courts, 6 o More Diversion staff (general), 3 • More Therapists (2) o More therapists (general), 2	4.3
	Specific Hiring Suggestions – 1 • Hire Culturally-Matched Staff (1) o Hire staff who are culturally-matched to the community they serve (general), 1	4.3
	Retain Clinical Staff – 1 • Reduce Staff Workload (1) o Less case manager responsibilities for Diversion lawyers, 1	4
Collaboration & Integrative Care (10 comments)	More Collaboration Within BHSD Agencies – 9 • Need more collaboration between Diversion services and AOA services (6) • Need more collaboration between BHSD programs (2) • Need more opportunities for collaboration with Diversion services (1)	5
	More Collaboration Between BHSD & Other SCC Departments – 1 • Need a single EMR for all County services (1)	5
Housing	Housing Stabilization (General Housing Need) – 10	2.1

(11 comments)	• More housing (general) (6) • More flex funds to secure housing (2) • More housing beds specific to Criminal Justice services (1) • More housing options for those in wheelchairs (1)	
	More Temporary Housing – 1	2.4
Access (6 comments)	Increase Community Awareness of BHSD Services – 2 • Community needs more awareness (general) (2)	Not Listed
	More Language/Translation Services – 2 • More Vietnamese language services (1) • Language (general) (1)	Not Listed
	Improve Call Center Integrated Screening Processes – 2 • Call Center should evaluate previous BHSD services history to reduce redundancy of services (1) • General calls to improve screening through the Call Center (1)	1.2

Family, General (n = 6)

STRENGTHS: "What Should Stay the Same?"

Access Processes / Procedures (n = 4)
CBOs, Clinics, Programs (n = 1)
Collaborative & Integrated Care (n = 1)
Criminal Justice Services (n = 2)
Crisis Services (n = 2)
Expanded Outpatient Treatment (n = 2)
Telehealth (n = 2)

NEEDS: "What Should be Added or Changed?"

Primary Themes	Sub-Themes	Corresponding Department Goal #
More Treatment Services (24 Comments)	Youth: Services for those who Decline Treatment – 7 • Services for adult youth who are pre-crisis and decline treatment when they need it (5) • Need a multi-service team to assist with the conservatorship process (1) • Need more parent support for adult youth who need treatment but consistently decline it (1)	3 [AOA]
	Youth: More Family Services – 4 • More family-centered approaches to treatment (2) • More inclusion of family in diversion programs (1) • Police should notify family members after a mental health emergency (1)	Not Listed
	More Injectable Antipsychotic for Those with Psychosis – 3	3 [AOA]
	Greater Residential/Inpatient Bed Capacity – 3 • More residential treatment (1) • Need more beds for those discharging from jail/prison (1) Need separate residential treatment for adults and TAY populations (1)	3 [AOA]
	More Dual Diagnosis Treatment – 2 • Need more dual diagnosis treatment programs (2)	3 [AOA]

	Expand Outpatient Treatment, Miscellaneous – 2 • Need more WRAP plans (1) • More group therapy (1)	3 [AOA]
	More Housing-Related Services – 1 • Services for those who are unhoused, and NOT in a BHSD-related housing program (1) o More case management for those applying for housing, 1	3.3
	More Supported Employment – 1 • More supported employment, generally (1)	Not Listed
	More Longer-Term Treatment – 1 • More emphasis on long-term substance use recovery programs (e.g., AA, NA, AlAnon) (1)	3 [AOA]
Workforce, Education, and Training (4 comments)	Increase Number of Clinical Staff – 2 • More peer support workers (1) • More Case Managers (1)	4.3
	Specific Hiring Suggestions – 2 • Hire case managers who are age-matched, especially for TAY-aged individuals (1) • Use Paraprofessionals to Meet Staffing Needs (1)	Not Listed
Access (1 comment)	Increase Community Awareness of BHSD Services – 1 • Need a single list of all BHSD Services (1)	Not Listed
Housing (1 comment)	Housing Stabilization (General Housing Need) – 1 • Need more housing (general) (1)	2.1
Improve Quality (1 comment)	General Comments About Care Quality – 1 • Residential treatment staff should be more engaged with clients on a daily basis (1)	Not Listed

LGBQPA2S+ (n = 7)

STRENGTHS: "What Should Stay the Same?"

Access Processes / Procedures (n = 1)

LGBTQ+ Services (n = 2)

NEEDS: "What Should be Added or Changed?"

Primary Themes	Sub-Themes	Corresponding Department Goal #
Workforce, Education, and Training (29 comments)	Increase Staff Training – 11 • More LGBTQ+ training for clinical staff (10) o Need BHSD staff training on LGBTQ+ intersectionality (e.g., polyamory, disability), 3 o Need more LGBTQ+ competency across BHSD services, 2 o Increase cultural competency within all BHSD services (general), 2 o More caregiver training on LGBTQ+ topics, 1 o More LGBTQ+ competency in prison MH services, 1 o More LGBTQ+ competency in re-entry services, 1 • Increase Cultural Competency (General) in BHSD Services (1)	Not Listed
	Specific Hiring Suggestions – 7 • Hire Culturally-Matched Staff (6) o Implement specialized recruitment for LGBTQ+ staff positions, 4 o Hire school therapists who are LGBTQ+-identified, 1 o Hire LGBTQ+-identified individuals to serve the community, 1 • Reduce barriers to hiring sex workers (e.g., formal education requirements) (1)	4.3
	Retain Clinical Staff – 5 • Make BHSD an affirming environment for LGBTQ+ staff (3) o Need to add a space for pronouns on all County forms, including internal/staff documents, 2 o Better incorporate LGBTQ+ staff input when making decisions for LGBTQ+ programs, 1 • Burnout Needs/Recommendations (2) o More burnout resources for staff with lived experience (e.g., peer support), 1	4

	○ More HR/BHSD support for LGBTQ+ staff after anti-LGBTQ+ aggressions in the workplace, 1	
	<u>Increase Staff Pay – 4</u> • Increase pay for CBO staff (3) • Increase Staff Pay (General Comments) (1)	4.2
	<u>Increase Number of Clinical Staff – 2</u> • More Clinical Staff (General) (1) • More Therapists (1)	4.3
Treatment Services (16 comments)	<u>LGBTQ+ Services – 6</u> • Expand clinical services for LGBTQ+ community (6) ○ Need more LGBTQ+-affirming physical spaces, 2 ○ Need more services for disabled LGBTQ+ individuals, 1 ○ Need LGBTQ+-specific sober living environment, 1 ○ Need more LGBTQ+ services in South County, 1 ○ Need additional LGBTQ+-focused facilities, 1	3 [AOA]
	<u>SUTS (including detox) – 5</u> • Need more harm reduction approaches (5)	3.1
	<u>Youth: Other Treatment Services – 2</u> • Expand the definition of family to "chosen family" (1) • Need more support for caregivers (1)	3 [CYF]
	<u>More Support Groups – 2</u> • Need more social support groups for LGBTQ+ individuals (2)	3 [AOA]
	<u>Expand Outpatient Treatment, Miscellaneous – 1</u> • More treatment for sex workers instead of focusing on preventing sex work (1)	3 [AOA]
Collaboration & Integrative Care (1 comment)	<u>More Collaboration Within BHSD Agencies</u> – 1 • Need clear instructions on how clinicians can refer to LGBTQ+ services (1)	5
Housing (4 comments)	<u>Housing Stabilization (General Housing Need) – 3</u> • More LGBTQ+-specific housing (3)	2.1
	<u>More Transitional Housing – 1</u> • Need more LGBTQ-specific crisis residential housing (1)	2.2

Improve Quality (7 comments)	<u>Need to Decrease LGBTQ+ Discrimination in BHSD Housing Programs – 7</u> • Need to decrease anti-LGBTQ+ discrimination in BHSD housing programs (5) • Need to better disseminate a process for LGBTQ+ consumers to report discrimination instances that happen in BHSD housing programs (2)	Not Listed

Middle Eastern Community (n = 7)

NEEDS: "What Should be Added or Changed?"

Primary Themes	Sub-Themes	Corresponding Department Goal #
Outreach & Prevention (13 comments)	Ethnic-Specific Outreach/Prevention – 5 • More Middle Eastern outreach (2) • More racial/ethnic anti-discrimination efforts to prevent Mental Health & Substance Use problems caused by anti-LGBTQ+ bias in Middle Eastern churches (1) • Need a CCWP team focused on Middle Eastern community (1) • Need a wellness center for Middle Eastern community (1)	Not Listed
	Reduce Community Stigma – 3 • Reduce community stigma via collaboration with religious/spiritual leaders (3)	Not Listed
	Increase Community Awareness of Mental Health & Substance Use – 2 • General need to increase community awareness of Mental Health & Substance Use (2)	Not Listed
	Outreach to Religious/Spiritual Venues – 2 • More outreach through religious organizations and houses of worship (1) • Outreach to the Middle Eastern community through religious organizations (1)	Not Listed
	General Outreach – 1 • Need outreach by non-Middle Eastern providers to facilitate privacy (1)	Not Listed
Access (8 comments)	Increase Community Awareness of BHSD Services – 6 • Community needs more awareness (general) (6)	Not Listed
	More Language/Translation Services – 2 • More translation services for Middle Eastern languages (2)	Not Listed
Treatment Services (4 comments)	Youth: Services to Bridge Intergenerational Divide – 1 • Services for youth, parents, and families struggling with inter-generational cultural conflicts (1)	3 [CYF]
	SUTS (including detox) – 1 • Need more residential substance use treatment programs (1)	3.1
	Services for Immigrants & Refugees – 1 • Need more LGBTQ+ education for immigrant families (1)	3 [CYF]

	More Support Groups – 1 • Need more support groups for long-term Covid cases (1)	3 [AOA]
Workforce, Education, and Training (4 comments)	Specific Hiring Suggestions – 2 • Hire Culturally-Matched Staff (2) • Hire Middle Eastern individuals to serve the community, 2	4.3
	Increase Number of Clinical Staff – 1 • More youth peer support staff (1)	4.3
	Increase Staff Training – 1 • More staff training on Middle Eastern culture (1)	Not Listed

North County (n = 32)

STRENGTHS: "What Should Stay the Same?"

Access Processes / Procedures (n = 2)
CBOs, Clinics, Programs (n = 1)
Collaborative & Integrated Care (n = 3)
Crisis Services (n = 4)
Housing (n = 1)
LGBTQ+ Services (n = 2)
Outreach & Prevention Services (n = 5)
Workforce, Education, and Training (n = 2)
Youth & School-Based Services (n = 10)

NEEDS: "What Should be Added or Changed?"

Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (28 Comments)	Youth: Youth Substance Use Prevention – 5 • More MH education in schools to prevent SU (3) • General support for additional youth substance use prevention (2)	3 [CYF]
	More Covid-19-related Services – 4 • More services focused on Covid-19-related grief (3) • More Mental Health & Substance Use treatment related to the long-term effects of Covid-19 (1)	3 [CYF]
	Crisis Services – 3 • Need an option for crisis care that does not include police accompaniment (2) • Need more mobile crisis teams (1)	3 [CYF]
	Youth: Family Services – 3 • More family-focused services (2) • More services to bridge the youth-elder divide (1)	3 [CYF]
	Youth: Youth Parent Services – 3	3 [CYF]

	• Parent Psychoeducation on Mental Health & Substance Use (3)	
	Youth: More Residential/Inpatient Beds – 2 • More options for inpatient adolescent stays (2)	3 [CYF]
	Youth: Miscellaneous Services – 2 • More Crisis Services (1) • More youth providers to recognize recurrent youth consumers (1)	3 [CYF]
	More Services to Reduce Isolation – 2	3 [CYF]
	Youth: School Services – 1 • More peer training in schools (1)	3 [CYF]
	Youth: Youth Substance Use Treatment Services – 1 • More dual diagnosis treatment for youth (1)	3 [AOA]
	Youth: More telehealth for youth (General) – 1	3 [CYF]
	Expand Outpatient Treatment, Miscellaneous – 1 • More pre-crisis intervention services (1)	3 [CYF]
Outreach & Prevention (14 comments)	General Outreach – 5 • More early intervention opportunities (2) • More prevention for those not on social media (1) • More small group or 1:1 outreach (1) • More prevention via social media (1)	Not Listed
	Reduce Community Stigma – 4 • Reduce Mental Health & Substance Use stigma in parents (2) • General calls to reduce community stigma (1) • Reduce stigma in recent immigrants (1)	Not Listed
	Increase Community Awareness of Mental Health & Substance Use – 2 • General need to increase community awareness of Mental Health & Substance Use (2)	Not Listed
	Ethnic-Specific Outreach/Prevention – 1 • More prevention for recent immigrants (1)	Not Listed
	School-Based Outreach – 1 • More school education on Mental Health & Substance Use (1)	3 [CYF]
	Outreach to Religious/Spiritual Venues – 1 • More outreach through religious organizations and houses of worship (1)	Not Listed

Workforce, Education, and Training (11 comments)	Increase Staff Training – 4 • Increase Cultural Competency (General) in BHSD Services (3) • More culturally-sensitive care for parents 50+ (1)	Not Listed
	Increase Number of Clinical Staff – 3 • More Youth-Focused Staff (2) • More Clinical Staff (General) (1)	4.3
	Retain Clinical Staff – 2 • More support for staff (general) (1) • Reduce programs/clinics "poaching" staff from each other (1)	4
	Specific Hiring Suggestions – 1 • Recruit from New Graduates (1)	4.3
	Increase Staff Pay – 1 • Staff must be paid based on the living costs of the Bay Area (1)	4.2
Collaboration & Integrative Care (6 comments)	More Collaboration Between BHSD & Other SCC Departments – 2 • Need more collaboration with SCC medical services – (1) o Need more MH training for PCP/ER staff, 1 • Need more teacher training on Mental Health & Substance Use (1)	5
	More Collaboration Within BHSD Agencies – 2 • Need more collaboration between BHSD programs, general (2)	5
	Need more innovative partnerships between BHSD and private entities – 2 • Better collaboration with nonprofit organizations, general (1) • Need better information sharing mechanism with Kaiser (1)	5
Access (4 comments)	More Language/Translation Services – 1 • Easier access to translation services (1)	Not Listed
	Easier/Faster Access to Treatment Services – 1 • Should be "easier" to access BHSD services (too many barriers, too many requirements for program entry, too much paperwork) (1)	1
	Increase Transportation Support – 1 • General Comments about Transportation as a Barrier to Accessing BHSD Services (1)	Not Listed
	Need Childcare Services During BHSD Appointments – 1 • Facilitate parents accessing BHSD services by providing childcare (1)	Not Listed

Providers: Adult & Older Adult Services (n = 24)

STRENGTHS: "What Should Stay the Same?"

Access Processes / Procedures (n = 1)
CBOs, Clinics, Programs (n = 1)
Crisis Services (n = 1)
Expanded Outpatient Treatment (n = 1)
Quality of Care (n = 1)
Telehealth (n = 2)
Workforce, Education, and Training (n = 2)

NEEDS: "What Should be Added or Changed?"

Primary Themes	Sub-Themes	Corresponding Department Goal #

Workforce, Education, and Training (17 comments)	Retain Clinical Staff – 10
	• Increase Staff Benefits (8)
	  o Providing/subsidizing childcare for BHSD employees, 5
	  o Reinstate Covid-19 sick pay for employees who are sick, 1
	  o More funding for staff to attain advanced clinical trainings, such as EMDR and DBT, 1
	  o More Mental Health & Substance Use services for BHSD staff, 1
	• More support for staff (general) (2)
		4.3

	Increase Staff Pay – 4 • Increase Staff Pay (General Comments) – (4)	4.2
	Specific Hiring Suggestions – 3 • Increase Intern Stipends (1) • Collaborate with Colleges to Build the Workforce (1) • Use Ad campaigns to promote the field of Mental Health (e.g., billboards highlighting how fulfilling it is) (1)	4.1
	Improve Call Center Integrated Screening Processes – 14	1.2

Access (17 comments)	• Need better diagnostic screening/assessment (e.g., psychotic symptoms, suicidality, history of hospitalization, eating disorders, types of symptoms) (5) • General calls to improve screening through the Call Center (4) • Need to ensure that clients are only sent for levels of care that are appropriate for the client (2) • Call Center should be staffed by clinicians (2) • Need to clearly assess client's desire for therapy versus medication (1)	
	<u>More non-Call Center access options – 2</u> • Need an option for direct referrals (e.g., walk-ins) without using the Call Center (2)	1.5
	<u>Increase Transportation Support – 1</u> • General Comments about Transportation as a Barrier to Accessing BHSD Services (1)	Not Listed
Treatment Services (14 Comments)	<u>Improvements to BHSD-CBO Contracts – 4</u> • Need more contract flexibility for non-billable tasks (e.g., consumer advocacy, burnout prevention) (1) • Need dedicated contact time for in-depth staff training (1) • Need more reimbursement for SUTS within MH programs (1) • PSH staff need more contract time for home visits (1)	3.2
	<u>More Housing-Related Services – 3</u> • Services for those who are unhoused, and NOT in a BHSD-related housing program (3) o Need an FSP-like program specifically for those who are chronically unhoused, 2 o More case management for those applying for housing, 1	3.3
	<u>Criminal Justice Services – 2</u> • SCC should stop using jails/prisons in place of Mental Health & Substance Use treatment (1) • Need to expand criminal justice competency beyond Mental Health Court (1)	3.4
	<u>More Services for those with Neurocognitive Conditions (e.g., Alzheimer's, cognitive decline, brain injury, neurocognitive deficits) – 2</u>	3 [AOA]
	<u>SUTS (including detox) – 1</u> • Need more SUTS for those with intellectual disabilities (1)	3.1
	<u>Expand Outpatient Treatment, Miscellaneous – 1</u> • Need an FSP-like program with lower entry requirements (1)	3 [AOA]
	<u>YOUTH: Youth Substance Use Prevention – 1</u> • More MH treatment to prevent development of SU problems (1)	3 [CYF]
Outreach & Prevention	<u>General Outreach – 1</u> • Need more community prevention services (1)	Not Listed

(3 comments)	<u>Increase Community Awareness of Mental Health & Substance Use – 1</u> • General need to increase community awareness of Mental Health & Substance Use (1)	Not Listed
	<u>Ethnic-Specific Outreach/Prevention – 1</u> • More ethnic-specific outreach (general) (1)	Not Listed
Collaboration & Integrative Care (1 comment)	<u>More Collaboration Between BHSD & Other SCC Departments</u> – 1 • Need more collaboration with SCC medical services – (1) o Need more integrated medical-Mental Health & Substance Use treatment programs, 1	5
Housing (1 comment)	<u>Housing Stabilization (General Housing Need) – 1</u> • More housing (general) (1)	2.1

Providers: Children, Youth, and Family Services (n = 32)		
STRENGTHS: "What Should Stay the Same?"		
Access Processes / Procedures (n = 1)		
CBOs, Clinics, Programs (n = 2)		
Housing (n = 1)		
Outreach & Prevention Services (n = 3)		
Youth & School-Based Services (n = 5)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (19 Comments)	Youth: More Longer-Term Treatment – 3 • More long-term outpatient therapy options (3)	3 [CYF]
	Youth: More Residential/Inpatient Beds – 3 • More options for inpatient adolescent stays (3)	3 [CYF]
	Services for Immigrants & Refugees – 3 • Need more cultural assimilation training for refugees (1) • More trauma-focused treatment for immigrants (1) • More services for immigrants, general (1)	3 [CYF]
	Youth: Expand Outpatient Treatment, Miscellaneous – 3 • More domestic violence services (2) • More group therapy (1)	3 [CYF]
	More Housing-Related Services – 1 • Services for those who are unhoused, and NOT in a BHSD-related housing program (1) o Need more services for college students who are unhoused, 1	3.3
	SUTS (including detox) – 1 • Need a medical detox program (1)	3.1
	Youth: Greater Residential/Inpatient Bed Capacity – 1 • More medical respite for those with Mental Health & Substance Use problems (1)	3 [CYF]

	Crisis care – 1 • Need more services for those presenting with high-acuity mental health challenges (1)	3 [CYF]
	Youth: Youth SUTS – 1 • More youth substance use treatment, general (1)	3 [CYF]
	Youth: Youth Parent Services – 1 • Establish a parent peer program (1)	3 [CYF]
	Services for Treatment-Declining Individuals – 1 • Need a multi-service team meeting to facilitate conservatorship for those who need it (1)	3 [CYF]
Access (17 comments)	More Language/Translation Services – 6 • More treatment services in Spanish (2) • More Vietnamese language services (2) • In-person translation services (2)	Not Listed
	More non-Call Center access options – 4 • Need an option for direct referrals (e.g., walk-ins) without using the Call Center (3) • Need an option for direct referrals between BHSD agencies/providers (1)	Not Listed
	Improve Call Center Integrated Screening Processes – 3 • General calls to improve screening through the Call Center (2) • Need to ensure that clients are only sent for levels of care that are appropriate for the client (1)	1
	Easier/Faster Access to Treatment Services – 2 • Should be "easier" to access BHSD services (too many barriers, too many requirements for program entry, too much paperwork) (2)	1
	Need Childcare Services During BHSD Appointments – 1 • Facilitate parents accessing BHSD services by providing childcare (1)	Not Listed
	Direct access to SUTS for those who are Unhoused – 1 • Faster treatment access for those who are unhoused with Mental Health & Substance Use problems (1)	3

Workforce, Education, and Training (10 comments)	Specific Hiring Suggestions – 5 • Hire Culturally-Matched Staff (1) o Hire staff who are culturally-matched to the community they serve (general), 1 • Recruit College Students Looking for Internships (1) • Use Paraprofessionals to Meet Staffing Needs (1) • Collaborate with Colleges to Build the Workforce (1)	4.3

	• Recruit from New Graduates (1)	
	Increase Staff Pay – 3 • Increase pay for paraprofessionals (e.g., case managers, peer support staff) (2) • Increase Staff Pay (General Comments) (1)	4.2
	Retain Clinical Staff – 1 • Increase Staff Benefits (1) o Financial support for BHSD staff to attain additional education, 1	4
	Increase Number of Clinical Staff – 1 • More Paraprofessionals (1)	4.3
Collaboration & Integrative Care (10 comments)	More Collaboration Between BHSD & Other SCC Departments – 10 • Need a single EMR for all County services (8) • Need more collaboration with SCC medical services (1) o Need more MH training for PCP/ER staff, 1 • Need more collaboration with schools' independent therapists (1)	5
Housing (5 comments)	Housing Stabilization (General Housing Need) – 4 • More housing, general (4)	2.1
	More Temporary Housing – 1	2.4
Outreach & Prevention (1 comment)	Reduce Community Stigma – 1 • Reduce stigma in recent immigrants (1)	Not Listed

Providers, Housing Services (n = 13)		
STRENGTHS: "What Should Stay the Same?"		
Crisis Services (n = 1)		
Housing (n = 5)		
Telehealth (n = 1)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Collaboration & Integrative Care (22 comments)	More Collaboration Between BHSD & Other SCC Departments – 17 • Need more integration between BHSD and Office of Supportive Housing (11) • Need to separate OSH and BHSD and instead have dedicated BHSD staff in-person at PSH locations (6) • Need more collaboration with SCC medical services (1) o Need more integrated medical-Mental Health & Substance Use treatment programs, 1	5
	More Collaboration Within BHSD Agencies – 5 • Need more collaboration between inpatient care and PSH staff for discharge planning (5)	5
Workforce, Education, and Training (19 comments)	Retain Clinical Staff – 11 • Burnout Needs/Recommendations (6) o More burnout resources focused on vicarious trauma, 3 o Reduce PSH staff burnout caused by the political pressure of the housing crisis, 1 o Reduce PSH staff burnout caused by the need to interact with a large number of community partners, 1 o Reduce burnout by setting aside funding and contract time for team building, 1 • Reduce Staff Workload (4) o Reduce documentation/training/productivity requirements for PSH staff, who must meet BHSD and OSH requirements, 2 o Reduce staff demands, 1 o Reduce productivity standards for PSH staff serving on-site programs vs. scattered site programs, 1 • Increase Staff Benefits (1)	3.3a

	o More funding for staff to attain advanced clinical trainings, such as EMDR and DBT, 1	
	<u>Increase Staff Pay – 6</u> • Permanent Supportive Housing (PSH) staff should be paid for their dual skillsets (both therapy and housing skills) (4) • Increase Staff Pay (General Comments) (2)	4
	<u>Increase Staff Training – 2</u> • More County staff training on AB1424 (1) • More staff training on HIMS (1)	Not Listed
Treatment Services (18 Comments)	<u>More Step-Down Treatment Services – 4</u> • Need more aftercare programs after psychiatric hospitalization (2) • Need more dual diagnosis crisis stabilization after psychiatric hospitalization discharge (2)	3.3
	<u>Greater Residential/Inpatient Bed Capacity – 4</u> • More crisis residential capacity (2) • More residential treatment (2)	3.3
	<u>Improvements to BHSD-CBO Contracts – 3</u> • Need more contract flexibility for non-billable tasks (e.g., consumer advocacy, burnout prevention) (1) • Need dedicated contact time for in-depth staff training (1) • PSH staff need more contract time for home visits (1)	3.2
	<u>More Housing-Related Services – 3</u> • Services for those who are unhoused, and currently engaged in a BHSD-related housing program (3) o More resources for scattered-site PSH, 2 o Need to ensure psychiatry and therapy services at every PSH site, 1	3.3
	<u>Crisis care – 2</u> • Need an option for crisis care that does not include police accompaniment (2)	3 [AOA]
	<u>More Hybrid Care – 2</u> • Incentivize more in-person availability while keeping all current telehealth options (2)	3 [AOA]
	<u>SUTS (including detox) – 1</u> • Need more after residential substance use treatment program (1)	3.3a
	<u>More Dual Diagnosis Treatment – 1</u> • Need more dual diagnosis treatment programs (1)	3.3a
Housing (1 comment)	<u>Housing Stabilization (General Housing Need) – 1</u> • More flex funds to secure housing (1)	2.1

Access (1 comment)	<u>Easier/Faster Access to Treatment Services – 1</u> • Should be "easier" to access BHSD services (too many barriers, too many requirements for program entry, too much paperwork) (1)	1

Providers: Refugee Services (n = 14)

STRENGTHS: "What Should Stay the Same?"

Access Processes / Procedures (n = 2)

Collaborative & Integrated Care (n = 1)

Crisis Services (n = 1)

Expanded Outpatient Treatment (n = 4)

NEEDS: "What Should be Added or Changed?"

Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (45 comments)	Services for Immigrants & Refugees – 12 • Need more cultural assimilation training for immigrants (8) • Need more cultural assimilation training for refugees (1) • Need to extend length of services for refugees (1) • Need more LGBTQ+ education for immigrant families (1) • More services for immigrants and refugees, general (1)	3 [AOA]
	More BHSD Services in Client's Homes – 7	3 [AOA]
	More Services to Reduce Isolation – 7	3 [AOA]
	Youth: Youth Parent Services – 6 • Parent Psychoeducation on Mental Health & Substance Use (6)	3 [CYF]
	Youth: Youth Parent Services – 6 • Parent Psychoeducation on Mental Health & Substance Use (6)	3 [CYF]
	Youth: Family-Focused Services – 2 • More collectivistic family services for refugees (1) • More services to bridge inter-generational family gaps (1)	3 [CYF]
	More Housing-Related Services – 1 • Services for those who are unhoused, and NOT in a BHSD-related housing program (1) o More case management for those applying for housing, 1	3.3

	More Hybrid Care – 1 • More in-person availability while keeping all current telehealth options (1)	Not Listed
	Expand Outpatient Treatment, Miscellaneous – 1 • More thorough psychological assessment (1)	3 [AOA]
	More Longer-Term Treatment – 1 • More outpatient therapy longer than 1 year (1)	3 [AOA]
	More Supported Employment – 1 • More employment support for immigrants (1)	Not Listed
Access (30 comments)	Increase Transportation Support – 19 • General Comments about Transportation as a Barrier to Accessing BHSD Services (19)	Not Listed
	More Language/Translation Services – 14 • More language/translation services (general) 7) • More ESL classes (5) • More services in Dari (1) • More services in Pashtu (1)	Not Listed
	More non-Call Center access options – 1 • Need an option for direct referrals (e.g., walk-ins) without using the Call Center (1)	1.5
	Need Childcare Services During BHSD Appointments – 1 • Facilitate parents accessing BHSD services by providing childcare (1)	Not Listed
Workforce, Education, and Training (16 comments)	Specific Hiring Suggestions – 8 • Increase Intern Stipends (3) • Hire Culturally-Matched Staff (2) o Hire staff who are culturally-matched to the community they serve (general), 1 o Hire refugees as translators, 1 • Collaborate with Colleges to Build the Workforce (1) • Recruit from New Graduates (1) • More Exceptions for Those Applying with Credentials from Outside the U.S. (1)	4
	Increase Staff Pay – 3 • Increase Staff Pay (General Comments) (2) • Staff must be paid based on the living costs of the Bay Area (1)	4.2
	Retain Clinical Staff – 3 • Burnout Needs/Recommendations (3)	4

	○ Reduce provider burnout (general), 3	
	<u>Increase Staff Training – 2</u> • Increase Cultural Competency (General) in BHSD Services (1) • More staff training on refugee mental health (1)	Not Listed
Housing (6 comments)	<u>Housing Stabilization (General Housing Need) – 6</u> • More housing, general (6)	2.1
Outreach & Prevention (5 comments)	<u>Reduce Community Stigma – 3</u> • General calls to reduce community stigma (1) • Reduce community stigma via collaboration with religious/spiritual leaders (1) • Reduce stigma in recent immigrants (1)	Not Listed
	<u>General Outreach/Prevention – 1</u> • Need more mental health prevention services (1)	Not Listed
	<u>Ethnic-Specific Outreach/Prevention – 1</u> • More efforts to reduce immigrant discrimination, in an effort to prevent Mental Health & Substance Use problems for immigrants (1)	Not Listed
Collaboration & Integrative Care (1 comment)	<u>More Collaboration Between BHSD & Other SCC Departments – 1</u> • Need more collaboration with SCC medical services – (1) ○ More integration between BHSD and primary care, 1	5
Improve Quality (1 comment)	<u>General Comments About Care Quality – 1</u> • BHSD services should be more trauma-informed (1)	Not Listed

Reentry (n = 18)		
STRENGTHS: "What Should Stay the Same?"		
CBOs, Clinics, Programs (n = 11)		
Criminal Justice Services (n = 4)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (26 comments)	More Criminal Justice Services – 14 • Reentry & Vocational Services (14) o Reentry services needs to verify the list of felon-friendly businesses, 5 o Need more reentry vocational centers, 3 o Need to add a transitional component to reentry vocational programs, 3 o Need longer-term Reentry services, 3	3.4
	More Supported Employment – 5 • More supported employment, generally (5)	Not Listed
	Crisis care – 3 • Need more emergency services available after 5pm (3)	3 [AOA]
	More Dual Diagnosis Treatment – 1 • Need better assessment for dual diagnosis presentations (1)	3 [AOA]
	More BHSD Services for Those without Citizenship – 1 • More BHSD services for those without U.S. citizenship (1)	Not Listed
	Services for Treatment-Declining Individuals – 1 • Need more services for those who need Mental Health & Substance Use services but don't realize they need the help (1)	3 [AOA]
	Need Reentry services for those who were released from prison years ago – 1	3.4
Improve Quality (5 comments)	General Comments About Care Quality – 5 • Reentry services should be more transparent about the time limitations (4) • Reentry service providers should be more supportive and friendly (1)	Not Listed

Outreach & Prevention (5 comments)	Outreach to Those who are Unhoused – 2 • Outreach efforts to those without stable housing (2)	3.3c
	General Outreach/Prevention – 2 • More Prevention Services (1) • More Outreach (1)	Not Listed
	Increase Community Awareness of Mental Health & Substance Use – 1 • General need to increase community awareness of Mental Health & Substance Use (1)	Not Listed
Access (4 comments)	Improve Call Center Integrated Screening Processes – 2 • Need better diagnostic screening/assessment (e.g., psychotic symptoms, suicidality, history of hospitalization, eating disorders, types of symptoms) (1) • Call Center should evaluate previous BHSD services history to reduce redundancy of services (1)	1.2
	Easier/Faster Access to Treatment Services – 1 • Should be "easier" to access BHSD services (too many barriers, too many requirements for program entry, too much paperwork) (1)	1
	Improve Call Center Response Times – 1 • Decrease wait time for the Call Center (1)	1.2
	More Assistance Navigating BHSD System – 1 • Help consumers navigate the process of accessing BHSD services (e.g., staff or flyers explaining how to start, what to expect, what to ask for) (1)	1.4
Workforce, Education, and Training (2 comments)	Increase Number of Clinical Staff – 2 • More Case Managers (2)	4.3
Housing (2 comments)	Housing Stabilization (General Housing Need) – 2 • More housing, generally (2)	2.1

South Asian: Punjabi (n = 27)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Outreach & Prevention (24 comments)	Reduce Community Stigma – 9 • General calls to reduce community stigma (8) • Reduce community stigma via collaboration with religious/spiritual leaders (1)	Not Listed
	Increase Community Awareness of Mental Health & Substance Use – 6 • General need to increase community awareness of Mental Health & Substance Use (6)	Not Listed
	Train the Community to Help & Refer – 4 • Need more trainings for community members to learn how to recognize Mental Health & Substance Use problems and effectively refer people for help (4)	Not Listed
	Ethnic-Specific Outreach/Prevention – 3 • More racial/ethnic anti-discrimination efforts to prevent Mental Health & Substance Use problems for stigmatized communities (anti-South Asian discrimination) (1) • More outreach resources in Punjabi (1) • Need to promote 988 in Punjabi spaces (1)	Not Listed
	School-Based Outreach – 1 • More school education on Mental Health & Substance Use (1)	3 [CYF]
	General Outreach – 1	Not Listed
Access (10 comments)	Increase Transportation Support – 4 • General Comments about Transportation as a Barrier to Accessing BHSD Services (4)	Not Listed
	More Language/Translation Services – 3 • Punjabi (3) o MH resources in Punjabi, 2 o Punjabi language option on 988, 1	Not Listed
	Increase Community Awareness of BHSD Services – 3 • Need a single list of all BHSD Services (2) • Community needs more awareness (general) (1)	Not Listed

Treatment Services (9 comments)	<u>YOUTH: School Services – 2</u> • More peer training in schools (1) • More bullying prevention in schools (1)	3 [CYF]
	<u>Expand Outpatient Treatment, Miscellaneous – 2</u> • More domestic violence services (2)	3 [AOA]
	<u>More Support Groups – 2</u> • Need a support group at the Punjabi Gurudwara (1) • Need advocacy support group (1)	3 [AOA]
	<u>YOUTH: Youth Substance Use Prevention – 1</u> • General support for additional youth substance use prevention (1)	3 [CYF]
	<u>YOUTH: Youth Parent Services – 1</u> • Parent Psychoeducation on how to help children's Mental Health & Substance Use problems (1)	3 [CYF]
	<u>More Services to Reduce Isolation – 1</u>	3 [AOA]

South County, English- and Spanish-Speaking (n = 42)

STRENGTHS: "What Should Stay the Same?"

Access Processes / Procedures (n = 2)

Housing (n = 1)

NEEDS: "What Should be Added or Changed?"

Primary Themes	Sub-Themes	Corresponding Department Goal #

Treatment Services (18 comments)	More Housing-Related Services – 7
	• Services for those who are unhoused, and NOT in a BHSD-related housing program (7)
	  o More case management for those applying for housing, 3
	  o More clinicians to go out to visit the unhoused wherever they can be found, 2
	  o Need more individual therapy for those seeking housing, 1
	• More community education on housing programs and requirements, 1
		3.3

	SUTS (including detox) – 3 • Need a medical detox program (1) • Need more residential substance use treatment programs (1) • Need more Fentanyl interventions (1)	3.1
	YOUTH: Youth Substance Use Prevention – 2 • More youth substance use prevention focused on mental health and education (1) • More vaping prevention for youth (1)	3 [CYF]
	YOUTH: Youth Parent Services – 2 • Parent Psychoeducation on Mental Health & Substance Use (2)	3 [CYF]
	YOUTH: More Therapy for youth (General) – 1 • Counseling services for youth (general) (1)	3 [CYF]
	Expand Outpatient Treatment, Miscellaneous – 1 • More capacity for individual therapy (1)	3 [AOA]
	More Dual Diagnosis Treatment – 1 • Need more dual diagnosis treatment programs (1)	3 [AOA]

	More BHSD Services for Those without Citizenship – 1 • BHSD should plan for expansion of services to all undocumented individuals starting in 2024 (1)	Not Listed
Workforce, Education, and Training (4 comments)	Increase Staff Pay – 2 • Increase pay for psychiatrists (1) • Increase pay for therapists/counselors (1)	4.2
	Increase Number of Clinical Staff – 1 • More Psychiatrists (1)	4.3
	Increase Staff Training – 1 • More staff training on trauma-informed care (1)	Not Listed
Access (4 comments)	More Language/Translation Services – 3 • Spanish (3) o Treatment services in Spanish, 3	Not Listed
	Easier/Faster Access to Treatment Services – 1 • Should be "easier" to access BHSD services (too many barriers, too many requirements for program entry, too much paperwork) (1)	1
Outreach & Prevention (3 comments)	General Outreach – 1	Not Listed
	Increase Community Awareness of Mental Health & Substance Use – 1 • Specifically the Hispanic/Latino/a/e community (e.g., through commercials) (1)	Not Listed
	School-Based Outreach – 1 • More outreach to public schools (1)	3 [CYF]
Housing (2 comments)	Housing Stabilization (General Housing Need) – 2 • More housing (general) (2)	2.1
Collaboration & Integrative Care (1 comments)	Need more innovative partnerships between BHSD and private entities – 1 • Need better information sharing mechanism with Kaiser (1)	5
Improve Quality (1 comment)	General Comments About Care Quality – 1 • Therapists should not fall asleep during sessions (1)	Not Listed

South County Older Adults (n = 3)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (5 comments)	More Housing-Related Services – 4 • Services for those who are unhoused, and NOT in a BHSD-related housing program (3) o More BHSD treatment services for those who are actively unhoused (e.g., those not staying in temporary, transitional, or stable housing), 3 • Services for those who are unhoused, and currently engaged in a BHSD-related housing program (1) o Need more Mental Health & Substance Use treatment for those who are unhoused, general, 1	3.3
	More Dual Diagnosis Treatment – 1 • Need more dual diagnosis treatment programs (1)	3 [AOA]
Access (2 comments)	Increase Community Awareness of BHSD Services – 1 • Community needs more awareness (general) (1)	Not Listed
	More Assistance Navigating BHSD System – 1 • Help consumers navigate the process of accessing BHSD services (e.g., how to start, what to expect, what to ask for) (1)	1.4
Housing (1 comment)	Housing Stabilization (General Housing Need) – 1 • More Housing (general) (1)	2.1

Spanish-Speaking Adults (n = 6)		
STRENGTHS: "What Should Stay the Same?"		
Access Processes / Procedures (n = 3)		
CBOs, Clinics, Programs (n = 1)		
Telehealth (n = 1)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
More Treatment Services (14 comments)	More Longer-Term Treatment – 3 • More long-term outpatient therapy options (3)	3 [AOA]
	More BHSD Services for Those without Citizenship – 2 • More BHSD services for those without U.S. citizenship (2)	3 [AOA]
	YOUTH: Youth Substance Use Prevention – 1 • More MH education in schools to prevent substance use (1)	3 [CYF]
	YOUTH: Family Therapy – 1 • More therapy to help with inter-generational family divides (1)	3 [CYF]
	SUTS (including detox) – 1 • Need more affordable resources for vaping cessation (1)	3 [AOA]
	More Services to Reduce Isolation – 1	3 [AOA]
	Expand Outpatient Treatment, Miscellaneous – 1 • More pre-crisis intervention services (1)	3 [AOA]
	Services for Treatment-Declining Individuals – 1 • More resources for parents with adult TAY children (e.g., 18-24) who decline Mental Health & Substance Use treatment (1)	3 [AOA]
	Crisis care – 1 • Need an option for crisis care that does not include police accompaniment (1)	3 [AOA]
	More Support Groups – 1 • Need more support groups for non-emergency clinical presentations (1)	3 [AOA]

	More Covid-19-related Services – 1 • Continue Covid-19 testing resources to facilitate Mental Health & Substance Use treatment programs (1)	3 [AOA]
Access (12 comments)	Improve Call Center User Experience – 5 • Better training for call handlers (1) • Increase cultural sensitivity when asking about citizenship status (1) • General (1) • Better explanation of limits to confidentiality, especially re: child abuse (1) • Improve client voice in treatment planning process (1)	1.2

	More Language/Translation Services – 3
	• Spanish (3)
	  o Treatment services in Spanish, 2
	  o BHSD forms in Spanish, 1
		Not Listed

	More non-Call Center access options – 3 • Need an option for direct referrals between BHSD agencies/providers (3)	1.5
	Increase Transportation Support – 1 • General Comments about Transportation as a Barrier to Accessing BHSD Services (1)	Not Listed
Workforce, Education, and Training (2 comments)	Increase Number of Clinical Staff – 1 • More Clinical Staff (General) (1)	4.3
	Retain Clinical Staff – 1 • Reduce Staff Workload (1) o Reduce clinician caseloads, 1	4
Outreach & Prevention (1 comment)	Increase Community Awareness of Mental Health & Substance Use – 1 • General need to increase community awareness of Mental Health & Substance Use (1)	Not Listed
Collaboration & Integrative Care (1 comment)	More Collaboration Within BHSD Agencies – 1 • Need more collaboration between BHSD programs (1)	5
Improve Quality (1 comment)	General Comments About Care Quality – 1 • Should better explain professional limits – 1	Not Listed

Spanish-Speaking LGBTQ+ Adults (n = 20)**		
STRENGTHS: "What Should Stay the Same?"		
CBOs, Clinics, Programs		
LGBTQ+ Services		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #

Treatment Services	LGBTQ+ Services
	• Expand clinical services for LGBTQ+ community
	  o Need a bilingual SUTS group for LGBTQ+ folx
	  o Need a group for Spanish-speaking trans women
	  o Need more activities within the [existing] Latinx LGBTQ+ group
	• Santa Clara County should do more to be a TGI+ sanctuary County
	  o Need more advocacy interventions for trans women/girls
	• Expand the Gender Health Center
	  o Need more services in the Gender Health Center
		3 [AOA]

	Treatment Services, Miscellaneous • More consistent group therapy offerings • Need more resources (general)	3 [AOA]
	Youth: Family Services • Need more family therapy for situations when the child discloses their identity ("comes out of the closet")	3 [CYF]
	SUTS (including detox) • Need a medical detox program	3.1
	More Supported Employment • More supported employment services for trans women/girls	Not Listed
	More BHSD Services for Those without Citizenship • More BHSD services for those without U.S. citizenship	3 [AOA]

Workforce, Education, and Training	Increase Number of Clinical Staff • More Clinical Staff (General) • More Case Managers	4.3
	Specific Hiring Suggestions • Hire Culturally-Matched Staff o Hire TGI+ individuals to serve the community • More Exceptions for Those Applying with Credentials from Outside the U.S. • Hire LGBTQ+ therapists who are bilingual	4.3

	Retain Clinical Staff
	• Reduce Staff Workload
	  o Peer mentors should only do outreach
	  o Reduce case manager responsibilities
		4

	Increase Staff Training • Increase Cultural Competency (General) in BHSD Services	Not Listed
	Increase Staff Pay • Increase Staff Pay (General Comments)	4.2
Outreach & Prevention	General Outreach • More outreach to LGBTQ+ older adults • More outreach (general)	Not Listed
	Ethnic-Specific Outreach/Prevention • More prevention for recent immigrants	Not Listed
Access	More Language/Translation Services • More BHSD services in Spanish	Not Listed
	More Assistance Navigating BHSD System • Help consumers navigate the process of accessing BHSD services (e.g., how to start, what to expect, what to ask for), specifically for LGBTQ+ elders	1.4

TGI+ (n = 9)		
STRENGTHS: "What Should Stay the Same?"		
LGBTQ+ Services (n = 8)		
Outreach & Prevention Services (n = 2)		
Youth & School-Based Services (n = 1)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Workforce, Education, and Training (17 comments)	Specific Hiring Suggestions – 6 • Hire Culturally-Matched Staff (4) o Hire staff who are culturally-matched to the community they serve (general), 1 o Implement specialized recruitment for LGBTQ+ staff positions, 1 o Hire Spanish-speaking staff members, 1 o Hire LGBTQ+-identified individuals to serve the community, 1 • Add an interview question about LGBTQ+ topics when hiring for LGBTQ+-focused positions (1) • Reduce barriers to hiring TGI+ applicants (e.g., formal education requirements) (1)	4.3
	Increase Staff Training – 5 • More LGBTQ+ training for BHSD clinical staff (4) o Need more funding for TGI+-focused training for BHSD clinicians, 1 o Need a better method of disseminating TGI+ trainings to those who need them, 1 o Need more than 30 minutes of mandatory LGBTQ+ training for newly-hired BHSD clinicians, 1 o Need more LGBTQ+ training for BHSD clinical staff (general), 1 Increase Cultural Competency (General) in BHSD Services (1)	Not Listed
	Increase Number of Clinical Staff – 3 • More Addiction Specialists (2) • More Clinical Staff (General) (1)	4.3
	Increase Staff Pay – 2 • Staff must be paid based on the living costs of the Bay Area (1)	4.2

	• Increase pay for paraprofessionals (e.g., case managers, peer support staff) (1)	
	<u>Retain Clinical Staff – 1</u> • Make BHSD an affirming environment for LGBTQ+ staff (1) o Need to allow pronouns to be displayed on Teams, as is done in other systems, such as the VA, 1	4
Treatment Services (12 comments)	<u>LGBTQ+ Services – 11</u> • Santa Clara County should do more to be a TGI+ sanctuary County (7) o General calls for additional programming to actualize SCC's declaration to be a TGI+ sanctuary, 2 o Need a County-wide "living document" with guidelines for SOGI data collection, 2 o Need an intersectional lens for supporting/resourcing TGI+ folx, 1 o Need more residential aftercare post gender affirmation surgery, 1 o Need more funding to support TGI+-led organizations who are already serving the TGI+ community, 1 • Expand clinical services for LGBTQ+ community (2) o Need more support for the older adult LGBTQ+ community, 1 o Need a consultation program for providers serving TGI+ folx, 1 • Expand the Gender Health Center (2) o Need an additional Gender Health Center: one for adults and one for children, 1 o Need a rehabilitation counselor for the Gender Health Center, 1	3 [AOA]
	<u>Expand Outpatient Treatment, Miscellaneous – 1</u> • More treatment for sex workers instead of focusing on preventing sex work (1)	3 [AOA]
Collaboration & Integrative Care (4 comments)	<u>More Collaboration Between BHSD & Other SCC Departments – 4</u> • Need more collaboration with SCC medical services – (4) o Need more cross-County collaboration Infections Disease department and BHSD, 4	5
Access (1 comment)	<u>More Assistance Navigating BHSD System – 1</u> • Help consumers navigate the process of accessing BHSD services (e.g., how to start, what to expect, what to ask for), specifically for TGI+ folx seeking care (1)	1.4
Outreach & Prevention (1 comment)	<u>Event-Focused Outreach – 1</u> • More community building events at drop-in centers (1)	Not Listed
Housing	<u>Housing Stabilization (General Housing Need) – 1</u>	2.1

(1 comment)	• More housing (general) (1)	

Unhoused, East San Jose (n = 1)		
STRENGTHS: "What Should Stay the Same?"		
Workforce, Education, and Training (n = 1)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (8 comments)	More Criminal Justice Services – 3 • Mental Health & Substance Use services in jail (2) o More MH treatment in jails/prisons, 1 o More family integration services for those in jail/prison, 1 • Need more services after consumers are released from jail/prison (1)	3.4
	More Housing-Related Services – 1 • Services for those who are unhoused, and NOT in a BHSD-related housing program (1) o More BHSD treatment services for those who are actively unhoused (e.g., those not staying in temporary, transitional, or stable housing), 1	3.3
	SUTS (including detox) – 1 • Need SUTS without punishing relapse (1)	3 [AOA]
	Greater Residential/Inpatient Bed Capacity – 1 • Need more beds for those discharging from jail/prison (1)	3 [AOA]
	More Dual Diagnosis Treatment – 1 • Need more dual diagnosis treatment programs (1)	3 [AOA]
	More Supported Employment – 1 • More supported employment, generally (1)	Not Listed
Workforce, Education, and Training (1 comment)	Retain Clinical Staff – 1 • Reduce BHSD staff strikes (1)	4
Outreach & Prevention	Prevention – 1 • Need more recidivism prevention through reentry services (1)	3.4

(1 comment)		

Vietnamese (n = 27)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services	Youth: Family Therapy Services • Need to keep family members informed of their loved ones' treatment locations • More services to help with inter-generational cultural family conflicts	3 [CYF]
	Youth: School Services • More school services, general	3 [CYF]
	Youth: Miscellaneous Treatment Services • More speech therapy for youth with disabilities	3 [CYF]
	Youth: Support Groups • Youth support groups (general)	3 [CYF]
	SUTS (including detox) • Need more SUTS, generally	3 [AOA]
	Expand Outpatient Treatment, Miscellaneous • Services for gambling addictions • More workshops on life skills	3 [AOA]
	Greater Residential/Inpatient Bed Capacity • More Board & Care beds	3 [AOA]
	More Services to Reduce Isolation	3 [AOA]
	More Support Groups • Need more support groups for seniors	3 [AOA]
Workforce, Education, and Training	Increase Number of Clinical Staff • More Paraprofessionals o More peer support workers	4.3
Access	Increase Community Awareness of BHSD Services • Community needs more awareness (general)	Not Listed

	Easier/Faster Access to Treatment Services • Need shorter wait for BHSD services	1
	Improve Call Center Response Times • Decrease wait time for the Call Center	1.2
Outreach & Prevention	Prevention & Early Intervention • Need more early intervention	Not Listed
	School-Based Outreach • More prevention in public schools • More school education on Mental Health & Substance Use	3 [CYF]
	Substance Use Prevention • More Substance Use Prevention (Generally)	Not Listed
	Event-Focused Outreach • More event-focused outreach (e.g., biking, hiking)	Not Listed
Housing	Housing Stabilization (General Housing Need) • More housing (general)	2.1

Young Men Involved in Juvenile Criminal Justice (n = 9)		
STRENGTHS: "What Should Stay the Same?"		
Criminal Justice Services (n = 8)		
Quality of Care (n = 6)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (1 comment)	Youth: Criminal Justice Services – 1 • Need more private locations for Mental Health & Substance Use treatment in jails (1)	3.4
Workforce, Education, and Training (1 comment)	Retain Clinical Staff – 1 • Reduce Staff Workload (1) o Reduce caseloads of therapists in juvenile jails , 1	4

Young Women in Juvenile Criminal Justice (n = 2)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (1 comment)	YOUTH: Criminal Justice Services – 1 • Should stop requiring Mental Health & Substance Use treatment in jails for youth (1)	3.4

Youth Group 1 (n = 7)		
STRENGTHS: "What Should Stay the Same?"		
CBOs, Clinics, Programs (n = 4)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Youth Treatment Services (27)	YOUTH: More telehealth for youth (General) – 5 • Telehealth allows youth to have time and access services (4) • Telehealth helps circumvent parent stigma (1)	3 [CYF]
	YOUTH: Youth Parent Services – 4 • Parent Psychoeducation on Mental Health & Substance Use (4)	3 [CYF]
	YOUTH: School Services – 3 • More anti-LGBTQ+ discrimination efforts in schools (1) • More anti-sexism trainings in schools (1) • Interventions aimed at reducing youth bullying in schools (1)	3 [CYF]
	YOUTH: More Physical Locations for Youth Drop–in Services – 3 • General need for more physical locations for youth treatment (3)	3 [CYF]
	YOUTH: Other Treatment Services – 3	3 [CYF]
	YOUTH: Longer-Term Treatment – 3 • Longer-term outpatient treatment (2) • More long-term psychiatry services (1)	3 [CYF]]
	YOUTH: Youth Substance Use Prevention – 2 • More alcohol prevention (1) • More youth-led prevention efforts (1)	3 [CYF]
	YOUTH: Youth Substance Use Treatment Services – 2 • More dual diagnosis treatment for youth (2)	3 [CYF]
	YOUTH: Support Groups – 2 • Youth support groups (general) (2)	3 [CYF]

Outreach & Prevention (7 comments)	<u>Reduce Community Stigma – 4</u> • Reduce Mental Health & Substance Use stigma in parents (3) • Reduce stigma in youth (1)	Not Listed
	<u>General Outreach – 1</u>	Not Listed
	<u>Ethnic-Specific Outreach/Prevention – 1</u> • More racial/ethnic anti-discrimination efforts to prevent Mental Health & Substance Use problems for stigmatized communities (anti-Muslim discrimination, anti-South Asian discrimination) (1)	Not Listed
	<u>School-Based Outreach – 1</u> • More school education on Mental Health & Substance Use (1)	3 [CYF]
Workforce, Education, and Training (3 comments)	<u>Increase Number of Clinical Staff – 3</u> • More youth-focused clinical staff (3) o More therapists for youth, 2 o More youth counselors in schools, 1	4.3

Youth Group 2, LGBTQ+ (n = 3)		
STRENGTHS: "What Should Stay the Same?"		
CBOs, Clinics, Programs (n = 1)		
LGBTQ+ Services (n = 1)		
Outreach & Prevention Services (n = 1)		
Quality of Care (n = 1)		
Telehealth (n = 1)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (6 comments)	More Services to Reduce Isolation – 2	3 [CYF]
	More Housing-Related Services – 1 • Services for those who are unhoused, and NOT in a BHSD-related housing program (1) o More BHSD treatment services for those who are actively unhoused (e.g., those not staying in temporary, transitional, or stable housing), 1	3.3
	More Dual Diagnosis Treatment – 1 • Need more dual diagnosis treatment programs (1)	3 [CYF]
	LGBTQ+ Services – 1 • More LGBTQ+-focused facilities (1)	3 [CYF]
	More Hybrid Care – 1 • More in-person availability while keeping all current telehealth options (1)	Not Listed
Housing (2 comments)	Housing Stabilization (General Housing Need) – 2 • More LGBTQ+-specific housing (1) • More housing (general) (1)	2.1
Workforce, Education, and Training (1 comment)	Retain Clinical Staff – 1 • Burnout Needs/Recommendations (1) o Reduce provider burnout (general), 1	4

Access (1 comment)	More non-Call Center access options – 1 • Need an option for direct referrals (e.g., walk-ins) without using the Call Center (1)	1.5
Outreach & Prevention (1 comment)	General Outreach – 1	Not Listed

Youth Group #3 (n = 14)		
STRENGTHS: "What Should Stay the Same?"		
Access Processes / Procedures (n = 1)		
CBOs, Clinics, Programs (n = 1)		
Youth & School-Based Services (n = 6)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (26 Comments)	YOUTH: School Services – 17 • Major youth concern: parents' access to therapy records (5) • Expand sex education to prevent sexual assault (4) • More school services for sexual assault (4) • Establish school mental health peer referral system (2) • Need more NAMI events at schools (1) • Need school therapist who aren't limited to discussing only academic topics (1)	3 [CYF]
	YOUTH: Youth Substance Use Prevention – 5 • More MH education in schools to prevent SU (4) • More youth substance use prevention without scare tactics (1)	3 [CYF]
	YOUTH: Substance Use Treatment Services – 2 • More dual diagnosis treatment (1) • More individual therapy during SUTS (1)	
	YOUTH: Need to Train Youth to Recognize and Refer Peers for Treatment – 1	3 [CYF]
	YOUTH: More telehealth for youth (General) – 1 • More virtual services for youth (1)	3 [CYF]
Workforce, Education, and Training (5 comments)	Specific Hiring Suggestions – 4 • Hire Culturally-Matched Staff (4) o Hire school therapists who are culturally matched, 4 ▪ From marginalized backgrounds [2]	4.3

	▪ LGBTQ+-identified [1] ▪ General need for culturally-matched school therapists [1]	
	<u>Increase Staff Training – 1</u> • More cultural training for school therapists (1)	Not Listed
Outreach & Prevention (5 comments)	<u>Reduce Community Stigma – 3</u> • Reduce Mental Health & Substance Use stigma in parents (2) • Reduce stigma in youth (1)	Not Listed
	<u>School-Based Outreach – 2</u> • More school education on Mental Health & Substance Use (1) • School wellness centers should be open outside of class lessons (1)	3 [CYF]
Access (4 comments)	<u>Increase Community Awareness of BHSD Services – 4</u> • Increase youth awareness of BHSD services (4)	Not Listed

Youth Group #4 (n = 12)		
STRENGTHS: "What Should Stay the Same?"		
CBOs, Clinics, Programs (n = 2)		
Expanded Outpatient Treatment (n = 1)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Outreach & Prevention (13 comments)	College Student Outreach – 7 • More outreach to college campuses (5) • More outreach to the college counseling centers (2)	3 [CYF]
	Substance Use Prevention – 3 • More Vaping Prevention (3)	Not Listed
	Increase Community Awareness of Mental Health & Substance Use – 1 • General need to increase community awareness of Mental Health & Substance Use (1)	Not Listed
	Ethnic-Specific Outreach/Prevention – 1 • More targeted outreach using the terminology of the ethnic community (e.g., Hmong) (1)	Not Listed
	Outreach to Those who are Unhoused – 1 • Outreach efforts to college students living in their cars on campus (1)	3.3c
Workforce, Education, and Training (9 comments)	Specific Hiring Suggestions – 6 • Hire Culturally-Matched Staff (4) o Hire Middle Eastern individuals to serve the community, 1 o Hire Hispanic/Latino/a/e staff to serve the community, 1 o Hire South Asian staff to serve the community, 1 o Hire staff who are culturally-matched to the community they serve (general), 1 • Recruit College Students Looking for Internships (2)	4.3
	Increase Number of Clinical Staff – 2 • More Therapists (2) o More therapists (general), 2	4.3

	Increase Staff Training – 1 • Increase Cultural Competency (General) in BHSD Services (1)	Not Listed
Treatment Services (6 comments)	More Covid-19-related Services – 2 • More services focused on Covid-19-related grief (2)	3 [CYF]
	YOUTH: School Services – 1 • Expand treatment services to middle school campuses (1)	3 [CYF]
	YOUTH: Youth Substance Use Prevention – 1 • More media campaigns aimed at vaping prevention (1)	3 [CYF]
	More Housing-Related Services – 1 • Services for those who are unhoused, and NOT in a BHSD-related housing program (1) o Need more services for college students who are unhoused, 1	3.3
	SUTS (including detox) – 1 • Need more affordable resources for vaping cessation (1)	3 [CYF]
Collaboration & Integrative Care (3 comments)	More Collaboration Between BHSD & Other SCC Departments – 3 • Need more collaboration with SCC medical services – (2) o More integration between BHSD and primary care, 2 • Need easier pathway from college counseling clinics to BHSD services (1)	5
Access (2 comments)	Increase Community Awareness of BHSD Services – 1 • Community needs more awareness (general) (1)	Not Listed
	Easier/Faster Access to Treatment Services – 1 • Should be "easier" to access BHSD services (too many barriers, too many requirements for program entry, too much paperwork) (1)	1

Youth, Unhoused (n = 6)		
STRENGTHS: "What Should Stay the Same?"		
Access Processes / Procedures (n = 2)		
CBOs, Clinics, Programs (n = 1)		
Expanded Outpatient Treatment (n = 4)		
Telehealth (n = 1)		
NEEDS: "What Should be Added or Changed?"		
Primary Themes	Sub-Themes	Corresponding Department Goal #
Treatment Services (21 comments)	More Supported Employment – 8 • More supported employment, generally (7) • More employment support for immigrants (1)	Not Listed
	YOUTH: Youth Substance Use Treatment Services – 6 • More dual diagnosis treatment for youth (3) • More detox services (1) • Need a drop-in space specific to youth substance use (1) • Suboxone program (1)	3 [CYF]
	Greater Residential/Inpatient Bed Capacity – 2 • More residential treatment (2)	3 [CYF]
	YOUTH: Support Groups – 1 • Support groups in inpatient settings (1)	3 [CYF]
	YOUTH: LGBTQ+ Services – 1 • More youth gender-affirming care (1)	3 [CYF]
	YOUTH: Services for Women – 1 • Female detox center (1)	3 [CYF]
	More Housing-Related Services – 1 • Services for those who are unhoused, and NOT in a BHSD-related housing program (1)	3.3

	○ More BHSD treatment services for those who are actively unhoused (e.g., those not staying in temporary, transitional, or stable housing), 1	
	<u>More Step-Down Treatment Services – 1</u> • Need more aftercare programs after psychiatric hospitalization (1)	3 [CYF]
Workforce, Education, and Training (13 comments)	<u>Increase Number of Clinical Staff – 6</u> • More Paraprofessionals (4) ○ More peer support workers, 4 • More Case Managers (1) • More Clinical Staff (General) (1)	4.3
	<u>Retain Clinical Staff – 5</u> • Increase Staff Benefits (4) ○ Reinstate Covid-19 sick pay for employees who are sick, 3 ○ Financial support for BHSD staff to attain additional education, 1 • Reduce Staff Workload (1) ○ Reduce clinician caseloads, 1	4
	<u>Increase Staff Pay – 2</u> • Increase pay for social workers (1) • Increase pay for psychiatrists (1)	4.2
Collaboration & Integrative Care (9 comments)	<u>More Collaboration Between BHSD & Other SCC Departments – 9</u> • Need more collaboration with SCC medical services – (9) ○ Need faster pathway to medical care, 6 ○ Need more integrated medical-Mental Health & Substance Use treatment programs, 3	5
Outreach & Prevention (7 comments)	<u>Event-Focused Outreach – 2</u> • More event-focused outreach (e.g., biking, hiking) (2)	Not Listed
	<u>Increase Community Awareness of Mental Health & Substance Use – 2</u> • General need to increase community awareness of Mental Health & Substance Use (2)	Not Listed
	<u>More In-Person Outreach – 2</u> • More drop-in centers (1) • More in-person outreach (1)	Not Listed
	<u>General Outreach – 1</u> • More home-based outreach (1)	Not Listed
Housing	<u>Housing Stabilization (General Housing Need) – 5</u>	2.1

(6 comments)	• More LGBTQ+-specific housing (3) • Easier access to housing (2)	
	More Temporary Housing – 1	2.4
Access (4 comments)	More non-Call Center access options – 2 • Need an option for direct referrals for those who are unhoused (2)	1.5
	Improve Call Center Integrated Screening Processes – 1 • Need to ensure that clients are only sent for levels of care that are appropriate for the client (1)	1.2
	Need Childcare Services During BHSD Appointments – 1 • Facilitate parents accessing BHSD services by providing childcare (1)	Not Listed

Glossary of Abbreviations, Acronyms, and Definitions

AOA: Adult and Older Adult Services

BHSD: Behavioral Health Services Department (of the County of Santa Clara)

CYF: Children, Youth, and Family Services

LGBTQAP2S+: Lesbian, Gay, Bisexual, Transgender, Queer, Asexual, Pansexual, Two Spirit +

MENA: Middle East and North Africa

MH: Mental Health

TAY: Transitional Aged Youth

TGI+: Transgender, Gender-diverse, and Intersex +

SACS: Suicide and Crisis Hotline

SCC: Santa Clara County or County of Santa Clara

SOGI: sexual orientation and gender identity

SU: Substance Use

SUTS: Substance Use Treatment Services

WET: Workforce, Education, and Training

Mental Health Services Act (MHSA)
FY2025 Community Program Planning Process
Kick-Off Meeting

Wednesday, September 13, 2023
9AM – 12PM
Learning Partnership Training Rooms 3 & 4

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

MEETING AGENDA – September 13, 2023	TIME
1. Welcome & Background (Sherri Terao) a. Introductions b. Welcoming Remarks & Housekeeping	9:00 AM
2. MHSA News a. Overview of MHSA (Jeanne Moral) b. Overview of SB 326: MHSA Modernization (Roshni Shah)	9:15 AM
3. Impacts of MHSA Modernization on Santa Clara County (Sherri Terao & Katelyn Lu) a. Updates	9:25AM
4. MHSA Fiscal Update (Tina Cordero) a. MHSA Projections b. MHSA Actuals vs Budgets	9:45 AM
5. Questions & Answers - Impacts of MHSA Modernization & MHSA Fiscal Update	10:05 AM
6. Break	10:30 AM
7. MHSA FY 2025 Annual Update Community Program Planning Process Timeline (Roshni Shah) a. Overview b. Questions & Answers	10:35 AM
8. Data Findings from 2023 MHSA Survey & Community Conversations (Dr. Joyce Chu) a. Presentation by Dr. Chu b. Questions & Answers	10:45 AM
9. MHSA Innovation Updates (Juan Miguel Munoz-Morris) a. Innovation Project Updates b. Questions & Answers	11:30 AM
10. SLC Subcommittee Activities & Updates (Siobhan Burgos & Dr. Joyce Chu)	11:45 AM
11. Closing Remarks & Next Steps	11:55 AM

Q/A sections are included in the schedule to provide an opportunity to ask questions and/or provide comment/input.

Give space, take space.

Meeting Agreements

3

Welcome & Background

- Introductions
- Housekeeping
  - Parking
  - Access to Restrooms
  - Safety Practices

4

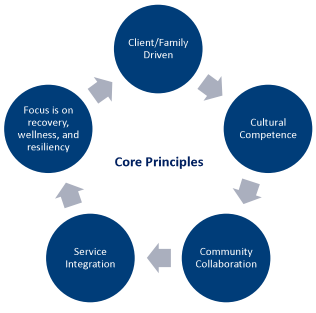
MHSA NEWS:
OVERVIEW OF MHSA

5

MHSA 101: BACKGROUND

November 2, 2004 General Election:
"*Should a 1% tax on taxable personal income above $1 million to fund expanded health services for mentally ill children, adults, seniors be established?*"
Prop. 63 passed with 6.2 million 'Yes' votes (53.8%)
Became effective as a California state law,
"the Mental Health Services Act" (MHSA) on January 1, 2005

The MHSA Provides:
- ❑ Funding, personnel, and other resources
- ❑ Best practices and innovative approaches
- ❑ Prevention, early intervention, treatment and recovery
- ❑ Community partnerships and stakeholder engagement



California Code of Regulations (CCR) § 3320

COUNTY OF SANTA CLARA
Behavioral Health Services

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MHSA 101: PRIORITY POPULATIONS

Underserved: A client diagnosed with a serious mental illness (SMI) and/or serious emotional disturbance (SED) and are receiving some services but are not provided with the necessary or appropriate opportunities to support their recovery, wellness and/or resilience.

- Includes clients who are so poorly served that they are at risk for homelessness, institutionalization, incarceration, out of home placement or other serious consequences.
- Includes members of ethnic/racial, cultural and linguistic populations.

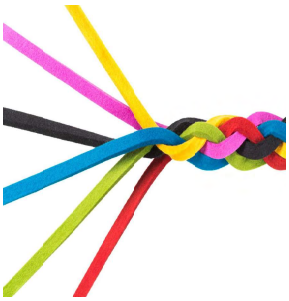
Unserved: Those individuals who may have SMI and/or SED and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with the county are also considered unserved.

COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA 101: MHSA PLEDGES A COMMITMENT TO INCLUSION

"Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations."

Mental Health Services Act (Revised January 27, 2020)



COUNTY OF SANTA CLARA
Behavioral Health Services

MHSA STAKEHOLDER LEADERSHIP COMMITTEE (SLC)

Overview

- Since 2005 the MHSA SLC has been in place to provide input and to advise the BHSD in its MHSA planning and implementation activities.
- Serves as the BHSD's primary advisory committee for MHSA activities.
- Consists of representatives of various stakeholder groups, including consumers, family members, and underserved cultural communities.
- MHSA SLC members review, comment, and provide input on MHSA three-year plans and annual updates.
- MHSA SLC meetings serve as a forum to assure wide-ranging representation in the MHSA community planning process.
- All MHSA SLC meetings are open to the public and allow for public comment.

Visit: https://bhsd.sccgov.org/about-us/mental-health-services-act/mhsa-stakeholder-leadership-committee

MHSA COMPONENTS

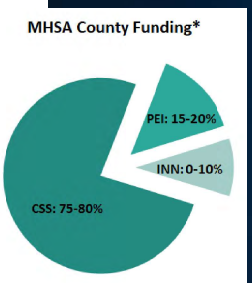
CSS: *Community Services & Supports*
- Outreach and direct services for children, Transitional Aged Youth (TAY), adults and older adults with SED and/or SMI. 51% of funds must be dedicated to Full-Service Partnership (FSP) programs.

PEI: *Prevention & Early Intervention*
Prevention services to prevent the development of mental health problems
- Early intervention services to screen and intervene with early signs of mental health issues. 51% of funds are dedicated to clients 25 years old and under.

WET: *Workforce Education & Training*
- Support to build, retain, and train a competent public mental health workforce

INN: *Innovation*
- Funding to test new approaches that may improve access, collaboration, and/or service outcomes for un-, under-, and inappropriately-served populations. Projects are short-term, for up to 5 years, and require State approval by the Mental Health Services Oversight and Accountability Commission (MHSOAC).

CFTN: *Capital Facilities & Technological Needs*
- Infrastructure to implement projects that are cost-effective/create efficient technological improvements and support facilities where MHSA-funded services will operate.



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MHSA NEWS

Overview of SB 326: MHSA Modernization

MHSA Modernization Updates

SB 326: Reforming behavioral health care funding to provide services to the most seriously ill and to treat substance use disorders

- Expands eligible services to include treatment for substance use disorders (SUDs) alone and allows counties to use funds in combination with other state & federal funds to expand SUD services.
- Because of this expansion to cover SUD, the bill updates the name of the MHSA to the Behavioral Health Services Act (BHSA).
- Recognizes the need for treatment beds and housing with supports to address a variety of serious behavioral health disorders.

Vision for Behavioral Health: Whole-Person Prevention & Care for All

Services for those most in need –including serious mental illness and substance use disorders –and continued investments in prevention, early intervention, and innovation

Accountability for real results for all mental health funding

Housing -thousands of new treatment beds and supportive housing to finally deliver needed unlocked, community-based settings

Workforce to meet the need and reflect California's diversity

MHSA Modernization Updates

- Modernizes county allocations (90%) to require the following priorities and encourage innovation in each area:
  - **35% for Housing Interventions** for children and families, youth, adults, and older adults living with serious mental illness/serious emotional disturbance (SMI/SED) and/or SUD who are experiencing homelessness or are at risk of homelessness.
    - Authorizes housing interventions to include rental subsidies, operating subsidies, shared housing, family housing for children and youth who meet criteria, and the non-federal share for certain transitional rent.
    - Half of this amount (50%) is prioritized for housing interventions for the chronically homeless. Up to 25% may be used for capital development.
  - **35% for Full Service Partnership (FSP) programs**, which are the most effective model of comprehensive and intensive care for people at any age with the most complex needs. These funds will be used to expand the number of FSP slots available across the state and are key to CARE Court being successfully implemented.

MHSA Modernization Updates

- Modernizes county allocations (90%) to require the following priorities and encourage innovation in each area:
  - **35% for Behavioral Health Services and Supports (BHSS)**, including outreach & engagement, early intervention, workforce education and training, capital facilities and technological needs, and innovative pilots and projects, to strengthen the range of services individuals, families, and communities need.
    - A majority (51%) of this amount must be used for Early Intervention.
    - A majority (51%) of Early Intervention services must be for people 25 years and younger
- Provides counties with flexibility within the above funding areas by allowing each county to individually move up to 7% from one category into another, to allow locals the ability to address their different local needs and priorities – based on data.
  - Funding changes can only be made during the 3-year plan cycle.
  - Flexibility aligns with the transition to implementation and is on-going
    - Shift 7% from any one service to another; 14% max –2026-27 through 2028-29
    - Shift 6% from any one service to another; 12% max –2029-30 through 2031-32
    - Shift 5% from any one service to another; 10% max –2032 forward

MHSA Modernization Updates

- **Creates new state-wide, state-led investments (10% of total BHSA funds):**
  - **Prevention (4% of total funding)** through population-based programming on behavioral health and wellness. These strategies target the entire population at the community level to reduce the risk of individuals developing a mental health or substance use disorder. For example, in school-linked settings, this prevention funding must focus on school-wide or classroom-based mental health and substance use disorder programs, not individual services.
    - A majority of Prevention (51%) programming must serve people 25 years and younger
  - **Workforce (3% of total funding)** investments to develop a culturally-competent and diverse behavioral health workforce to address our statewide need, and leverage th0ese dollars to draw down additional federal funding that will benefit the entire state system with a $2.4 billion investment over 5 years.
  - **Funding for state administration (3% of total funding)** used to develop statewide outcomes, conduct oversight of county outcomes, train and provide technical assistance, research and evaluate, and administer programs.

MHSA Modernization Updates

EXPANDS THE BEHAVIORAL HEALTH WORKFORCE TO REFLECT AND CONNECT WITH CALIFORNIA'S DIVERSE POPULATION

The proposal recognizes and supports the critical need to expand a culturally-competent and well-trained behavioral health workforce to address behavioral health capacity shortages and expand access to services.

- Provides up to 3% of annual BHSA funds for the California Health and Human Services Agency (CalHHS), in collaboration with the Department of Health Care Access and Information, to implement a statewide behavioral health workforce initiative, including leveraging federal dollars for a $2.4 billion workforce initiative under BH-CONNECT, a proposed federal waiver.
- Authorizes counties to also fund additional, local workforce initiatives using resources from their local BHSA allocation prioritized for Behavioral Health Services and Supports

MHSA Modernization Updates

FOCUSING ON OUTCOMES, ACCOUNTABILITY, AND EQUITY

OUTCOMES: **The proposal replaces the existing MHSA-specific plan with a new County Integrated Plan for Behavioral Health Services and Outcomes, which includes all local behavioral health funding and services**

- Requires counties to demonstrate coordinated behavioral health planning using all services and sources of behavioral health funding (e.g., BHSA, opioid settlement funds, realignment funding, federal financial participation), to provide increased transparency and stakeholder engagement on all local services.
- Requires stratified local data analysis to identify behavioral health disparities and consider approaches to eliminate those disparities
- Requires the Department of Health Care Services (DHCS) to work with counties and stakeholders to establish outcome metrics for state and county behavioral health services and programs

MHSA Modernization Updates

FOCUSING ON OUTCOMES, ACCOUNTABILITY, AND EQUITY

ACCOUNTABILITY: The proposal establishes a new, annual <u>County Behavioral Health Outcomes, Accountability, and Transparency Report</u> to provide public visibility into county results, disparities, spending, and longitudinal impact on homelessness.

- Requires counties to report to DHCS their annual service utilization data and expenditures of state and federal behavioral health funds, unspent dollars, and other information. Authorizes DHCS to impose corrective action plans on counties that fail to meet the requirements established by this section
- Authorizes up to 2% (and up to 4% for counties with a population of 200,000 or less) of local BHSA revenue to be used for local resources to assist counties in improving plan operations, quality outcomes, reporting fiscal and programmatic data and monitoring subcontractor compliance for all county behavioral health funding, on top of the existing 5% county administrative costs.
- Reduces authorized local prudent reserve amounts in the BHSA to allow for needed investments while still saving for an economic downturn.
- Strengthens the independent state Oversight and Accountability Commission by increasing its scope of advisory review to all behavioral health funding, mirroring the county integrated plans and reports; continuing its status as an independent agency; and adding additional community representation, namely for transition-age youth and for individuals who are aging or disabled, and other critical community perspectives.

MHSA Modernization Updates

FOCUSING ON OUTCOMES, ACCOUNTABILITY, AND EQUITY

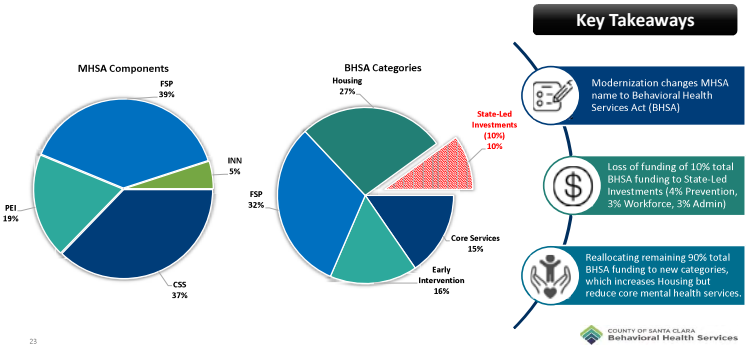
EQUITY: The proposal connects the Behavioral Health System statewide for all Californians.

- <u>For those with Medi-Cal health insurance</u>: Authorizes DHCS to align the terms of the county behavioral health plan contracts regarding administration, infrastructure, and organization with Medi-Cal managed care plan contracts.
- <u>For those with commercial health insurance</u>: Directs the Department of Managed Health Care (DMHC) and DHCS to develop a plan with stakeholder engagement for achieving parity between commercial and Medi-Cal mental health and substance use disorder benefit. This may include, but is not limited to, phasing in alignment of utilization management, benefit standardization, and covered services.

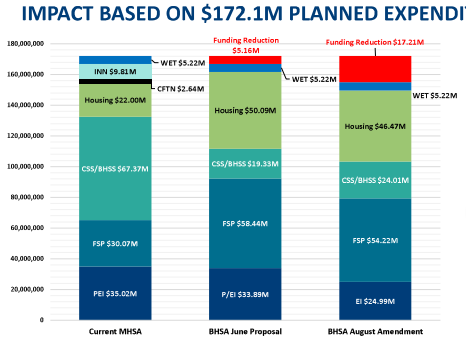
IMPACT OF PROPOSED BHSA MODERNIZATION ON SANTA CLARA COUNTY - AUGUST AMENDMENT

SEPT 2023

MHSA COMPONENTS VS BHSA CATEGORIES FUNDING ALLOCATIONS



IMPACT BASED ON $172.1M PLANNED EXPENDITURES



<u>Footnote</u>: Analysis does not reflect substance use disorders (SUD) requirements and loss of services due to Medi-Cal federal match (FFP)

Key Takeaways

- Loss of 10% ($17.2M) of total expenditure budget to state-led investments.
- Loss of funding for core mental health outpatient, crisis, and recovery services by 64%.
- Innovation and Capital Facilities and Technology Needs may be eliminated.

COUNTY OF SANTA CLARA Behavioral Health Services

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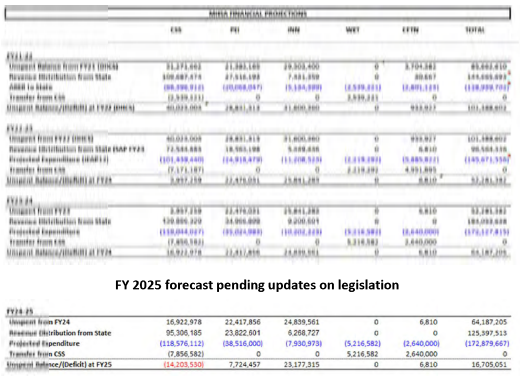
MHSA Fiscal Updates

MHSA Financial Projections



FY 2025 forecast pending updates on legislation

MHSA Actual vs Budget*

Component	FY21 MHSA Budget	FY21 MHSA Expense	FY22 MHSA Budget	FY22 MHSA Expense	FY23 MHSA Budget	FY23 MHSA Expense
1. CSS Total	83,773,829	90,797,258	90,559,055	98,396,912	111,635,191	103,576,336
2. PEI Total	25,889,255	20,965,975	25,902,571	20,068,045	30,151,830	25,671,985
3. INN Total	8,087,736	4,337,438	11,572,079	5,134,399	13,934,072	10,951,709
4. WET Total	3,129,104	2,445,332	2,621,821	2,539,221	4,092,788	2,322,113
5. CFTN Total	5,241,566	4,412,106	5,129,512	2,801,123	8,365,000	3,119,414
Grand Total	126,121,490	122,958,109	135,785,038	128,939,700	168,178,881	145,641,557

*Data based on DHCS Annual Revenue & Expenditure Report (ARER) FY2021 and FY2022 actuals and excludes one-time annual adjustments

Key Takeaways:

1. MHSA revenues have been declining & annual expenses are increasing each year

2. Historical unspent amount is declining

QUESTIONS?

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BREAK

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MHSA FY 2025 ANNUAL UPDATE

COMMUNITY PROGRAM PLANNING PROCESS TIMELINE

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Timeline for the MHSA FY2025 Annual Plan Update Community Planning Process

Data Collection, Analysis & Review

Jan 1 – Mid-March 2023
Survey data collection
Community conversations
Mid-March to May 2023
Data compilation & analysis
May to June 2023
BHSD reviews initial data findings

Planning Process

September – January 2024
September – October 2023
BHSD System of Care data findings & program updates
November – January 2024
Presentation & discussion of BHSD program recommendations

Local Review Process & Alignment with County Budget Process

February 2024: 30-day public comment period*
April 2024: BHSD budget proposals shared with Health & Hospital Committee (HHC)
May 2024: Countywide budget workshops
May 2024: BHB hearing*
June 2024: BOS hearing*

*Required by Cal. Code Regs. Tit. 9, § 3315

Our Contributors - Thank you for your support with the MHSA Survey & with hosting Community Conversation Sessions!

Allcove	Cultural Communities Wellness Program	Los Gatos Union School District	Palo Alto Unified School District
Alum Rock Union School District	Downtown Behavioral Health	Mekong Community Center	Probation
Asian Americans for Community Involvement	East San Jose Public Library	Mexican Consulate	Project Safety Net
Behavioral Health Contractors Association	East Side Union High School District	Milpitas Unified School District	Q Corner
Behavioral Health Urgent Care	Evans Lane Wellness & Recovery Center	Momentum for Health	Re-entry Services
Bill Wilson Center	Forensic Diversion and Reintegration - BHSD	Moreland School District	San Jose State University
CalWORKS Community Health Alliance	Franklin McKinley School District	Morgan Hill Unified School District	San Jose Unified School District
Cambrian School District	Fremont Union High School District	Mothers against Murder	Santa Clara County Office of Education
Caminar	Gardner Health Services, Ethnic Wellness Center	Mount Pleasant Elementary School District	Silicon Valley Gurdwara
Campbell Union High School District	Gilroy Senior Center	Mountain View Los Altos School District	South County Behavioral Health
Campbell Union School District	Gilroy Unified School District	Mountain View Whisman School District	Stanford University School of Medicine
Central Treatment and Recovery	Indian Health Center	Muslim Center	Telecare Muriel Wright Recovery Center
Central Wellness and Benefits Center	Josefa Chaboya de Narvaez Behavioral Health	Muslim Community Association, Mexican Consulate and the Re-entry Resource Center	The LGBTQ Youth Space of Caminar
Collaborative Courts, Forensic Diversion and Reintegration-BHSD	Lived Experience Advisory Board Silicon Valley (LEABSV)	National Alliance on Mental Illness-Santa Clara County The Office of LGBTQ+ Affairs	Ujima
Community Solutions	Loma Prieta School District	National Alliance on Mental Illness-Santa Clara County The Office of LGBTQ+ Affairs	Vietnamese American Service Center (VASC)
County Behavioral Health Services Department Teams (Access / Unplanned Services, Administrative Services, Children Youth & Families, Finance; and Adult/Older Adult)	Los Altos Union School District	Office of the Public Defender	Young Men's Christian Association (YMCA) of Silicon Valley
County of Santa Clara Probation Department – Juvenile Hall	Los Gatos Union School District	Orchard School District	

Public/Stakeholder Meetings/Activities*
To be Conducted Onsite/In-Person

MHSA FY2025 Annual Plan Update

Date	Meeting
October 4, 2023 1-4pm	Access & Unplanned + Workforce Education & Training (WET) data SSA Auditorium (333 W. Julian St.)
October 11, 2023 1-4pm	Children, Youth & Families (CYF) Data Charcot Training Rooms 1 & 2 (2310 N. First Street, Suite 102)
October 18, 2023 1-4pm	Housing + Adult/Older Adult (AOA) data SSA Andrew Hill Training Room (353 W. Julian)
November 1, 2023 1-3pm	Round 1 Program Recommendations: Housing + AOA SSA Auditorium (333 W. Julian St.)
November 16, 2023 1-3pm	Round 1 Program Recommendations: Access & Unplanned, WET, CYF SSA Andrew Hill Training Room (353 W. Julian)
November 29, 2023 1-3pm	Round 2 Program Recommendations: Access & Unplanned, WET, CYF SSA Auditorium (333 W. Julian St.)
December 15, 2023 10am-12pm	Round 2 Program Recommendations Housing + AOA SSA Auditorium (333 W. Julian St.)

*Note: Additional planning /refinement meetings may be scheduled. Please stay connected for schedule info: https://bhsd.sccgov.org/about-us/mental-health-services-act.

QUESTIONS?

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DATA FINDINGS FROM 2023 MHSA SURVEY & COMMUNITY CONVERSATIONS

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Link to the Data report

https://qr.page/g/3MPInqMAYfT

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Methodology & Participants of the Community Planning Process

Community Planning Process
to inform the FY25 update

3 Sources of Data
(collected Jan-Mar '23)

- 29 Community Conversation Groups
- SCC Mental Health & Substance Use Survey
  Consumer/Family Feedback
- SCC Mental Health & Substance Use Survey
  Tracking MHSA domains over time

In thinking about mental health & substance use services in Santa Clara County…

What should stay the same? What should the County not change?

Suggestions or Recommendations for the Behavioral Health Department's Priorities?

In thinking about mental health & substance use services in Santa Clara County…

What should be added or changed? Any communities or programs that need more attention?

5 BHSD Community-Driven Goals

#1 Timely Access	Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services
#2 Housing	Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter
#3 Emerging Needs	Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations
#4 WET	Develop Innovative Solutions to Address Professional Workforce Shortages
#5 Integrated Systems / Policy	Adapt to and Help Shape the Rapidly Shifting State Policy Landscape

COUNTY OF SANTA CLARA
Behavioral Health Services

Mental Health & Substance Use Community Survey
Sponsored by the Santa Clara County Behavioral Health Services Department

COUNTY OF SANTA CLARA
Behavioral Health Services

心理健康和藥物濫用服務社區調查

COUNTY OF SANTA CLARA
Behavioral Health Services

Serbey pang-kumunidad ukol sa kalusugang pang-kaisipan at sa pag-gamit mga sangkapna

COUNTY OF SANTA CLARA
Behavioral Health Services

نظر سنجی جامعه‌ای سلامت روان و مصرف مواد

Community Survey
6 Languages

Chinese
English
Farsi
Spanish
Tagalog
Vietnamese

COUNTY OF SANTA CLARA
Behavioral Health Services

Khảo sát cộng đồng về sức khỏe tâm thần và trị liệu cai nghiện

COUNTY OF SANTA CLARA
Behavioral Health Services

Encuesta comunitaria de salud mental y uso de sustancias

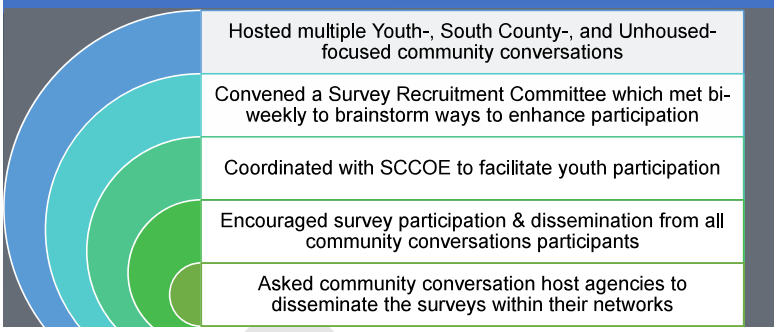
Multi-Method Survey Outreach *(Jan-March 2023)*
to Recruit a Diverse Sample of County Consumers/Stakeholders

Online Campaign	BHSD Partner Outreach	Cultural Community Outreach
Social media ads Email messages Newsletters	BHSD community-serving partners County Clinics County offices Self-help centers Providers	Engagement of community peers Cultural places / organizations

Department-level Participants

- 29 Community Conversations
- 435 stakeholders in Community Conversations
- 1603 stakeholder comments
- 186 consumers or family members on the survey

Efforts to Boost Youth, South County, and Unhoused Participation



List of 29 Community Conversation Groups

(N=435)

Region
1. North County Community
2. South County Older Adults
3. South County Spanish & English Speaking, Some Unhoused

Children, Youth, Families
4. Youth Group 1
5. Youth Group 2, LGBTQ+
6. Youth Group 3
7. Youth Group 4 University students
8. Youth who are Unhoused
9. Family Members, General
10. Providers: Children, Youth, & Family Services
11. Young Men Involved in Juvenile Justice
12. Young Women Involved in Juvenile Justice

Cultural Communities
13. TGI+
14. LGBQPA2S+
    Youth Group 2, LGBTQ+
15. Spanish Speaking LGBTQ+ Adults
16. Spanish Speaking Adults
    South County Spanish & English Speaking, Some Unhoused
17. African Immigrant Community
18. South Asian (Punjabi) Community
19. African American
20. Vietnamese Community
21. Middle Eastern Community
22. Providers: Refugee Services

Justice-Involved
23. Diversion Community
24. Reentry Community
    Young Men Involved in Juvenile Justice
    Young Women Involved in Juvenile Justice

Unhoused
25. Unhoused
26. Adults in Residential/Transitional Housing (Unhoused)
27. Providers: Supportive Housing
    Youth who are Unhoused
    South County Spanish & English Speaking, Some Unhoused

General / Other
28. Providers: Adult & Older Adult
29. Consumers/Clients, General

Older Adults
South County Older Adults

South County Data

- 2 South County-related Community Conversations
- 45 South County stakeholders in Community Conversations
- 48 stakeholder comments re: South County
- 14 South County consumers or family members on the survey

Unhoused Data

- 5 Unhoused-related Community Conversations
- 26 Unhoused stakeholders in Community Conversations
- 134 stakeholder comments about housing
- On the Survey: 69 individuals who not stably housed
  - 22 were BHSD clients
  - 7 were community members
  - 31 did not answer items to determine if they were consumers/family members

Youth Data

- 9 Youth-related Community Conversations
- 95 Youth stakeholders in Community Conversations
- 441 stakeholder comments re: Youth
- 25 Youth consumers or family members on the survey

Average Demographics of Consumer Survey Sample

Age
72% Adult / 18% Older Adult / 10% Youth

Disability
47% Yes / 53% No

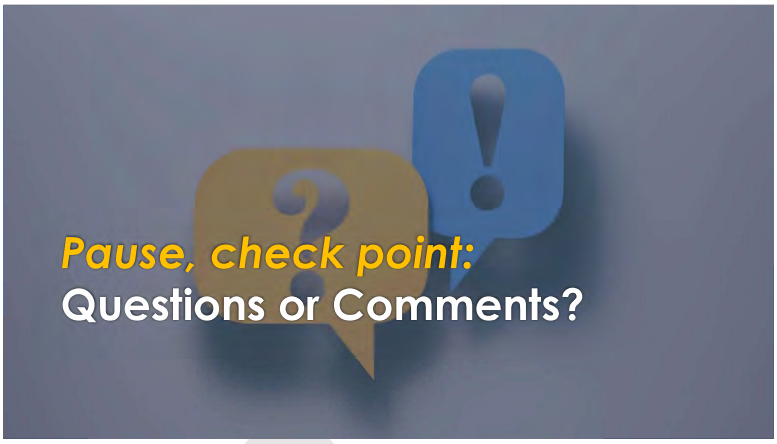
Gender Identity
58% Cis Women / 37% Cis Men / 5% TGI+

Race / Ethnicity
30.9% Latinx / 30.1% White / 22.7% Asian / 17.1% Black or African American / 2.2% MENA / 1.1% Pacific Islander or Native Hawaiian

Stably housed
88% Yes / 12% No

City of Residence
Mostly from San Jose, followed by Santa Clara & Gilroy

Sexual Orientation
86% Heterosexual / 14% LGBQAP2S+



Department-Level Findings

BHSD System Strengths
(207 comments)

County Programs & Agencies (47 comments)
- Goodwill, Re-entry
- Allcove
- Evans Lane

Quality of Care (31 comments)

Youth & School Services (28 comments)
- Student Wellness Centers
- Downtown San Jose Youth Center

Access to Care (19 comments)
- General Access comments
- 988
- Mobile Mental Health Vans/Trucks

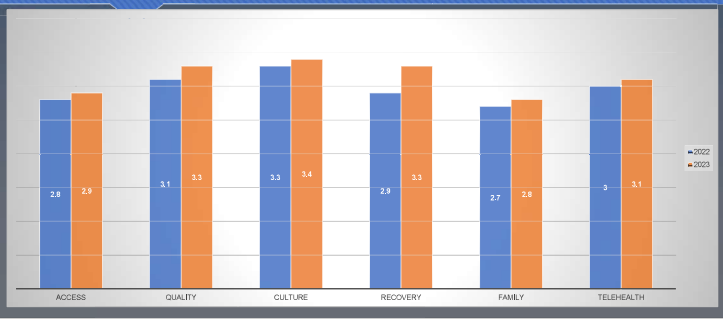
Strengths from the survey

The top strength from the survey can be conceptualized as <u>Quality of Care</u>

- "Services are helpful."
- "My mental health and substance use treatment providers talk to each other and coordinate services with other agencies."
- "Services are focused on patient-centered recovery."

Progress on MHSA domains & priorities

Consumer/Family Survey Averages, by Domain: 2022 vs. 2023



Top Community Needs: Year-by-Year Comparison

2022 Primary Stakeholder-Identified Needs	Number of comments
Treatment Services	309
Workforce Education and Training	225
Access Pipeline	186
Prevention/Outreach	158
Youth & Families	116
Quality of Care	90
Housing	83
Cultural Considerations	52
Criminal Justice	32

2023 Primary Stakeholder-Identified Needs	Number of comments
Treatment Services	498
Workforce Education and Training	265
Access to Care	225
Prevention/Outreach	162
Collaborative & Integrative Care	93
Housing	61
Quality of Care	33

Top Community Needs: Year-by-Year Comparison

2022 Primary Stakeholder-Identified Needs	Number of comments
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Top Community Needs: Year-by-Year Comparison

2022 Primary Stakeholder-Identified Needs	Number of comments
Treatment Services (including Youth & Families, Criminal Justice)	~~309~~ 457
Workforce Education and Training	225
Access Pipeline	186
Prevention/Outreach	158
Quality of Care	90
Housing	83
Cultural Considerations	52

2023 Primary Stakeholder-Identified Needs	Number of comments
Treatment Services	498
Workforce Education and Training	265
Access to Care	225
Prevention/Outreach	162
Collaborative & Integrative Care	93
Housing	61
Quality of Care	33

Cultural Considerations

Most Frequently Mentioned Primary Needs / Areas of Growth *(mapped onto BHSD priorities)*

- **#1: More Treatment Services** (498 comments)
- **#2: Workforce, Education, & Training** (265 comments)
- **#3: Access** (225 comments)
- **#4: Prevention/ Outreach** (162 comments)
- **#5: Collaborative/ Integrative Care** (93 comments)
- **#6: Housing** (61 comments)

Recommendations
More Treatment Services
(498 comments)

BHSD Priority #3 (Emerging Needs)
Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations

- **#1. More treatment services for high-need populations**
  Youth, LGBTQ+ individuals, refugees, immigrants, and women.
- **#2. Increase capacity for substance use-related services & programs**
  Detox services, dual diagnosis treatment, and youth substance use treatment and prevention
- **#3. Reduce stigma & increase MHSU knowledge among parents**
- **#4. Continue and expand support to facilitate youth access to Wellness Centers**
  (both school- and non-school-based)

Recommendations
More Treatment Services

BHSD Priority #3 (Emerging Needs)
Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations

- **#5. Expand criminal justice services**
  Additional Treatment in Jails, Expand beyond Collaborative Courts, Reentry Vocational Centers
- **#6. Continue LGBTQ+ services**
- **#7. Maintain telehealth options while expanding in-person services**
- **#8. Continue and expand BHSD services for those who are unhoused**

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

Recommendations for Workforce, Education, and Training

(265 comments)

WET Rec #1
Increase staff positions/retention (clinicians/therapists, peer support, case managers)

WET Rec #2
Essential Strategies: Reduce Staff Turnover, increase pay

WET Rec #3
Hire Culturally-Matched Staff Members

WET Rec #4
More trainings for staff, particularly cultural trainings (e.g., LGBTQ+, Black and African Ancestry, Middle Eastern, DEI)

WET Rec #5: Widely market job openings and provide application support

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

Community recognition of BHSD staff shortage: 3.0 ("somewhat agree")

Community member interest in seeking BHSD employment: 193 expressed interest

Top Reasons for Not Applying:

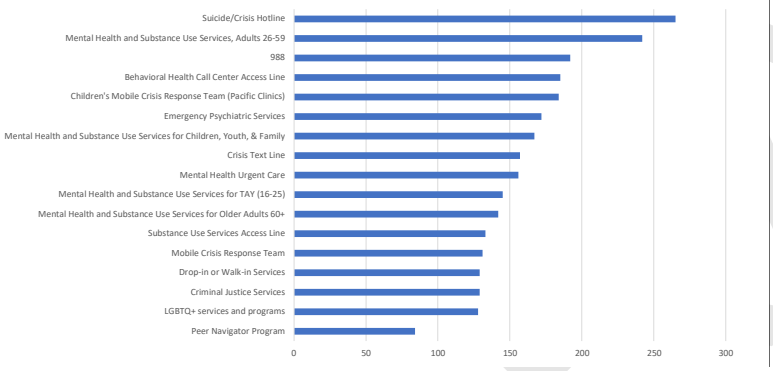
#1 • Educational Background Didn't Match (N=89)

#2 • Didn't Know Where to Find Job Openings (N=88)

#3 • Needed Application Support (N=45)

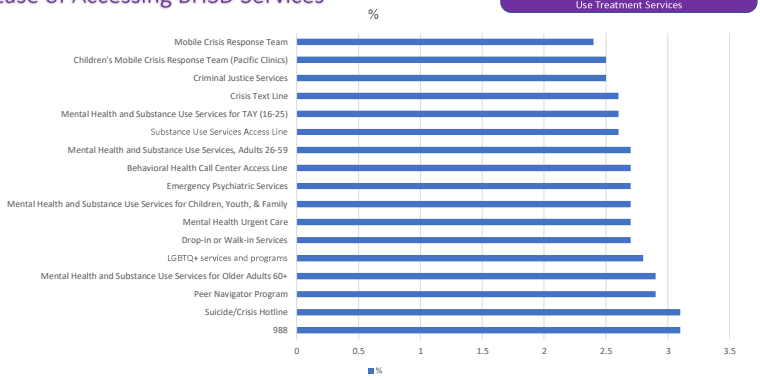
General Community Survey
Awareness of BHSD Services

BHSD Priority #1 (Timely Access)
Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services



General Community Survey
Ease of Accessing BHSD Services

BHSD Priority #1 (Timely Access)
Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services



BHSD Priority #1 (Timely Access)
Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services

General Community Survey

Ease of Accessing BHSD services

In the 2023 sample:
Every single BHSD service was rated as "easy to access"

In the 2022 sample:
Only 2 BHSD services were rated as "easy to access."

Recommendations Timely Access to Care

(235 comments)

BHSD Priority #1 (Timely Access)
Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services

Access Rec #1: Continue to increase community awareness and accessibility of BHSD services, particularly 988, the peer navigator program, and walk-in services

Access Rec #2. Faster / easier connection to treatment services

Access Rec #3. Improve call center integrated screening processes

Access Rec #4. Options to access care without the Call Center (e.g., direct referral)

Recommendations
Access to Care (235 comments)

Access Rec #5. Continue language availability at the Call Centers

Access Rec #6. Increase language/translation services in treatment (i.e., in-person, Spanish, Vietnamese, Punjabi)

Access Rec #7. Offer clients the practical supports needed to participate in treatment, particularly transportation and childcare

General Community Survey – Barriers to Help
"Why did you not seek help?"

#1 There aren't enough services N=36

#2 My problems aren't serious enough N=22

#3 There is a lack of help in my language N=17

#4 Don't have the resources to get help (money, childcare, etc.) N=16

Prevention & Outreach

Community satisfaction with prevention and outreach programming: 2.5 ("mostly true")

Consumers find out about services from many sources
Importance of outreach to a variety of venues, partners, & community helpers

How did you initially find out about mental health and substance use services?		
From a Provider	37.3%	(n = 57)
Word of Mouth	25.5%	(n = 39)
Call Center or Access Line	23.5%	(n = 36)
The Internet	19.6%	(n = 30)
Walk-In	11.8%	(n = 18)
Called the Clinic	10.5%	(n = 16)
988	2.6%	(n = 4)

Recommendations
Prevention & Outreach (179 comments)

(Spans many of the BHSD priorities #1-3)

#1: Increase community awareness and decrease stigma through community helper trainings & outreach

In-person where communities gather (e.g., parents, youth, substances, on social media, child abuse, Sikh, Hispanic/Latin/o/a/e, immigrants, at faith-based organizations, etc.).

Outreach should occur through the variety of venues, partners, and community helpers that represent where individuals first find out about services (i.e., via providers, word of mouth, 988 or the call center, online, directly through clinics).

Recommendations
Prevention & Outreach (179 comments)

(Spans many of the BHSD priorities #1-3)

#2: Expand ethnic-specific outreach efforts

Address discrimination, low MHSU awareness, and high stigma among underserved ethnic minority populations (e.g., Middle Eastern, South Asian, immigrants, African American), at places where ethnic communities gather and trust.

#3: Expand outreach to youth through schools and college campuses

Recommendations: Integrated Systems/Policy (93 comments)

BHSD Priority #5 (Integrated System/Policy)
Adapt to and Help Shape the Rapidly Shifting State Policy Landscape

#1: Streamline organizational structures to facilitate a unified system between **BHSD and external services**
Public schools, universities, community emergency services, the County's health and hospital system, law enforcement, primary care

#2: Increase communication/ coordination **within BHSD services**
(e.g., direct agency referrals, a single EMR for all BHSD agencies)

#3: Collaborate with Santa Clara County schools to implement **peer referral systems**

Recommendation for Housing (61 comments)

BHSD Priority #2 (Housing)
Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter

Housing Recommendation: Increase housing availability

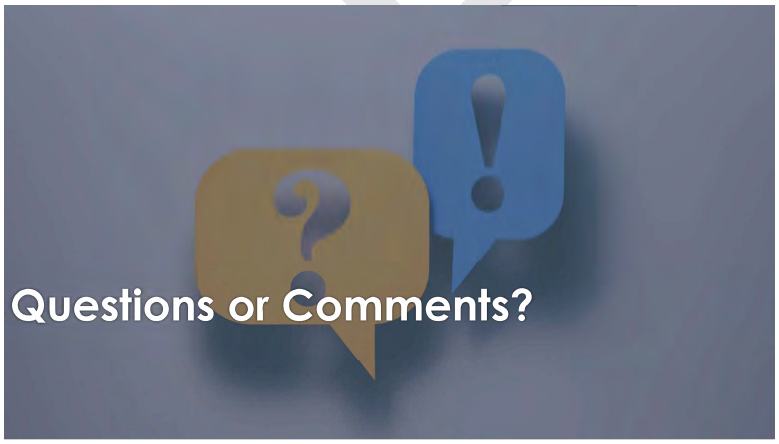
- Long-term housing stabilization
- More Temporary Housing
- More Permanent Supportive Housing

Recommendations Quality of Services (33 comments)

1. Continue current efforts at implementing recovery-oriented approaches
2. Implement and disseminate quality control measures
3. (6 comments) LGBTQ+ training for staff at transitional & temporary housing sites

63.6% of stakeholder comments mapped directly onto the 5 Main Department Goals

Prevention/outreach comments which span Goals #1,2,3 account for an additional 12.7%



MHSA INNOVATION UPDATES

INNOVATION PROJECTS AT A GLANCE

Program	Annual Amount*	Clients Served**	Cost per Client
INN 12 Psychiatric Emergency Response Team (PERT)	$ 922,087	455	$ 2,092
INN 13 Allcove	$ 3,197,014	477	$ 7,931
INN 14 Independent Living Empowerment Program (ILEP)	$ 372,851	N/A	(No clients receive services)
INN 15 Trusted Response Urgent Support Team (TRUST)	$ 5,744,343	5,000	$ 1,149
INN 16 Addressing Trauma/Stigma among Vietnamese & African American/ Ancestry Communities	$ 584,380	10,000	$ 58

*Dollar amounts are estimates prior to FY23 ARER adjustment

**Client numbers in RED are estimates, while those noted in BLACK are actuals from FY23

INN12: PSYCHIATRIC EMERGENCY RESPONSE PROGRAM (PERT)

During FY23 the PERT program had:

- **455 Incidents** (6 incarcerations)
- Average response time: **13 minutes**
- Average encounter time: **44 minutes**
- Over 460 resources provided

Cumulative for the project:

- **2,398 Incidents** (20 arrests)
- Average response time: **14 minutes**
- Average encounter time: **46 minutes**

COUNTY OF SANTA CLARA Behavioral Health Services

INN 13: ALLCOVE

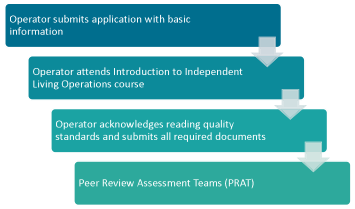
Cumulative Results:

- **477 youth engaged** in the center(s) (48%)
- **83%** of young people visiting the center expressed interest in **mental health services**
- Consolidated to 1 site due to flooding
- Youth served resided in **75 different zip codes** in the Bay Area and Northern CA
- Significant challenges during implementation, resulting in changes but **maintaining fidelity**
- **Continued expansion** of the program and increased community presence
- **Overwhelming satisfaction** from youth with the staff and center, and would recommend the allcove program to a friend

INN 14: INDEPENDENT LIVING AND EMPOWERMENT PROGRAM (ILEP)

Highlights from FY23:

- Enrolled **6 member homes**, working on additional 7 applications (goal for the year was set at 15)
- Incorporated new partnerships and trainings
- 24 trainings offered to operators/staff
- prePRAT at Lewis House (master lease program, ACT, AOT)
- 3 grievances investigated (2 operators, 1 unaffiliated home)



COUNTY OF SANTA CLARA Behavioral Health Services

INN 15: TRUSTED RESPONSE URGENT SUPPORT TEAM (TRUST)

- Soft launch November 2022
- **2,000+ calls received** since launch:
  - **98%** of calls diverted from Law Enforcement
  - **25%** of calls stabilized over the phone
- Call Center, North County, San Jose, and Gilroy teams operating **24/7**
- Currently hiring for West Valley, anticipated launch in fall/winter 2023
- Accepting applications for the TRUST Community Advisory Board (CAB)
- TRUST vehicles near completion

TRUSTED RESPONSE URGENT SUPPORT TEAM

Pacific Clinics

Momentum for Health

INN 16: TRAUMA/STIGMA IN AFRICAN AMERICAN/ANCESTRY & VIETNAMESE COMMUNITIES

Highlights from year 1

Ujima:

- 75 Healing Circle Events (806 dup., 453 und.)
- 29 Parent Cafes (124 dup., 35 und.)
- 22 Tabling Events (1,878 people reached)
- 26 referrals

VIVO:

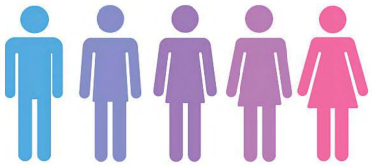
- 56 workshops-cafes & circles (1,045 dup., 607 und.)
- 6 tabling events (570 people reached)
- Outreach: Weekly airtime on Vietnamese radio (40,000 est. listeners)
- 488 referrals

COUNTY OF SANTA CLARA Behavioral Health Services

INN 17: TRANSGENDER, NONBINARY, AND GENDER EXPANSIVE (TGE) CENTER

Final plan approved by OAC on July 27, 2023!
4.5-year project
$11.9M Budget, 15 FTEs proposed
Steering committee will guide development
Working on RFP for services and hiring Program Manager 2

Features:
1. Drop-in Respite Services
2. Access to computers/tech
3. Advocacy and Social Events Space
4. Training and mentorship
5. Clothing/garment closet
6. Assistance securing housing



COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Please take a moment & provide your feedback on today's meeting!

QUESTIONS?

SLC Subcommittee Activities & Updates

SLC Outreach & Survey Subcommittees

SLC Outreach Subcommittee Update

Members
- Armina Husic
- Mary Gloner
- Mary Ann Dewan
- Shelly Viramontez
- Rochelle Fong
- LouMeisha Brown
- Daniel Gutierrez

Goals
- Fill 16 SLC vacancies
- Improve SLC application process

Current Tasks
- Creating outreach materials
- Prioritizing positions and concentration efforts
- Updating SLC application to be accessible & user friendly

SLC Survey Subcommittee Update

Challenges

- Burnout for stakeholders
- Balance community burden & utility
- Length prohibitive for diverse stakeholder engagement
- Unused questions

Principles for the Community Planning Process (CPP) Redesign

1. Keep the survey as brief as possible
2. Streamline the demographics
3. Streamline items assessing MHSA principles
4. Be intentional in determining how often to ask each item

Survey Subcommittee

Anne Baumgarten

Armina Husic

LouMeshia Brown

Peggy Cho

Drafted revised surveys
(3-3.5 pages in length, down from 14)

Pilot testing with consumers & community members

CLOSING REMARKS

https://www.surveymonkey.com/r/XNZKTFM

94

Thank you!

For any questions about MHSA and the FY2025 MHSA Planning Process, please email MHSA@hhs.sccgov.org.

Mental Health Services Act (MHSA)
FY2025 Community Program Planning Process
Access & Unplanned Services System of Care
& Workforce Education & Training (WET) Data Meeting

Wednesday, October 4, 2023, 1:00 PM - 4:00 PM
333 W. Julian St., San Jose, CA 95110
Auditorium

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

MEETING AGENDA – October 4, 2023	TIME
1. Welcome & Background (Roshni Shah) a. Introductions b. Welcoming Remarks & Housekeeping	1:00 PM – 1:10PM
2. Data Findings from 2025 MHSA Survey & Community Conversations (Dr. Joyce Chu) a. Presentation by Dr. Chu b. Questions & Answers	1:10 PM– 1:55PM
3. Break	1:55 PM – 2:00 PM
4. Data Findings from the Access & Unplanned Services System of Care (Bruce Copley) a. Presentation of Data b. Questions & Answers	2 – 3:10 PM
5. Data Findings from the MHSA Workforce Education & Training (WET) Team (Jeannette Ferris) a. Presentation of Data b. Questions & Answers	3:10 – 3:50 PM
6. Closing Remarks & Next Steps	3:50 - 4PM

COUNTY OF SANTA CLARA Behavioral Health Services

2

Q/A sections are included in the schedule to provide an opportunity to ask questions and/or provide comment/input.

Give space, take space.

Meeting Agreements

Welcome & Background

Introductions

Housekeeping

- Parking
- Access to Restrooms
- Safety Practices

Follow along with today's presentation!

https://tinyurl.com/EventsCPP

DATA FINDINGS FROM 2023 MHSA SURVEY & COMMUNITY CONVERSATIONS

Feedback Forms at your seats

If you prefer to provide comments in an online form, feel free to use this link or QR code:
https://tinyurl.com/MHSA2025

Today's Agenda

Data Presentation

Access & Unplanned Services Findings / Recommendations

Workforce, Education, & Training Findings / Recommendations

Q&A

Access/Unplanned Participants

Access & Unplanned Services Participants

- 29 Community Conversations
- 435 stakeholders in Community Conversations
- 577 stakeholder comments
- 90 consumers or family members on the survey

Access/Unplanned Demographics: Consumer/Family Survey Sample (n = 90)

Age
80% Adult / 12.2% Older Adult / 7.8% Youth

Disability
53% Yes / 47% No

Gender Identity
61.5% identified as cisgender women, 29.2% as cisgender men/boys, and 9.2% TGI+

Race / Ethnicity
42.7% Latino; 42.7% White; 18.3% Asian; 12.2% Black; 12.2% Native American, American Indian, Alaskan Native; and 2.4% Middle Eastern / North African

Stably housed
90% Yes / 10% No

City of Residence
Mostly from San Jose, followed Gilroy, Milpitas, Santa Clara, & Sunnyvale

Sexual Orientation
84% Heterosexual / 16% LGBQPA2S+

Access/Unplanned-Specific Findings

Access / Unplanned System Strengths
(56 comments)

Helpful Access Processes & Procedures
- Access to BHSD services
- 988
- Mobile mental health trucks/vans
- Offering services throughout the day (e.g., night-time classes)
- Navigator program

LGBTQ+ Services

Outreach & Prevention

Crisis Services

Access/Unplanned System Strengths from the survey

The top strength from the survey can be conceptualized as <u>Quality of Care</u>

- "MHSU services are helpful." (n = 34)
- "Services are focused on patient-centered recovery." (n = 25)
- "My mental health and substance use treatment providers talk to each other and coordinate services with other agencies." (n = 24)
- "Services help me accomplish my goals." (n = 18)
- "Providers understand my needs." (n = 17)

Access/Unplanned Services: Top Stakeholder Needs, Year-by-Year Comparison

2022 Primary Access/Unplanned Stakeholder-Identified Needs	Number of comments
Access	200
Prevention/Outreach	105
LGBTQ+ Needs	64
Access Pipeline	55
Cultural Considerations	54
Workforce, Education, & Training	21
Treatment Services	18
Quality of Care	2

2023 Primary Access/Unplanned Stakeholder-Identified Needs	Number of comments
Access	235
Prevention/Outreach	179
Treatment Services	88
Workforce, Education, & Training	54
Collaborative & Integrative Care	19
Quality of Care	1
Housing	1

Top Stakeholder Access/Unplanned Needs & Corresponding BHSD Goals

- **#1 Timely Access** — Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services
- **#2 Housing** — Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter
- **#3 Emerging Needs** — Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations
- **#4 WET** — Develop Innovative Solutions to Address Professional Workforce Shortages
- **#5 Integrated Systems / Policy** — Adapt to and Help Shape the Rapidly Shifting State Policy Landscape

2023 Primary Access/Unplanned Stakeholder-Identified Needs	Number of comments	% Overlap with BHSD Goals
Access	235	42.6%
Prevention/Outreach	179	1.7%
Treatment Services	88	68.2%
Workforce, Education, & Training	54	100%
Collaborative & Integrative Care	19	100%
Quality of Care	1	100%
Housing	1	0%

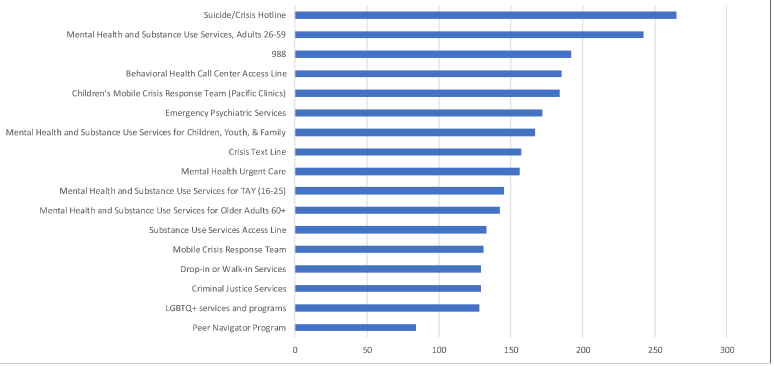
36.0% of Access & Unplanned stakeholder comments mapped directly onto the 5 Main Department Goals

Most frequently mentioned themes of change

- **#1: Access** (235 comments)
- **#2: Outreach & Prevention** (179 comments)
- **#3: More Treatment Services** (88 comments)
- **#4: Workforce, Education, & Training** (54 comments)
- **#5: Integrative & Collaborative Care** (19 comments)

General Community Survey Awareness of BHSD Services

BHSD Priority #1 (Timely Access)
Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services



General Community Survey Ease of Accessing BHSD Services

BHSD Priority #1 (Timely Access)
Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services

BHSD Priority #1 (Timely Access)
Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services

General Community Survey

Ease of Accessing BHSD services

In the 2023 sample:
Every single BHSD service was rated as "easy to access"

In the 2022 sample:
Only 2 BHSD services were rated as "easy to access."

Access & Unplanned Services Recommendations
Timely Access to Care

(235 comments)

BHSD Priority #1 (Timely Access)
Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services

- **Access Rec #1:** Continue to increase community awareness and accessibility of BHSD services, particularly 988, the peer navigator program, and walk-in services
- **Access Rec #2.** Faster / easier connection to treatment services
- **Access Rec #3.** Improve call center integrated screening processes
- **Access Rec #4.** Options to access care without the Call Center (e.g., direct referral)

Access & Unplanned Services Recommendations
Access to Care

(235 comments)

- **Access Rec #5.** Continue language availability at the Call Centers
- **Access Rec #6.** Increase language/translation services in treatment (i.e., in-person, Spanish, Vietnamese, Punjabi)
- **Access Rec #7.** Offer clients the practical supports needed to participate in treatment, particularly transportation and childcare

General Community Survey – Barriers to Help
"Why did you not seek help?"

#1 There aren't enough services N=36	**#2** My problems aren't serious enough N=22
#3 There is a lack of help in my language N=17	**#4** Don't have the resources to get help (money, childcare, etc.) N=16

Access & Unplanned Services:
Prevention & Outreach

Community satisfaction with prevention and outreach programming: 2.5 ("mostly true")

Consumers find out about services from many sources
Importance of outreach to a variety of venues, partners, & community helpers

How did you initially find out about mental health and substance use services?		
From a Provider	37.3%	(n = 57)
Word of Mouth	25.5%	(n = 39)
Call Center or Access Line	23.5%	(n = 36)
The Internet	19.6%	(n = 30)
Walk-In	11.8%	(n = 18)
Called the Clinic	10.5%	(n = 16)
988	2.6%	(n = 4)

Access & Unplanned Services Recommendations
Prevention & Outreach

(179 comments)

(Spans many of the BHSD priorities #1-3)

#1: Increase community awareness and decrease stigma through community helper trainings & outreach

In-person where communities gather (e.g., parents, youth, substances, on social media, child abuse, Sikh, Hispanic/Latin/o/a/e, immigrants, at faith-based organizations, etc.).

Outreach should occur through the variety of venues, partners, and community helpers that represent where individuals first find out about services (i.e., via providers, word of mouth, 988 or the call center, online, directly through clinics).

Access & Unplanned Services Recommendations
Prevention & Outreach

(179 comments)

(Spans many of the BHSD priorities #1-3)

#2: Expand ethnic-specific outreach efforts

Address discrimination, low MHSU awareness, and high stigma among underserved ethnic minority populations (e.g., Middle Eastern, South Asian, immigrants, African American), at places where ethnic communities gather and trust.

#3: Expand outreach to youth through schools and college campuses

Access & Unplanned Services Recommendations
Additional Treatment Services

(88 comments)

BHSD Priority #3 (Emerging Needs)
Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations

1. Expand the variety and availability of LGBTQ+ services
2. Continue and expand crisis care efforts

Mobile Crisis & TRUST related comments

Strengths (9 comments)

Seen more mobile crisis services

- "I've seen a lot of mobile [crisis] services that the County is supporting."
- "I have seen more [mobile crisis] teams"

Positive experiences with mobile crisis

- 5 general comments mentioning the strength of mobile crisis services/teams
- "TRUST"
- "I think we should maintain a commitment to mobile response teams"
- "I think that that [the mobile crisis] model is wonderful."
- "I concur with mobile response teams [being helpful]"
- "[Mobile crisis] came by a couple of times and talked to [my son] …during Covid…pandemic times…on the front porch for a really long time. They had practitioners, and they also had police that came just in case to apparently…protect the practitioners…They would talk to [my son] for a really really long time, and that was very, very helpful…I think that it prevented some hospital[izations]"
- "Great things to say about some of the police services that end up occurring during my son's mental crisis stuff…"

Mobile Crisis & TRUST related comments

Areas of Need (7 comments)

Increase Availability

- "…need to add more [mobile crisis team] coverage to all of Santa Clara County"

Desire for Crisis Care Without Law Enforcement

- "Remove criminal justice involvement from mental health"
- "Break…up with the police."
- "Mobile Response model without automatically including police"
- "Once a lady told me about her daughter. She wanted to [die by] suicide, she called the police and what [the police] did was take the lady outside and talk to the girl. Of course, they weren't able to see the problem. When a person has problems, [the police] don't recognize it or they can't see it…"
- "Having services that don't require involvement by law enforcement, particularly with clients that may have active warrants and things… everybody is showing up [to a crisis] with a different goal in mind, the specific example was having requested mobile crisis for a client who is in crisis and law enforcement showing up and because there's an active warrant rather than serving the mental health crisis, they are immediately arrested… and this is not an isolated incident"

Process Challenges

- Mobile crisis won't necessarily come unless PD. Is there, and PD won't necessarily come if we say mobile crisis is on the way"

Mobile Crisis survey responses

Family Involvement

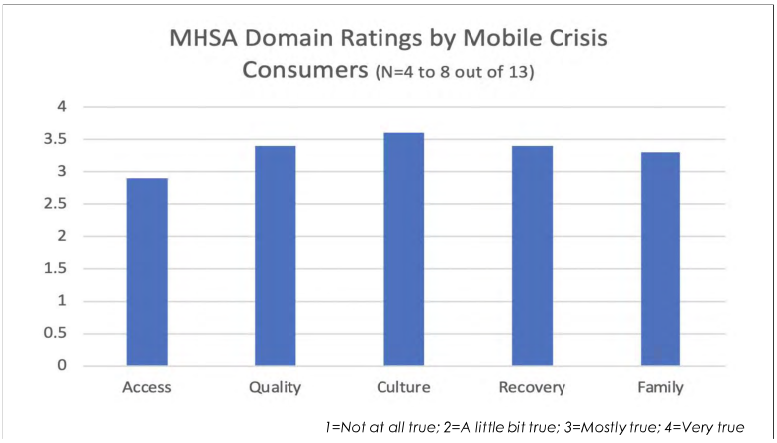
- 6 out of 7 mobile crisis consumer respondents were asked if they wanted family or other supports to be part of their treatment

Somewhat hard to get connected

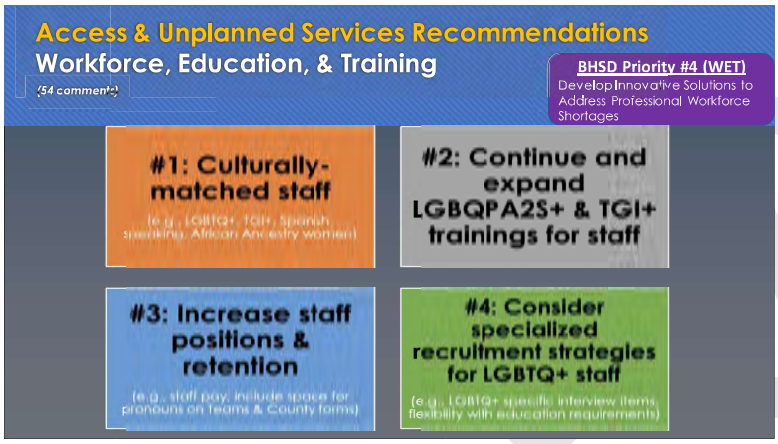
31. How hard was it to get connected to your mental health or substance use provider?

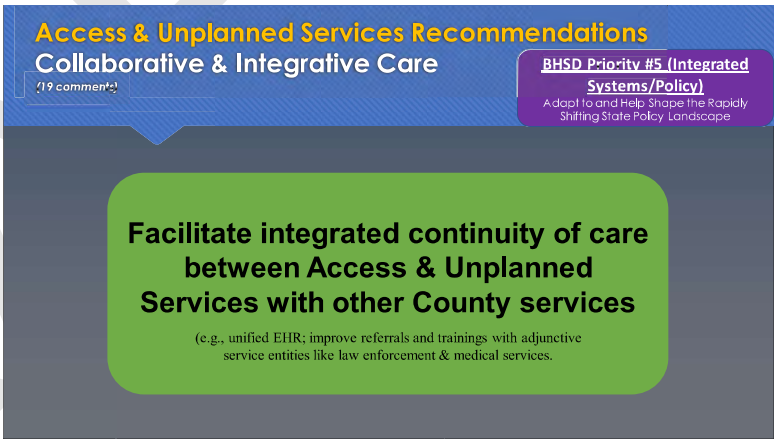
○ 1=Not at all hard ○ 2=Not very hard ○ 3=Somewhat hard ○ 4=Very hard

M=2.75, SD=1.2 (N=8)


MHSA Domain Ratings by Mobile Crisis Consumers (N=4 to 8 out of 13)
4
3.5
3
2.5
2
1.5
1
0.5
0
Access
Quality
Culture
Recovery
Family
1=Not at all true; 2=A little bit true; 3=Mostly true; 4=Very true


Access & Unplanned Services Recommendations
Additional Treatment Services
(88 comments)
BHSD Priority #3 (Emerging Needs)
Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations
1
Expand the variety and availability of LGBTQ+ services
2
Continue and expand crisis care efforts
3
Enhance services for high-need but treatment-declining individuals


Access & Unplanned Services Recommendations
Workforce, Education, & Training
(54 comments)
BHSD Priority #4 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages
#1: Culturally-matched staff
(e.g., LGBTQ+, TGI+, Spanish speaking, African Ancestry women)
#2: Continue and expand LGBQPA2S+ & TGI+ trainings for staff
#3: Increase staff positions & retention
(e.g., staff pay; include space for pronouns on forms & County forms)
#4: Consider specialized recruitment strategies for LGBTQ+ staff
(e.g., LGBTQ+ specific interview items, flexibility with education requirements)


Access & Unplanned Services Recommendations
Collaborative & Integrative Care
(19 comments)
BHSD Priority #5 (Integrated Systems/Policy)
Adapt to and Help Shape the Rapidly Shifting State Policy Landscape
Facilitate integrated continuity of care between Access & Unplanned Services with other County services
(e.g., unified EHR; improve referrals and trainings with adjunctive service entities like law enforcement & medical services.


WET-specific Findings


WET Strengths
(6 comments)
Inflation adjustments
Cost-of-living adjustments
Internship stipends
Loan forgiveness grants
Efforts to recruit additional staff
(specifically case managers and peer support)

WET: 5 Sub-Themes → 7 Recommendations

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

- **#1: Hire More Clinical Staff** (82 comments)
- **#2: Hiring Suggestions** (59 comments)
- **#3: Staff Retention** (51 comments)
- **#4: Staff Training** (43 comments)
- **#5: Increase Staff Pay** (31 comments)

100% of stakeholder comments mapped directly onto

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

WET Recommendation #1
Increase staff positions / hires *(82 comments)*

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

- Peer Support
- Therapists, including for South County
- Case Managers
- Diversion Services Staff, including Collaborative Court assessors
- More Youth-Focused Staff (e.g., licensed therapists)
- Others: Psychiatrists, Addiction specialists, Staff for the African immigrant community

WET Recommendation #2
Hire Culturally-Matched Staff *(35 comments)*

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

- LGBTQ+
- Middle Eastern
- Women
- Spanish-speaking
- TGI+
- Hispanic/Latin/o/a/e
- South Asian
- TAY-aged

WET Recommendation #3
Consider essential strategies to retain staff & enhance the work environment *(51 comments)*

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

Increase Staff Benefits
- Childcare for BHSD staff
- Reinstate Covid-19 sick pay
- Fund Higher Education Degrees
- Fund Advanced Clinical Trainings (e.g., Dialectical Behavioral Therapy, Eye Movement Desensitization & Reprocessing, DBT)

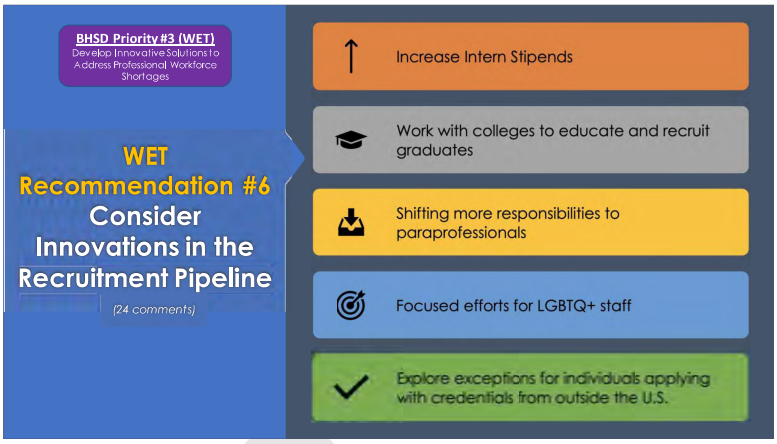
Address Burnout
- Vicarious trauma resources
- Support Permanent Supportive Housing Staff burnout due to pressures of housing crisis & dual agencies (BHSD + Office of Supportive Housing)
- HR/BHSD support after anti-LGBTQ+ workplace aggressions

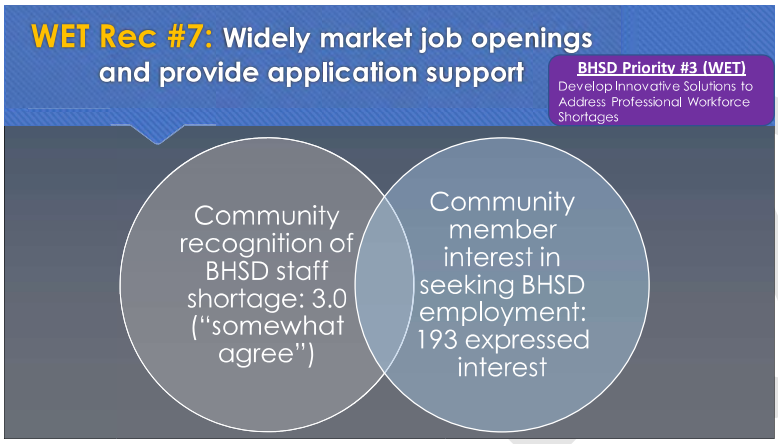
Reduce Staff Workload
- Smaller clinician caseloads
- Reduce Permanent Supportive Housing staff double burden for documentation/trainings/productivity

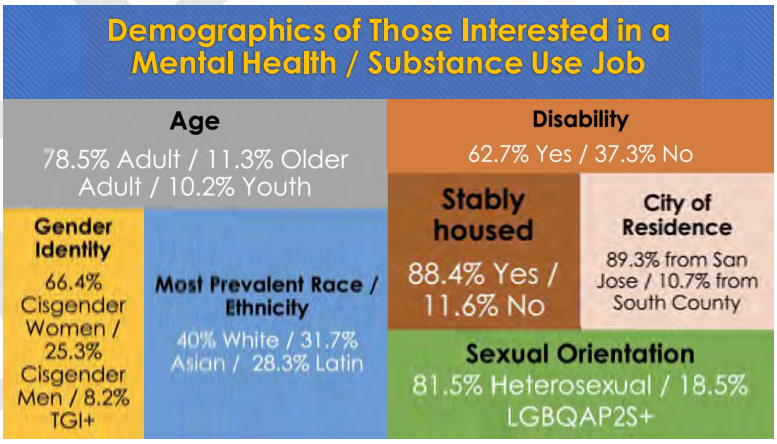
WET Recommendation #4
Staff Trainings *(43 comments)*

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

Cultural Trainings	Other Trainings
• LGBTQ+ • Diversity, Equity, & Inclusion • Middle Eastern culture • Black & African Ancestry culture	• AB1424 (consideration of family information in involuntary psychiatric treatment) • Trauma-informed care • Harm reduction • More staff trained in psychiatric emergency services • "Soft skills" (e.g. customer services) • Service access eligibility requirements at access points (e.g., Call Center & Cultural Wellness Center) • Homeless Management Information Systems training







Areas of Interest for Employment in Mental Health & Substance Use	n
Peer Support	119
Counseling	99
Substance Use Treatment	56
Clinician	51
Psychiatrist	34

58 individuals had applied to a MHSU position over the last 12 months

Challenges in Applying for a Mental Health / Substance Use Position	n
"I was worried about my benefits being reduced or impacted."	12
"I was worried about my employment gap / years out of the workforce."	10
"I needed support to start the employment process (resume, filling out application, interviewing, etc.).	8

Reasons for Not Applying for a Mental Health or Substance Use Position

"My educational background didn't match what was needed for the job."	89
"I don't know where to find job openings."	88
"I needed support to start the employment process (resume, filling out application, interviewing, etc.)."	45
"Worried about my employment gap / years out of the workforce."	41
"Worried about my benefits being reduced or impacted."	36
"Concerns about my legal status or history."	33
"There aren't' enough disability accommodations."	25

BREAK

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Q&A

ONLINE FEEDBACK FORM
SCAN QR CODE OR
AVAILABLE AT:
HTTPS://TINYURL.COM/MHSA2025

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COUNTY OF SANTA CLARA
Behavioral Health Services

Access & Unplanned Services
MHSA Presentations

Agenda

MHSA Program Presentations	
• 988/CSPL	Lan Nguyen
• Behavioral Health Call Center	Joe Tansek
• TRUST Program	Jamina Hackett
• PERT Program	Sandra Hernandez
• LEL Program	Sandra Hernandez
• IHOT Program	Lindsay Cross
• Suicide Prevention Program	Mego Lien
• Navigator Program	Rosa Ortiz (Alicia fill in)
• The Q Corner & Caminar's LGBTQ Wellness	Alicia Musquiz
• Gender Affirming Care Clinic (GACC)	Ben Geilhufe

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

COUNTY OF SANTA CLARA
Behavioral Health Services

988/CSPL CALL CENTER

CSPL Services

- Crisis phone line 24 hours a day / 7 days a week
- 988 Crisis Text and Crisis Chat 1pm – 9pm, Monday - Sunday
- Provide direct support to individuals because of suicide attempt or self -harm injury.
- Survivor of Suicide Support Group
- Provide support to individuals who have lost a loved one due to suicide
- Connect to resources

CRISIS AND SUICIDE PREVENTION LIFELINE (CSPL) - ROLE WITH 988

- County-operated, toll-free, confidential phone line to help people in crisis, give emotional support, suicide prevention, crisis intervention, and referrals to resources
- **CSPL** *previously known as the Suicide and Crisis Services (SACS):* assist in defusing and de-escalating the crisis and helping to return the individual to their usual level of functioning
- CSPL is now able to:
  Refer callers to community mobile response programs including Mobile Crisis Response Teams (MCRT), In-Home Outreach Teams (IHOT), and Mobile Response and Stabilization (MRSS) as well as Crisis Stabilization Units

PREVIOUS	CURRENT
Local Toll-Free Lifeline: 855-278-4204 **National Suicide Prevention Lifeline:** 800-273-8255	**Lifeline: 988** • The previous numbers remain active • In September 2022 BHSD launched a 988 public awareness campaign. • BHSD is working to inform residents about the new number with the hope that the public dials 988 when they need help/are in mental crisis.

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CSPL FY23 CALL VOLUME

Month	988				Local Lines 855-278-4204 & 800-704-0900			
	Offered	Answered	Unanswered	Answer Rate	Offered	Answered	Unanswered	Answer Rate
Jul-22	1,833	1,437	396	78%	4164	2870	1294	68.92%
Aug-22	2,195	1,728	467	79%	3908	2949	959	75.46%
Sep-22	2,246	1,578	668	70%	3854	2659	1195	68.99%
Oct-22	2,139	1,591	548	74%	4010	2706	1304	67.48%
Nov-22	1,716	1,449	267	84%	3664	2794	870	76.26%
Dec-22	1,805	1,597	208	88%	3485	2859	626	82.04%
Jan-23	1,921	1,711	210	89%	3466	2901	565	83.70%
Feb-23	1,784	1,595	189	89%	3267	2641	626	80.84%
Mar-23	2,055	1,893	162	92%	4092	3447	645	84.24%
Apr-23	2,216	2,057	159	93%	4050	3332	718	82.27%
May-23	2,348	2,217	131	94%	3900	3140	760	80.51%
Jun-23	2,239	2,127	112	95%	4282	3565	717	83.26%
Total /Average Total	**24,497**	**20,980**	**3,517**	**85%**	**46,142**	**35,863**	**10,279**	**77.83%**

CSPL FY23 Referrals to Crisis Services

CSPL Referrals	MCRT			MRSS			TRUST *Go live 11/7			IHOT		911
	Referred	Field Visit (FV)	% FV	Referred	Field Visit (FV)	% FV	Referred	Field Visit (FV)	% FV	Referred	Field Visit	Referred
Jul 16 - Jul 31	75	9	12%	2	2	100%	0	0	0	1	0	1
Aug 2022	183	38	21%	14	12	86%	0	0	0	4	1	1
Sept 2022	156	36	23%	9	6	67%	0	0	0	1	0	1
Oct 2022	164	44	27%	13	10	77%	0	0	0	2	0	2
Nov 2022	84	22	26%	11	9	82%	32	19	59%	0	0	0
Dec 2022	172	46	27%	26	13	50%	221	77	35%	0	0	1
Jan 2023	158	45	28%	23	13	57%	216	82	38%	0	0	2
Feb 2023	166	33	20%	22	3	14%	187	70	37%	0	0	4
Mar 2023	99	27	27%	28	8	29%	178	59	33%	0	0	4
Apr 2023	197	57	29%	46	8	17%	268	90	34%	0	0	6
May 2023	146	39	27%	27	5	19%	213	71	33%	0	0	3
Jun 2023	106	47	44%	22	6	27%	216	58	27%	0	0	7
Totals	1,706	443	26%	243	95	52%	1,531	526	37%	8	1	32

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Promoting 988

- In September 2022, BHSD launched a public awareness campaign promoting 988 among county residents
- The campaign includes three phases targeting different cultural groups represented in the county (languages: English, Spanish, Vietnamese, Chinese, Tagalog, Farsi)
- BHSD is collaborating with VTA to bring additional awareness to 988 throughout the county

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COUNTY OF SANTA CLARA
Behavioral Health Services

BEHAVIORAL HEALTH CALL CENTER

Overview of Services

- Toll free 24/7 call center available for screening and referral to Mental Health or Substance Use Treatment Services
- Staffing: mix of multilingual clinical staff (LMFT/LCSW, and Rehabilitation Counselors), and Clerical staff (Health Services Representatives and Office Specialists).
- Calls come in from the community, family members, EPS, hospital staff (both medical and psychiatric), Parents/guardians, law enforcement, and conservators.

How to Access 1-800-704-0900

- BHSD Call Center services
  - Crisis and Suicide Prevention Lifeline
  - Referrals to Specialty MH or DMC/ODS services
  - Assisted Outpatient Treatment (AOT) services (AKA Laura's Law)
  - Navigation Services
  - Connection to Quality Improvement for Grievances and Appeals
  - Mobile Crisis and response Team (MCRT) connection
  - Screening and referrals to SUTS outpatient services and SUTS residential services
  - Medication Assisted Treatment referrals
  - Detox referrals

Performance Tracking

FY23	Service Level	ASA	Calls Offered	Calls Answered	Abandoned Rate/#of Calls	AVG Abandoned Delay	ATT
July 2022	68%	9:26	2556	1726	32.47%/830	11:41	10:52
Aug 2022	80%	5:46	2215	1773	19%/442	9:49	10:04
Sept 2022	77%	7:14	2156	1664	20%/435	11:46	11:05
Oct 2022	70%	8:57	2393	1666	27%/647	12:28	11:05
Nov 2022	80%	5:24	2108	1677	17%/372	10:00	9:58
Dec 2022	81%	4:24	1870	1522	16.84%/315	10:04	10:21
Jan 2023	85%	3:46	2306	1949	13.23%/305	8:56	9:57
Feb 2023	84%	4:18	2320	1943	13.53%/314	7:28	9:56
Mar 2023	77%	6:05	2845	2204	19.61%/558	11:42	10:49
Apr 2023	74%	6:13	2359	1752	23.27%/549	11:20	8:31
May 2023	76%	5:02	2762	2107	19.15%/529	10:51	9:04
Jun 2023	81%	2:20	2234	1808	23.5%/426	7:43	10:12

Successes

- **Successful integration of MH and SUTS line of business**
  - All agents cross-trained
  - Reduced the phone tree size and complexity
  - Progress regarding wait/hold times

Challenges

- **Staffing Coverage**
  - Currently staffed for 8-5 M-F operations and using on-call for afterhours and weekends
  - Finding staff to volunteer to take weekend/evening shifts
  - Covering breaks and lunches, which occur at the busiest times is a challenge
- **Training**
  - Post integration, longer time required for training on MH and SUTS calls
  - Training staff takes existing staff off the lines

COUNTY OF SANTA CLARA
Behavioral Health Services

TRUST PROGRAM

TRUSTED RESPONSE URGENT SUPPORT TEAM

COUNTY OF SANTA CLARA Behavioral Health Services

Trusted Response Urgent Support Team (TRUST) Program Development

2020: Stakeholder Leadership Committee (SLC) stakeholders proposed **INN 15: The Community Mobile Response (CMR) Program**

2021: TRUST approved for a 4.5 year Innovation project

2022: TRUST Services Launch in November

2023: TRUST Fully Operational 24/7; West Valley Expansion Request

TRUST

COUNTY OF SANTA CLARA Behavioral Health Services

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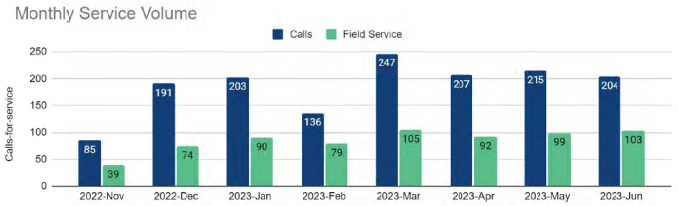
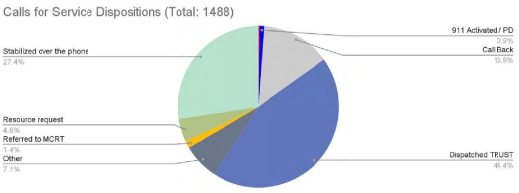
NUMBERS SERVED

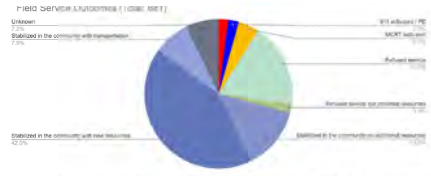
November 2022 – June 30, 2023
1,488 Total Calls



*Note: This is preliminary data and may not reflect what is included in the final MHSA report.

TRUST DATA CONT.





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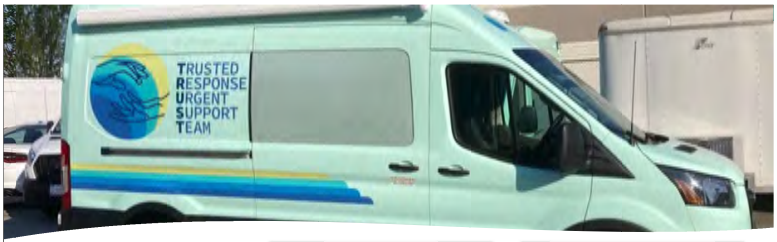


TRUST CHALLENGES & ACCOMPLISHMENTS

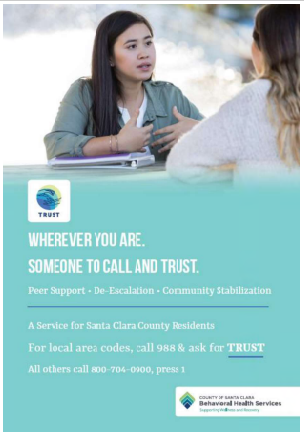
Challenges	Accomplishments
• Staffing to full capacity • Data Collection and Assessment • Vehicles	• All teams operating 24/7 • West Valley Expansion • Vehicles Completed • Marketing Launch

TRUST SUCCESS STORY

During an encampment clean up, a law enforcement officer came across an unhoused individual who needed assistance, prompting a call to TRUST. A TRUST field team arrived within 20 minutes of being dispatched, and was able to have a conversation with the client and the officers that were present.

The TRUST team explained the services available and developed a safety plan to support the client. TRUST was able to transport the client and their belongings to a safe place. The officer was surprised at the team's ability to swiftly find an appropriate location for transportation, as well as assist with transporting their items.

The officer shared their interaction with the Law Enforcement Capitan who has made it a goal to spread knowledge of TRUST services as a resource to other officers.



COUNTY OF SANTA CLARA
Behavioral Health Services

PERT & PEER LINKAGE EVALUATION PROGRAM

PSYCHIATRIC EMERGENCY RESPONSE TEAM (PERT)

- A licensed behavioral health clinician and law enforcement (LE) officer work in close collaboration to respond to mental health crises.
- Clinician and LE partner conduct assessments, de-escalate crises in the field, and offer resources, safety planning, and follow-up services as needed. Supports family with informing them of the AB 1424 form.
- Team is dispatched via 911 to the highest acuity behavioral health crises. Officer is dressed down/plain clothes and uses an unmarked vehicle.
- Jurisdictions: 2 teams in Unincorporated Santa Clara County (Sheriff's Office), Palo Alto PD, San Jose PD, Morgan Hill PD
- *Unable to offer Peer Support however, program is open to including this position to the team.

PROGRAM GOALS

Assist clients in need with immediate behavioral health services, de-escalate crisis situations, provide the best quality of crisis care, and connect clients to appropriate referrals, resources, and services. The overarching goals of the PERT and Peer Linkage program are to:

1. Increase access to and use of mental health services, particularly for transitional age youth, by connecting individuals to peer support services after crisis episodes to assist with their recovery.
2. Reduce stigma for clients in crisis by having law enforcement and clinicians respond to incidents in plain clothes and unmarked vehicles.
3. Promote help-seeking behavior by individuals, families, and the community.
4. Improve law enforcement officers' knowledge, attitudes, and behaviors in response to mental health issues.
5. Improve outcomes for clients using crisis services, including reduced hospitalizations and incarcerations.

PERT DATA FY 2020-2021 THROUGH FY 2122-2023

2,398 Total Number of PERT Incidents

14 min Average PERT Response Time

46 min Average PERT Encounter Time

Table 1. Total PERT Incidents by Team and Incident Source, FY 20-23 (N=2,397)

Incident Source	Sheriff's Office	Palo Alto	San Jose	Morgan Hill	Total
Follow-ups	599	146	66	29	840
Dispatch Calls for Service	276	217	157	104	754
Consultations	433	47	32	14	526
Referrals	189	35	10	41	275
Critical Incidents	2	0	0	0	2
Total	1,499	445	266	188	2,397

Note. San Jose PERT had one additional PERT incident whose incident source was unknown; this incident is not reflected in Table 1.

PERT DATA FY 2020-2021 THROUGH FY 2122-2023 CONTINUED

Table 2. Frequency of PERT Incidents by Client Age, FY 20-23 (N=1,141)

Client Age Group	All PERTS	Sheriff's Office	Palo Alto	San Jose	Morgan Hill
Children/Youth (0-15)	7%	10%	6%	5%	3%
Transition Age Youth (16-25)	16%	21%	13%	11%	13%
Adult (26-59)	50%	55%	43%	50%	43%
Older Adult (60+)	19%	11%	20%	27%	28%
Unknown/Declined	9%	4%	17%	7%	13%

Note percentages may not precisely total 100% due to rounding.

SUCCESSES

- The BHSD project team played an integral role in the implementation of PERT and overcame many initial and ongoing challenges.
- The Santa Clara County PERTs have built strong agency relationships that are viewed as foundational to the PERT model's success.
- Relationship-building among PERT staff is viewed as crucial in fostering the partnership and trust necessary for successful crisis co-response.
- By broadening crisis response, SCC PERT's approach is seen as the future of policing and has garnered wide-ranging attention and support.
- Created a culture shift amongst officers.

CHALLENGES AND LESSONS LEARNED

- BHSD faced significant initial and ongoing barriers to establishing the Peer Linkage component of the PERT program.
- In response to the absence of a Peer Linkage component, PERT clinicians took on additional roles originally reserved for peer support staff, including data collection and incident follow-ups.
- The absence of the Peer Linkage component also offered lessons learned for PERT staff as it pertains to role clarity and capacity.
- Regional differences complicate efforts to standardize PERT across departments.

PERT PROGRAM SUSTAINED

As a result of the success of the program and PERT's goals, including increasing access to and use of mental health services and promoting help-seeking behaviors with the goal of preventing or minimizing future crises, 8 clinicians have been approved by the BOS to continue the program. Additionally, some cities and university police departments did seek out and obtain alternative funding sources to continue PERT operations independently within their own jurisdictions. Cities and University BHSD is working with are: San Jose PD, Palo Alto PD, Santa Clara PD, San Jose State University PD, and Campbell PD.

COUNTY OF SANTA CLARA
Behavioral Health Services

LAW ENFORCEMENT LIAISONS

LAW ENFORCEMENT LIAISON (LEL) TEAM

- The mission is to enhance teamwork, training, discussion, and collaboration with law enforcement agencies throughout the County.
- Provide specialized training to police officers to improve their responses to a person with a mental health issue.
- The goal of the LEL Team is to provide police officers and first responders with the support and tools they need to improve their responses to someone experiencing a mental health crisis.
- The training is meant to provide law enforcement departments, fire departments and EMS Staff with information so they can help residents get the mental health services and support they need.

PROGRAM GOALS, OBJECTIVES & OUTCOMES

- Increase collaboration and enhance teamwork between law enforcement, other first responders and Behavioral Health Care Services.
- Increase the ability to interact more effectively and safely with those experiencing a mental health related crisis.
- Connect individuals experiencing mental health crisis to appropriate services.
- Trauma-Informed Policing
- Interactive Video Simulation Training (IVST)
- Mobile Response to a Crisis (De-escalation)

CLIENTS SERVED

FY 2022-2023 Unduplicated N =1167
Number Served
1167

87

COUNTY OF SANTA CLARA Behavioral Health Services

SURVEY RESULTS FY 23

Quality of the Information provided: 99%

Quality of the debriefing & discussion post exercises: 99%

Exercises reflected real field situations: 96%

Student knowledge of de-escalation techniques: 96% *Pre class 58%

Student recognitions of signs & symptoms of mental illness:99% *Pre class 69%

Student recognition of Dual Diagnosis signs and symptoms: 81% *Pre class 45%

SUCCESSES:

- Filming **ten** new IVST Scenarios that include LGBTQ+ situations, Multi-lingual situations and other realistic and contemporary situations.
- LELs have become a source to contact when other methods of connecting with BHSD may be lacking or falling through the cracks.
- LELs received **525** direct referrals and consultations

88

COUNTY OF SANTA CLARA Behavioral Health Services

COUNTY OF SANTA CLARA
Behavioral Health Services

IN HOME OUTREACH TEAM (IHOT) PROGRAM

In Home Outreach Team (IHOT)

- **Program Description**: The IHOT program is designed to provide intensive outreach and engagement, mental health screening, in-home intervention, family education, and support and linkage to treatment for individuals who are not voluntarily engaging in services and connect them with ongoing mental health treatment.

- **Objectives & Goals**: Reduce the number of repeat Emergency Psychiatric Services (EPS), Emergency Dept, Jail, Mobile Crisis Team and Law Enforcement visits for individuals that are not connected to behavioral health and substance treatment services. Outreach to and engage with individuals that have been resistant to care in the past and successfully link them to ongoing behavioral health services.

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

Demographic Information & Numbers Served

FY22-23 Total individuals served=373

Age Group	Numbers Served
16-25	35
26-59	305
60+	33
Total	373

Residential Status	Numbers Served
Unhoused/Transient	170
Housed	169
Unknown	34
Total	373

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

Program Outcomes

Outcome 1: Targeted outreach and engagement would meet people "where they're at" and facilitate connection to the appropriate level of services per consumer.

- The IHOT program increased their ability to connect with individuals in the community, in custody, at court dates or at the hospital by improving tracking of individuals in hospital or custody settings, outreaching to known locations/support systems and relying on support from community agencies i.e., MCRT, TRUST and Law Enforcement. IHOT staff increased ability to appropriately screen individuals for services needed and connect individuals to appropriate resources and behavioral health services using a centralized IHOT email address to screen referrals and support from Call Center staff.

Outcome 2: Utilization of higher cost services will decrease as utilization of more cost effective and levels of care that appropriately meet consumers' needs will increase.

- IHOT teams were able to connect 100 of 373 referred individuals to either community based or County behavioral health services which decreased these individuals visits to higher cost services i.e., EPS, ED, County Jail.
- During fiscal year 2022-2023, the IHOT program was able to increase the number of individuals connected with ongoing behavioral health services from 55 in FY2021-2022 to 100 in FY2022-2023.

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

Challenges

- The biggest barrier and challenge that has been faced by the IHOT programs are locating and connecting with referred individuals. Oftentimes, due to the individual's housing status, it has been challenging for the IHOT staff to contact referred individuals due to their phone numbers, addresses or locations changing since referral was made.

- The IHOT teams make every effort to outreach to referred individuals by attempting to locate individual at address provided, contacting phone number(s) provided and attempting to locate individual at hospitals, jail, court dates, community locations/programs or homeless encampments. Multiple attempts are made to locate and connect with referred individuals before referrals are closed out.

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Success Story

The Bill Wilson Center IHOT team was able to outreach to and engage with one of their older adult clients that was homeless in San Jose. Several of these engagement efforts were joint visits with MCRT and Law Enforcement. Bill Wilson Center, with assistance from Law Enforcement and the County IHOT team, were able to contact this individual's family that lived in Sacramento and reconnect individual with her extended family. The client's family was able to provide some emotional support and financial support to client and temporarily housed this individual. The Bill Wilson Center IHOT team was able to connect this individual to behavioral health services in Santa Clara County.

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

COUNTY OF SANTA CLARA
Behavioral Health Services

SUICIDE PREVENTION PROGRAM

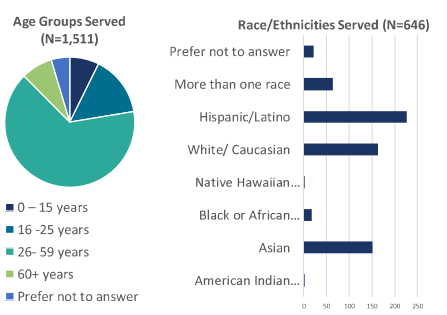
SUICIDE PREVENTION PROGRAM

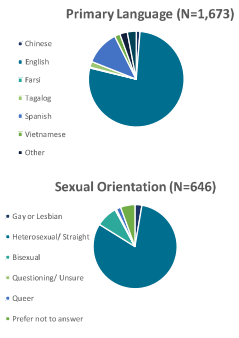
FY23 Number Served (duplicated)

1,191,200

**Est. reach of 988 and SP campaigns = 1,181,257*

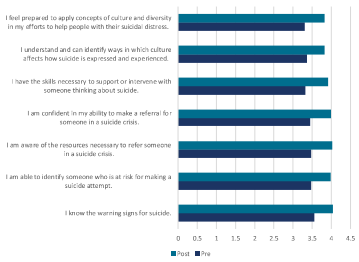
**Remaining served = 9,943*





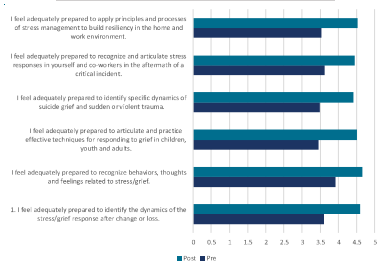
Sample Program Outcomes: Trainings

Community Helper Trainings (pre N=452-454; post N=293-295)



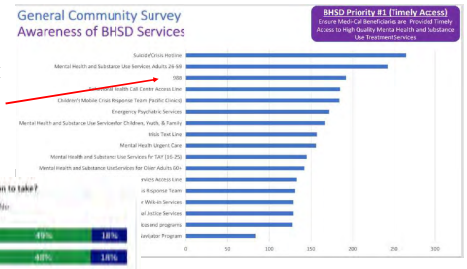
Measuring Suicide Prevention-Related Competencies: Pre-Post Training Differences in Overall Mean Score (7 items);
Scores: 1=Strongly Disagree, 5=Strongly Agree

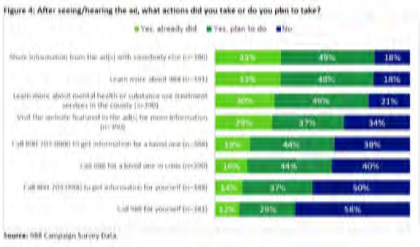
Critical Incident Stress Management Trainings (N=34)



Change in Self-Report of Grief Response Preparedness for CISM trainings: Pre-Post Training Differences in Overall Mean Score (6 items);
Scores: 1=Strongly Disagree, 5=Strongly Agree

Sample Program Outcomes: Public Awareness Campaigns

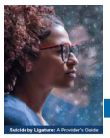


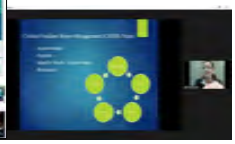


Source: 988 Campaign Survey Data

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Successes





Challenges

- **Staffing + maintenance of programming**
  - Since Jan 2021, SP Manager role filled for 4 months
  - 1 of 2 Prevention Program Analyst codes cut
  - Currently 2 full-time SP staff
- **High 2022 suicide count**
  - Rising rate among Latinx/e population
- **Continuous improvement in data/evaluation efforts**
  - Logic model/evaluation merge with Substance Use Prevention

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

COUNTY OF SANTA CLARA
Behavioral Health Services

NAVIGATOR PROGRAM

BH Navigator Program

- **Program Description**

The peer run BH Navigator program helps connect individuals and families to County and community resources, and guide them through the behavioral health system, ensuring that all community members have access to accurate and relevant information, linkage to services, and partnership navigating various support opportunities.

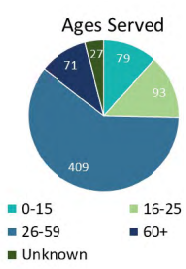
- **Objectives and Goals**

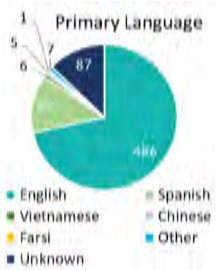
The BH Navigator Program launched in July 2022 to connect individuals and families to County, County-contracted, and community-based services, and when appropriate, even identifies private resources and helps guide the public through the mental health system. The goal is to connect residents with the resources that best fit their needs.

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

DEMOGRAPHIC INFORMATION & NUMBERS SERVED

FY22-23 Total individuals served= 7,750
Demographics collected = 679





COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

DEMOGRAPHIC INFORMATION & NUMBERS SERVED

- Age Ranges 0-15: 79, 16-25: 93, 26-59: 409, 60+: 71, Unknown 27
- Race: American Indian/Alaska Native: 5, Asian (Cambodian, Chinese, Filipino, Indian, Japanese, Korean, Pakistani, Vietnamese and Other): 52, Black or African American: 30, White/Caucasian (Middle Eastern): 159, Other: 273, Prefer not to answer: 3, Unknown: 157
- Ethnicity: Caribbean: 2; Central American: 113; European: 1; Hispanic/Latino (undefined): 11; Other Hispanic/Latino: 151; Other Non-Hispanic/Non-Latino: 224; Prefer not to answer: 5; South American: 2; Unknown 170.
- Gender (Assigned at Birth/Current): Male: 332, Female: 344, Unknown: 3
- Sexual Orientation: Gay or Lesbian: 4, Heterosexual/Straight: 151, Bisexual, 4, another sexual orientation: 4, prefer not to answer: 77, Unknown: 439
- Primary Language English: 486, Spanish: 87, Vietnamese: 6, Chinese: 5, Farsi: 1, Other 7, Unknown: 87).
- Military Status: Veteran: 1, No Military: 86, Unknown: 592
- Disability Status: Difficulty hearing or speaking: 1, Other communication disability: 6, Physical/Mobility: 1, Other non-communication disability: 164, No Disability: 68, Unknown: 439

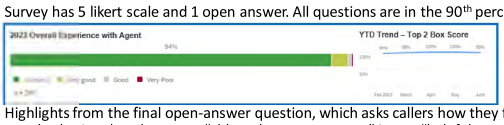
FY22-23 Total individuals served= 679

COUNTY OF SANTA CLARA Behavioral Health Services

PROGRAM OUTCOMES

The BH Navigator Program used a Qualtrics IVR Survey to obtain Customer Satisfaction starting in February 2023 through present.

- First 6 months of surveys = 462 Surveys
- Survey has 5 likert scale and 1 open answer. All questions are in the 90th percentile of Top 2 Box scores



- Highlights from the final open-answer question, which asks callers how they feel about the call, include people sharing that they were "able to locate resources," it was "helpful to understand what options exist," and that the agents were "clear and concise" and "patient, helpful, and supportive."
- Dozens of answers expressed appreciation for the help provided for getting the information and clarification they were looking for, and callers shared feeling "prepared," "relieved," "a huge relief," and "really grateful."

COUNTY OF SANTA CLARA Behavioral Health Services

SUCCESSES

The BH Navigator Program functions as a call center; however, we have been working on implementing in-person peer support services throughout Santa Clara County.

- In person services launched in June 2023 with other community service providers at the Los Gatos Public Library, West Valley Community Services - Cupertino, Community Services Agency – Mountain View, Sunnyvale Community Services, and Peninsula Healthcare Connection at the Palo Alto Superior Courthouse; and the Milpitas Library started the first week of September.
- This service modality offers increased access to services for individuals who are better supported in in-person and in their community, rather than by phone or email, including individuals who are unhoused in the locations served. Peer Navigators are at each of the new partnership sites once a week for half a day.
- Kaiser Foundation Grant funds Outreach Activities. BHSD has outreached to 1,024 community members and 47 providers throughout Santa Clara County and is in the process of creating three video advertisements to enhance outreach efforts. Grant was renewed for a second year!

COUNTY OF SANTA CLARA Behavioral Health Services

CHALLENGES

- Difficult finding partners in the South County region due to limited confidential spacing; however, we are now in the planning phase with the Morgan Hill Unified School District.
- Still finalizing partnerships with community-based providers in the East San Jose area.
- Outreach challenges: Kaiser grant funds a half time position, so there are some challenges in this area due to scheduling conflicts and finding events taking place at the specific locations outlined in our grant.

COUNTY OF SANTA CLARA Behavioral Health Services

COUNTY OF SANTA CLARA
Behavioral Health Services

2SLGBTQIA+ WELLNESS PROGRAMS
PEI Programs:
THE Q CORNER &
CAMINAR'S LGBTQ WELLNESS

2SLGBTQIA+ PEI WELLNESS PROGRAMS:

The Q Corner & Caminar's LGBTQ Wellness

- Program Description:
  Peer driven support for 2SLGBTQIA+ Community Members in Santa Clara County to have access to welcoming, affirming, knowledgeable, and competent behavioral health services and community resources.
- Objectives:
  Address disparities in access and connectedness to safe, competent behavioral health resources and services and decrease the impacts of social isolation and other mental health challenges for 2SLGBTQIA+ adults in Santa Clara County through outreach initiatives, one on one and group peer support, community engagement activities, and linkage to safe, appropriate resources, along with capacity building efforts such as trainings, resource development, and consultation.

COUNTY OF SANTA CLARA Behavioral Health Services

2SLGBTQIA+ PEI WELLNESS PROGRAM GOALS

Goals:

- Diversify and multiply the reach of all 2SLGBTQIA+ Wellness Services across Geographical regions, Language needs, and Intersectional cultural identities (ie. across race/ethnicity)
- Increase Direct Clinical (through collaboration and colocation with the Gender Affirming Care Clinic) and Peer Support Services to 2SLGBTQIA+ Community Members, including specialized gender affirming care services for trans, nonbinary, and gender expansive folks
- Offer comprehensive menu of Supports and Services to Families/Caretakers and Schools supporting 2SLGBTQIA+ Youth including transgender, nonbinary, and gender expansive children, youth, and young adults
- Increase access and linkage to improved services through intensive collaboration with system partners across mental health, substance use, suicide and crisis prevention and response, health services, housing, criminal justice, etc.
- Establish systemwide Baseline Competency for 2SLGBTQIA+ knowledgeable, welcoming, and affirming environments and supports through foundational Training and Technical Assistance
- Expand Network of Specialized Services, including Behavioral Health Services through a community of practice of dedicated and individualized Training and Consultation staff and supports
- Improve Efficacy and Quality of System through implementation of culturally responsive SOGI Data Collection and Administrative and Clinical Best Practice Recommendations.

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

Demographics and Numbers Served

- Ages: About 75% of folks at 26-59, 15% are 16-25, 5% are 60+
- SOGI: The program serves folks of all gender identities and sexual orientations, with a focus on reaching community members in the 2SLGBTQIA+ community and all kinds of service providers
- Other demographics: The program services folks of all races, ethnicities, abilities living situations, and languages 5% Spanish speaking, but anticipate that growing with new Spanish speaking team).

FY 22-23 Total individuals served

The Q Corner Peer Support = 15,105

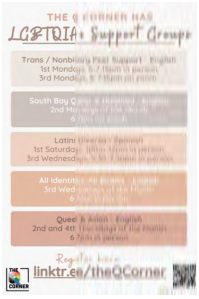
The Q Corner Trainings = 1,633

Caminar LGBTQ Wellness = 3,290

FY 22-23 Total individuals served = 20,028

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

Program Outcomes



Outcome 1:
Increase and diversity support to all 2SLGBTQIA+ individuals across Geographical regions, Language needs, and Intersectional cultural identities (ie. across race/ethnicity), through collaboration with clinical services (the Gender Affirming Care Clinic), to Families/Caretakers and Schools supporting 2SLGBTQIA+ Youth, through intensive collaboration with system partners across mental health, substance use, suicide and crisis prevention and response, health services, housing, criminal justice, etc.

- 5 Support groups and many activities (hiking, DND, holiday gatherings)
- Over 150 gender affirming garment and print resource orders were fulfilled
- Over 150 community events were attend
  - 5000+ connections through events
- 5000+ connections through social media
- Collaboration with the new Harm ReduQion Team
- Planning for School and Family supports began
- Resources expanded in Spanish and Vietnamese languages

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

Program Outcomes

Outcome 2:
Establish systemwide Baseline Competency for 2SLGBTQIA+ knowledgeable, welcoming, and affirming environments, expand specialized services for 2SLGBTQIA+ folks, and improve efficacy and quality of services through foundational and advanced Training and Technical Assistance, Consultation and supports, and the implementation of culturally responsive best practices and protocols.

- Over 80 trainings were conducted in FY23
- Over 20 different types of trainings were offered (which includes many new offerings)
- Participants from all County and community systems of care and services participated, including BHSD, the health system, social services, criminal justice, housing services, educational professionals, and so much more.
- Trans Care Coalition best practice recommendations are widely available and utilized.

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

Successes

Quotes on Overall Services:

- "I have trained on quality care for LGBTQ children, youth and families in all of the states and in many other countries. The leadership BHSD's LGBTQ Services have demonstrated in building comprehensive services for LGBTQ populations and, in particular, with transgender and gender expansive individuals, is unsurpassed."

Quotes on Peer Support:

- "Thank you for being there for the community. I love coming in and seeing the welcoming faces and colorful decor. I'm happy to show my son that there is a place where he can always come and be accepted for who he is."
- "You have helped us to understand that we are not alone. We honestly have felt so alone in our struggles. I felt very seen and heard and affirmed on so many levels"
- "I think this experience will be life changing for me. With the right affirmations and tools, so much is possible"

Quotes on Trainings:

- "The students were so appreciative of the knowledge and information you provided. Thank you for being so open and kind to students who are learning more about how to support the LGBTQ+ community as they grow professionally. I think your friendly disposition put many at ease to have discussions after your presentation. We had some really great discussion points afterwards and it was great to hear students being open and vulnerable."
- "I thought that it was very powerful, and I had a number of students come and talk to me today about how they want to continue that conversation and spread the message that you shared with other students on campus. I also plan on taking a lot of what you shared in my trainings with staff and faculty. So, thank you! We greatly appreciate the time, energy, humor, and wisdom that you shared with us."

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

Challenges

- We continue to need the additional positions that were approved in last year's MHSA 3 year planned but deferred for FY25 implementation. These positions will allow us to continue to meet the diverse language, cultural, and geographic needs across our County.

- We continue to need to move into a space that accommodates the needs of our services, so that community members have a place that they can come to connect with staff and one another, where we can host wellness activities and groups, and where we can provide a holistic range of wellness services to clients participating in clinical behavioral health services through the GACC.
- Due to the time it takes to hire, the Spanish speaking Family Support Team just got into place at the end of FY23, so FY24 will see much expansion in these services.

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

COUNTY OF SANTA CLARA
Behavioral Health Services

GENDER AFFIRMING CARE CLINIC (GACC)

2SLGBTQIA+ CSS Wellness Programs:
Gender Affirming Care Clinic (GACC)

Program Description:
To provide specialty gender affirming outpatient Behavioral Health Services to transgender and gender diverse community members ages 5 and older. This clinic exists because of the significant mental health disparities faced by the TGD community and ongoing difficulty accessing quality, gender affirming care.

Population Served:
- TGD community members, ages 5+
- Insurance: Medi-Cal, community members with no insurance

MHSA Survey & Community Conversation Findings:
- ❑ Treatment Services Rec #1: focus on high-need populations, including LGBTQ+ clients
- ❑ Additional Treatment Services Rec: expand availability of LGBTQ+ services, specifically physical spaces and TGI sanctuary efforts

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

2SLGBTQIA+ CSS Wellness Programs:
Gender Affirming Care Clinic (GACC)

Program Goals:

1. Expand access to specialty mental health services for transgender and gender diverse individuals through direct services provided at the Gender Affirming Care Clinic.

2. Increase comprehensive supports available to families of transgender and gender diverse children, youth, and young adults through collateral work at the Clinic.

3. Increase collaboration with other County and County contracted mental health providers to improve experience of all Transgender and gender diverse clients throughout all behavioral health services.

4. Increased collaboration with system partners across other service systems (ie. suicide and crisis prevention and response, health services, housing, criminal justice, etc.) to improve access and linkage to affirming services.

5. Establish community wide Baseline Competency for trans knowledgeable, welcoming, and affirming environments and supports through community-based education and subject matter expertise.

6. Expand Network of Specialized Services, including Behavioral Health Services through a community of practice of dedicated and individualized training and consultation supports

7. Improve workflows for patients navigating changes in levels of care to ensure all clients are paired with trans competent providers at all services (beyond only Clinic)

8. Reduce behavioral health disparities experienced by population, including feelings of isolation, thoughts of suicide, suicide attempts, disabling mental health challenges, and need for higher level of care interventions.

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

2SLGBTQIA+ CSS Wellness Programs:
Gender Affirming Care Clinic (GACC)

GACC Services (for enrolled participants):

- Screening, Intake, and Assessment for Specialty Mental Health Services
- Behavioral Health Counseling: Individual, Groups, Family system
- Specialized gender affirmative care
- Letters of Support for gender affirming medical intervention
- Peer Support connected to Treatment Goals
- Targeted Case Management
- Psychiatry
- Psychoeducation: providing resources on gender diversity including social affirmation, legal affirmation, medical affirmation, and more
- Connection to all Q Corner, LGBTQ Wellness, and other community services to provide holistic care

Services available both in person and telehealth

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

GACC: Successes

- Program structure and clinical operating systems have been identified and developed
- Completed full design of space and furniture in partnership with Facilities team and Pivot Design Firm
- GACC program EHR system has been developed in collaboration with TSS and is ready for intake, documentation and billing
- Medi-Cal Site Certification completed, GACC opened for telehealth services on September 5th, 2023
- All positions approved by the board of supervisors have been successfully filled:
  - ✓ Program Manager (hired October 31st, 20220)
  - ✓ 1 Mental Health Peer Support Worker, hired July 2023)
  - ✓ 1 Clinician (hired July 2023)
  - ✓ Clinical Supervisor (hired August 2023)

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

GACC: Challenges

- We continue to need the additional 7 positions that were slated for the clinic and have not yet been submitted to the board for approval. These positions will support the overall operation of the GACC services, including individual, group and family therapy, psychiatry (medication management), clerical services, and peer support services.
  - ✓ 2 Clinicians
  - ✓ 1 Mental Health Peer Support Worker
  - ✓ 1 Psychiatrist
  - ✓ 1 Psych Tech
  - ✓ 2 Health Services Representatives
- We continue to need to move into a space that will accommodate our services. We have been working towards building out a physical location including renovations and full design of both clinical and drop-in spaces. There have been a few hurdles along the way but we are poised to complete the design portion and move into the space when we are cleared to do so, so that we can offer in-person services to clients contracted with the clinic.

COUNTY OF SANTA CLARA Behavioral Health Services Supporting Wellness and Recovery

Mental Health Services Act (MHSA)

WORKFORCE EDUCATION & TRAINING (WET) Annual Update FY23

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Declaration Of Mental Health And Substance Use As A Public Health Crisis In Santa Clara County

- January 2022 Board of Supervisors: Ellenberg and Lee
- Substantial workforce shortages exist today for behavioral health workers, especially in publicly-funded systems, and forecasts indicate significant future shortages. These nationwide trends that are particularly pernicious in Santa Clara County, are worsening, and disproportionately exclude ethnic, racial, and economically marginalized groups.

Declaration Of Mental Health And Substance Use As A Public Health Crisis In Santa Clara County

Work collaboratively with the Behavioral Health Contractors' Association, high schools, community colleges, universities, student groups, providers and other stakeholders to develop and fund short-term and long-term workforce strategies to meet local demand by the County and community behavioral health providers that is prepared to provide timely and effective care to residents by a behavioral health workforce that represents the diversity of our County.

Declaration Of Mental Health And Substance Use As A Public Health Crisis In Santa Clara County

- This should include strategies to address wage parity across publicly-funded, school and commercial care providers, expanding access to workforce development and training opportunities for students, and other innovative workforce development approaches that remove barriers to developing a diverse, non-traditional practitioner pool and workforce.

WET Purpose

We strive to increase the capacity of a well-trained workforce that represents the community that we serve. It is critical to have a diverse workforce that includes consumers, family members, licensed professionals and others who share similar cultural perspectives and languages to provide client driven, recovery-oriented and strength-based behavioral health services.

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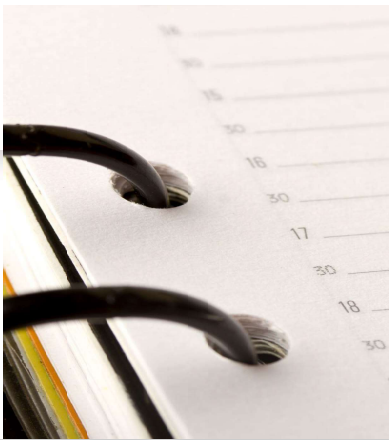
WET PRIORITIES

- Develop & maintain well-trained workforce
- Trainings that promote equity for unserved and underserved populations
- Trainings that support recovery orientation across all programs
- Evidence-based approaches to maximize improvements in health
- Address workforce shortages
- Peer Certification Program
- Develop & maintain retention strategies



WET PROGRAMS

- TRAININGS
- WORKFORCE DEVELOPMENT COMMITTEE
- LOAN REPAYMENT PROGRAM
- WORKFORCE TUITION PROGRAM
- SCHOLARSHIPS
- STUDENT INTERNS
- PEER INTERNS

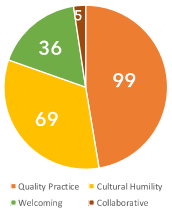
WET Training Programs

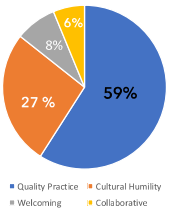
FIVE (5) YEAR TRENDS

5 Year Summary	FY 19	FY 20	FY 21	FY 22	FY 23
Number of Trainings Provided	152	84	140	144	209
Number Attended	4861	2886	4927	4127	6322

Training Data FY 23

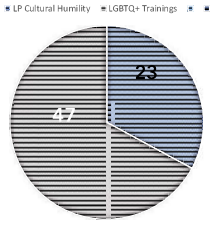
Number of Trainings		Number of Training Participants	
Quality Practice	99	Quality Practice	3733
Cultural Humility	69	Cultural Humility	1683
Welcoming	36	Welcoming	515
Collaborative	5	Collaborative	391

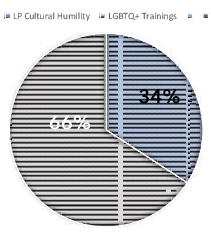




Cultural Humility & LGBTQ+ Trainings

Total Number of Trainings			Number of Training Participants	
LP Cultural Humility	23		LP Cultural Humility	575
LGBTQ+	47		LGBTQ+	1108





Overall Top 10 Trainings FY23

1. Cultural Humility Trainings
2. CPT Code Training
3. Co-Occurring Trainings
4. Trauma Informed Services 101
5. 5150 Trainings
6. Reflective Practice
7. Law & Ethics
8. Client Culture
9. Motivational Interviewing
10. NAMI

Co-Occurring Trainings

Informed Level

Foundation level that identifies core skills for treatment support.

Status: Trainings are available in sccLearn for County & CCP staff to attend for their Informed certification.

Capable Level

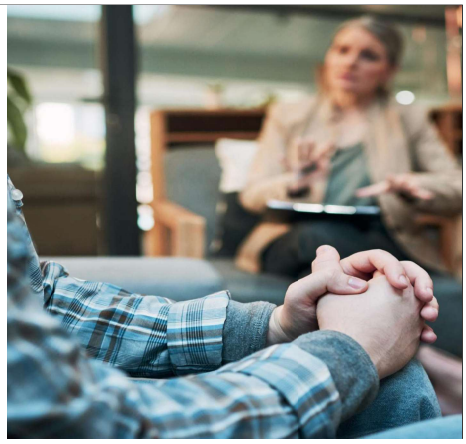
Next level training that provides an integrated assessment and treatment for mild to moderate co-occurring disorders.

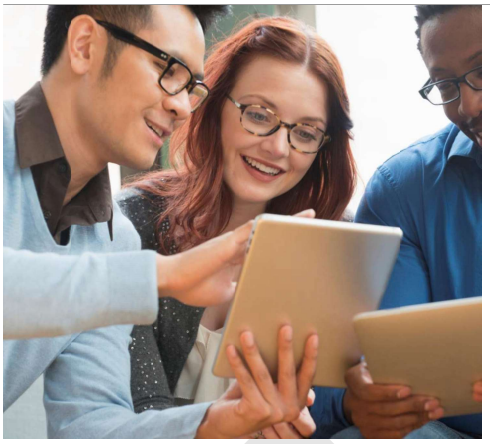
Status: Capable Level trainings available for County & CCP to attend. San Jose City College professors are the primary instructors. Certification in sccLearn will go live in October/November.

Enhanced Level

Highest level of training for integrated treatments for moderate to severe co-occurring disorders.

Status: Pending development upon the completion of the Co-Occurring Capable certification program.





Peer Specialist Certification Training

- Peer Support Services
- Specialty Mental Health Services
- Drug Medi-Cal Organized Delivery System
- Crestwood provided 2 Trainings for Santa Clara County
- Approximately 30 peer support staff attended the 2-week in-person training

FY23 TRAINING SUCCESSES

Co-Occurring Disorder (COD) Trainings
Roughly 650 staff attended COD trainings that increased their knowledge and skills to work with clients with both Mental Health and Substance Use challenges.

Provided over 200 Trainings to approximately 6,300 workforce members

Hired Training Manager in May 2023

CPT Training
Provided CPT training to approximately 650 staff in May and June 2023

Workforce Development Committee Members

County Participants
- Program Manager II
- Program Manager III
- Psychiatric Social Worker II
- Associate Management Analyst
- Management Analyst
- IT Business Analyst

County Contracted Provider Members
- Alum Rock Counseling Center
- Community Solutions
- Family & Children Services, a division of Caminar
- Gardner Family Health Network
- HealthRIGHT 360
- Momentum for Health
- Rebekah Children's Services
- Stars Behavioral Health Group

Behavioral Health Contractor Association

Workforce Development Committee

Promotion of Public Behavioral Health	Recruitment	Staff Development & Retention
Conduct a Behavioral Health Profession Public Awareness Campaign • Provided information to over 200 High School students regarding working in the Behavioral Health systems. Of those 200 students, 148 wanted to learn more about behavioral health as a result. • Fostered development of behavioral health certificate programs at San Jose City, Mission and Gavilan Community Colleges • Planned to pilot a summer skill building course and internship program during summer 2023. • Secured funding for the Youth in Technology program to develop interactive marketing material and promotional videos.	**Increase the impact and scope of the Educational Loan Repayment and Workforce Tuition Programs** • Successfully awarded 150 workforce members to be in the Loan Repayment Program or Workforce Tuition Program **Increase the impact and scope of Student and Peer Internship Stipend Programs** • Additional slots for Students and Peers were added to the WET stipend program for both County and CCP programs. • County received funding for 6 new student interns and 1 new peer intern. CCP received WET funding for 28 new student interns and 14 new peer interns. • Participated in seven (7) career fairs and promotional events. • Hosted a virtual behavioral health career fair with 26 local employers present.	Recommendations were made to BH Executive Team on how to **revise any County requirements** that exceed State requirements. Committee members continue to research and evaluate **trainings for Behavioral Health middle managers** Implemented a regional behavioral health **compensation survey** Workforce Analysis.

Loan Repayment and Workforce Tuition Programs

- Funding is available from the Department of Health Care Access and Information for 226 Behavioral Health workforce members (County & Contract Providers) to receive $10,000 per student/staff to help with either tuition or loan repayment costs in exchange for a 24-month work commitment.
- **Loan Repayment Program** provides funding to qualified staff working in a recognized hard-to-fill or hard-to-retain positions within the Behavioral Health system of care.
- **Workforce Tuition Program** provides funding for post-graduate clinical master and doctoral education for services performed in our Behavioral Health system of care. Approved students will be in their final year of education.

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Award Information

	Cohort 1	Cohort 2	Awarded
Loan Repayment Program	71	77	$1,480,000
Workforce Tuition Program	2	0	$20,000
Total	73	77	$1,500,000

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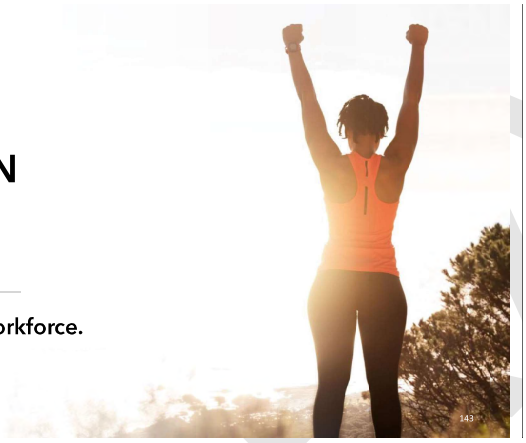
FY23 INTERN PROGRAM

Building the future workforce.



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INTERN PROGRAM OVERVIEW

- The Student Intern Program recruits local graduate-level clinical interns, and undergraduate level social work interns. We provide training and placement opportunities as well as career pathway into public behavioral health services.
- Student interns are provided with training and guidance to be highly employable. Many students apply and obtain employment within BHSD upon graduation.
- We also coordinate the development and implementation of peer support workers, and recruits peer interns.

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CURRENT AFFILIATED SCHOOLS

- **Master Social Work (MSW)**
  - San Jose State University - MSW
  - California State University Monterey - MSW
  - UC Berkeley – MSW
  - San Francisco State University MSW Program
- **Marriage Family Therapist (MFT) and Professional Clinical Counselor (PCC)**
  - San Jose State University – M.S. Clinical Mental Health
  - Santa Clara University – M.A. Counseling Psychology
  - Palo Alto University – M.A. Counseling
  - National University - M.A. Clinical Psychology
  - University of San Francisco - M.A. in Counseling Psychology
  - William Jessup University – M.A. in Counseling Psychology

COUNTY OF SANTA CLARA Behavioral Health Services

FY23 County Student Internship Placement

- **Children Youth and Family Clinics**
- **Adult Clinics**
- **Criminal Justice Involved Programs for youth and adult**
- **Crisis response program**

Stipend Criteria

Stipends are funded through the Workforce, Education and Training (WET) component of the Mental Health Service Act (MHSA)

WET supports the development of a public mental health workforce which can service the identified disparities in our community.

Stipends are available for 2nd year MSW/MFT/LPCC students as well as people with lived experience who meet eligibility criteria.

Stipends recipients are selected based on their background and ability to serve the diversity in our community.

Stipend recipients are expected to commit to one year of employment in the Santa Clara County public mental health field.

Stipend Rate Increases

Student Intern Rate

- Increased for both County and CCP's
- The hourly rate increased from $13.85 to $18.00.

Peer Intern Rate

- The hourly rate increased from $16.00 to $18.00 for CCP Peer Interns

Years	2019-2020	2020-2021	2021-2022	2022 - 2023
County Student Interns	16	16	NA	14
County Student Stipends	4	6	NA	10
Collaborative Student Interns	14	12	18	12
County Peers	1	1	1	3
Collaborative Peers	2	2	1	1
TOTALS	33	31	20	30

STIPEND RECIPIENTS

- Most of our Stipend recipients are bicultural and/or bilingual, and many are from diverse cultural background. We have been able to retain most of the stipend recipients in the Santa Clara County Public Behavioral Health System upon graduation.

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COUNTY STUDENT INTERN PROGRAM

- Fourteen (14) Student Interns for County programs
- Students are placed in the following divisions: Adult/Older Adult, Children Youth & Family, Forensic Diversion and Reintegration & Access and Unplanned Services
- Ten (10) are receiving Stipends with commitment to work for the BHSD or partner agencies upon graduation.
- Seven (7) Student Interns passed bilingual tests
  - Five (5) Spanish speaking student interns
  - One (1) Mandarin speaking student intern
  - One (1) Vietnamese speaking student intern

PEER INTERN PROGRAM

The mission of the Peer Intern Program is to provide training opportunities for consumers and family members so that they will successfully complete their internship training, develop knowledge, skills and self-care tools necessary to manage employment, stay healthy and obtain permanent employment in the behavioral health field.

Trainings include:

- Peer Support
- Group Facilitation
- Program Development
- Clerical/Computer Skills
- Community Outreach
- Information and Referral

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COUNTY PEER INTERN PROGRAM

- Three (3) new BHSD Programs were identified for Peer Intern Placement and the three Peer Interns were accepted to work in the respective programs.
- Successful outcomes for the three peer interns are indicated below:
  - Hired into a coded position,
  - Transitioned into a different BHSD position, and
  - Pursuing higher education in a related health field.

CCP STUDENT AND PEER INTERN PROGRAMS

- County Contract Providers (CCP) Student Intern Program
- Twelve (12) graduate level students (MSW/MFT/PCC) received stipends
- AACI (4 students), HOPE Services (3 students), Pacific Clinics (1 student), and Momentum (4 students).
- One (1) Peer Intern at Caminar
- First Peer Intern Collaborative Meeting was held on November 4, 2022 – to support CCP recruiting and hiring efforts to increase number of Peer Interns

INTERN COLLABORATIVE

- Monthly meetings
- Collaboration on internship program
- Promotion on careers in behavioral health
- Eligible for WET Stipends for student & peer interns

Current 10 County Contracted Programs

- Asian American for Community Involvement (AACI)
- Alum Rock Counseling Center
- Caminar
- Community Solutions
- Gardner Family Care Corporation
- Hope Services
- Momentum for Health
- Pacific Clinics
- Rebekah Children's Services
- Starlight Community Services

COUNTY OF SANTA CLARA Behavioral Health Services

Recruitment Strategies Increase More Intern Positions

County Intern Increase

- Number of Student Interns with stipend spots for BHSD increased from twelve (12) to eighteen (18)
- Number of Peer Intern stipend spots for BHSD increased from three (3) to four (4)

County Contract Provider Intern Increase

- Number of Student Intern stipend spots for CCP's increased from twenty (20) to forty-eight (48)
- Number of Peer Intern stipend spots for CCP's increased from ten (10) to twenty-four (24)

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Recruitment Challenges Continue

Despite Extra Intern Slots

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STUDENT INTERN SUCCESSES

Student Intern Program resumed in FY23 after a one-year pause.

Four (4) previous and experienced Intern Supervisors returned to continue supporting the Student Intern Program.

Recruited seven (7) new Intern Supervisors

STUDENT INTERN SUCCESSES

Three (3) new placement sites that included justice involved programs.

MH Diversion Program
BH Treatment Court
Narvaez Clinic

Virtual Open House and Fairs for Recruitment

50% of the Student Interns passed bilingual test in threshold languages (Spanish, Vietnamese & Chinese)

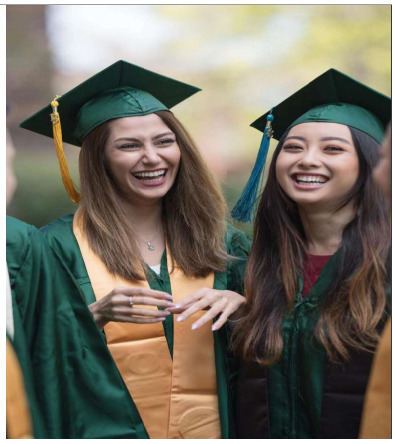
Hired 11 Student Interns

Positive Support for our Student Intern Program

My internship was such an enriched, supportive, and clinically challenging opportunity. I enjoyed everything about it. I am excited to be further engaging in this role as a clinician!

My internship was beyond what I could have imagined. I had a growth of learning because of all the staff that ensured I met my personal and clinical goals. My supervisor was the reason why I was able to grow so much as he was very dedicated to my learning and ensured I was always meeting the expectations of my internship duties.

I have had a wonderful experience at the SIP! It has been such a gift to be able to be a part of such an amazing internship opportunity! The amount of knowledge I have gained has been truly a gift. I had the privilege to work with seasoned clinicians and have learned so much.



PEER INTERN SUCCESSES

- Successful transition to a permanent position of the Peer Intern
- Identified three (3) new BHSD programs to host and train peer interns
- Collaboration with BHSD programs to recruit and hire peer interns
- Hired and successfully trained three (3) new peer interns

Scholarships

Increasing the number of scholarships for a total of 30 Bachelor Level students is paused.

We are maintaining 14 slots at SJSU.

SCHOLARSHIPS

- San Jose State University's (SJSU) Bachelor of Arts Social Work (BASW) program
- Requirements to volunteer in a Santa Clara County public behavioral health agency for 100 hours and receive sixteen (16) hours of seminar class on mental health topics at SJSU.
- Upon graduation, requirement to work for One calendar year (2080 hours) for a Santa Clara County public behavioral health system, or to pursue graduate study in a related field.
- Career pathways for bachelor's students.
- In FY23 due to staffing issues at SJSU, there was minimal promotion for the scholarships which is why the number of recipients are low.

ACADEMIC YEAR	NUMBER OF RECIPIENTS
2020-2021	10
2021-2022	14
2022-2023	3

COUNTY OF SANTA CLARA Behavioral Health Services

SCHOLARSHIP SUCCESSES

Collaborated with SJSU to identify flexible options for students to complete program requirements

Conducted Virtual Informational Session and Video Recording to promote interest

WET staff and the new SJSU Scholarship Coordinator are meeting on a bimonthly/monthly basis to collaborate and strategize on promoting the scholarships.

CAREER SUMMER INSTITUTE

- One-week-long summer program for high school students to learn about the public mental health services and employment in the mental health field to support workforce development
- Collaborating with Andrew Hill High School and the Intern Collaborative to create and coordinate the event
- In FY23, we had 23 High School students participate in this program

Comments from Andrew Hill High School Students

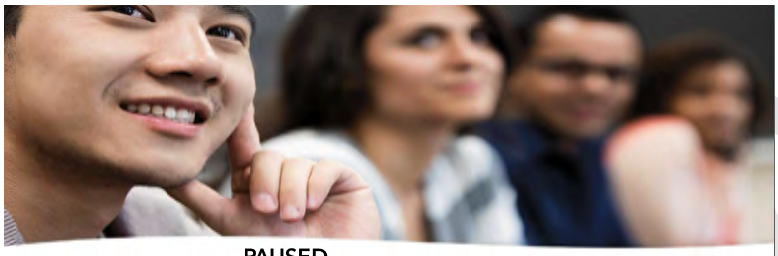
"I truly enjoyed this CSI Program this summer. It was very informing, especially to someone who's about to go to college and decide what part of the medical field they want to follow."

"Thank you for this amazing opportunity!!!"

"CSI is probably one of the most valuable field trips that I went to."

"I really liked the CSI program; this program is a very good way to learn about the health field no matter which career path or job you chose. Also, you will learn more about job opportunities."

"I had a lot of fun, thank you!."



PAUSED

Peer Mentoring for High School and Community College Students

Eight high school students to participate in 4-week summer program – Student Intern I

Sixteen community college students to participate in 6-week program – Student Intern II

Program Manager I – Oversee program development & implementation and provide support for Career Pathways program.

- Ambassadors
- Peer Mentors
- Engaging Young Adults

COUNTY OF SANTA CLARA Behavioral Health Services

Audio Visual Needs

Upgrade Audio Visual (AV) Equipment for Learning Partnership Trainings Rooms

Update: Specifications for the room upgrades were completed. Working with procurement specialist to secure vendor to update training rooms.

TRAINING TEAM PAUSED

2.0 FTE Program Manager I

2.0 FTE Training & Staff Development Specialists

Blended staffing model – both licensed and non-licensed staff

STUDENT INTERN III PAUSED

- Psychology
- Public Health
- Health Science
- Sociology

COUNTY OF SANTA CLARA Behavioral Health Services
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Thank you!

Jeannette Ferris, WET Coordinator
Program Manager III
Email: jeannette.ferris@hhs.sccgov.org

Chiaki Nomoto, Career Pathways
Program Manager II
Email: chiaki.nomoto@hhs.sccgov.org

Danielle Bone-Hayslett, Training
Program Manager II
Email: danielle.hayslett@hhs.sccgov.org

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

CLOSING REMARKS & NEXT STEPS

PLEASE TAKE A FEW MINUTES TO FILL IN THE SURVEY

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Public/Stakeholder Meetings/Activities*

MHSA FY2025 Annual Plan Update

Date	Meeting
October 4, 2023 1-4pm	Access & Unplanned + Workforce Education & Training (WET) data SSA Auditorium (333 W. Julian St.)
October 11, 2023 1-4pm	Children, Youth & Families (CYF) Data Charcot Training Rooms 1 & 2 (2310 N. First Street, Suite 102)
October 18, 2023 1-4pm	Housing + Adult/Older Adult (AOA) data SSA Andrew Hill Training Room (353 W. Julian)
November 1, 2023 1-3pm	Round 1 Program Recommendations: Housing + AOA SSA Auditorium (333 W. Julian St.)
November 16, 2023 1-3pm	Round 1 Program Recommendations: Access & Unplanned, WET, CYF SSA Andrew Hill Training Room (353 W. Julian)
November 29, 2023 1-3pm	Round 2 Program Recommendations: Access & Unplanned, WET, CYF SSA Auditorium (333 W. Julian St.)
December 15, 2023 10am-12pm	Round 2 Program Recommendations Housing + AOA SSA Auditorium (333 W. Julian St.)

Thank you!

For any questions about MHSA and the FY2025 MHSA Planning Process. please email MHSA@hhs.sccgov.org.

Mental Health Services Act (MHSA)
FY2025 Community Program Planning Process
Children, Youth & Families System of Care Retreat

Wednesday, October 11, 2023, 1:00 PM - 4:00 PM
2310 N. First Street, Suite 102, San Jose, CA 95131
Charcot Training Center, Rooms 1 &2

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

MEETING AGENDA – 10/11/2023	TIME
1. Welcome & Background (Roshni Shah) a. Introductions b. Welcoming Remarks & Housekeeping	1:00 PM - 1:10 PM
2. Data Findings from 2023 MHSA Survey & Community Conversations (Dr. Joyce Chu) a. Presentation by Dr. Chu b. Questions & Answers	1:10 PM - 2:10 PM
3. Break	2:10 PM - 2:20 PM
4. Highlights from the Children, Youth & Families System of Care (Zelia Faria Costa) a. Program Highlights b. Questions & Answers	2:20 PM - 3:50 PM
5. Closing Remarks & Next Steps	3:50 PM - 4:00 PM

COUNTY OF SANTA CLARA
Behavioral Health Services

2

Welcome & Background

Introductions

Housekeeping

- Parking
- Access to Restrooms
- Safety Practices

3

Q/A sections are included in the schedule to provide an opportunity to ask questions and/or provide comment/input.

Give space, take space.

Meeting Agreements

4

Follow along with today's presentation!

https://tinyurl.com/EventsCPP

5

DATA FINDINGS FROM 2023 MHSA SURVEY & COMMUNITY CONVERSATIONS

6

Feedback Forms at your seats

If you prefer to provide comments in an online form, feel free to use this link or QR code:
https://tinyurl.com/MHSA2025

CYF Participants

Efforts to Boost Youth, South County, and Unhoused Participation

- Hosted multiple Youth-, South County-, and Unhoused-focused community conversations
- Convened a Survey Recruitment Committee which met bi-weekly to brainstorm ways to enhance participation
- Coordinated with SCCOE to facilitate youth participation
- Encouraged survey participation & dissemination from all community conversations participants
- Asked community conversation host agencies to disseminate the surveys within their networks

Recruitment Advisory Committee

Catherine Aspiras
LouMeshia Brown
Dinh Chu
Rita Mamarian
Gabby Olivarez
Jennifer Pham
Elania Reis
Juan Troy

List of 9 CYF Community Conversations

Children, Youth, Families

4. Youth Group 1 (7, *English*)
5. Youth Group 2, LGBTQ+ (3, *English*)
6. Youth Group 3 (14, *English*)
7. Youth Group 4, University students (12, *English*)
8. Youth who are Unhoused (6, *English*)
9. Family Members, General (10, *English*)
10. Providers: Children, Youth, & Family Services (32, *English*)
11. Young Men Involved in Juvenile Justice (9, *English*)
12. Young Women Involved in Juvenile Justice (2, *English*)

Youth Data

- 9 Youth-related Community Conversations
- 95 Youth stakeholders in Community Conversations
- 441 stakeholder comments re: Youth
- 25 Youth consumers or family members on the survey

Average Demographics: CYF Consumer/Family Survey Sample (n = 25)

Age
64% Adult / 12% Older Adult / 24% Youth

Disability
26% Yes / 74% No

Race / Ethnicity
45.8 % Latinx / 33.3% White / 20.1% Asian / 16.7% Black or African American / 4.2% MENA / 0% Pacific Islander or Native Hawaiian

Gender Identity
70% Cis Women / 30% Cis Men / 0% TGI+

City of Residence
Mostly from San Jose (83%), followed by North County (12.5%) and South County (4.2%)

Sexual Orientation
81% Heterosexual / 19% LGBQPA2S+

CYF-Specific Findings

CYF System Strengths

- Youth & Student Wellness Centers
- Quality of CYF Services
- Specific services
  - Early childhood services
  - Strengthening Families workshop
  - TAY services
- CYF Services in Juvenile Justice

CYF Strengths from the survey

The top strength from the survey can be conceptualized as <u>Quality of Care</u>

- "My mental health and substance use treatment providers talk to each other and coordinate services with other agencies." (25%)
- "Services are focused on patient-centered recovery." (20%)
- "MHSU services are helpful." (20%)
- "Services are available from peers." (20%)
- "Services help me accomplish my goals." (20%)
- "Services are available in a crisis." (20%)

Top Stakeholder CYF Needs: Year-by-Year Comparison

2022 Primary CYF Stakeholder-Identified Needs	Number of comments
Treatment Services	94
Youth & Families	69
Workforce Education and Training	68
Access Pipeline	55
Prevention/Outreach	40
Quality of Care	33
Criminal Justice	6
Cultural Considerations	2
Housing	1

2023 Primary CYF Stakeholder-Identified Needs	Number of comments
Treatment Services	185
Workforce Education and Training	62
Prevention/Outreach	38
Access	29
Collaborative & Integrative Care	20
Housing	15
Quality of Care	8

Top Stakeholder CYF Needs & Corresponding BHSD Goals

- #1 Timely Access: Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services
- #2 Housing: Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter
- #3 Emerging Needs: Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations
- #4 WET: Develop Innovative Solutions to Address Professional Workforce Shortages
- #5 Integrated Systems / Policy: Adapt to and Help Shape the Rapidly Shifting State Policy Landscape

2023 Primary CYF Stakeholder-Identified Needs	Number of comments	% Overlap with BHSD Goals
Treatment Services	186	100%
Workforce Education and Training	62	100%
Prevention/Outreach	38	21.1%
Access	29	34.5%
Collaborative & Integrative Care	20	100%
Housing	15	100%
Quality of Care	8	0%

68.1% of CYF stakeholder comments mapped directly onto the 5 Main Department Goals

Most frequently mentioned themes of change

- #1: More Treatment Services (186 comments)
- #2: Workforce, Education & Training (62 comments)
- #3: Outreach & Prevention (38 comments)
- #4: Access (29 comments)
- #5:Integrative & Collaborative Care (20 comments)
- #6: Housing (8 comments)

CYF Recommendations More Treatment Services (185 comments)

BHSD Priority #3 (Emerging Needs): Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations

- #1. Expand variety and availability of CYF-specific services & treatment
  - Sexual assault prevention/intervention, outpatient services
- #2. Reduce stigma & increase MHSU knowledge among parents
- #3. Increase capacity for substance use-related services & programs
  - Detox services & dual diagnosis treatment, for youth

CYF Recommendations More Treatment Services (185 comments)

BHSD Priority #3 (Emerging Needs): Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations

- #4. Continue and expand support to facilitate youth access to Wellness Centers (both school- and non-school-based)
- #5. Enhance services for high-need by treatment-declining TAY

CYF Recommendations WET (62 comments)

BHSD Priority #3 (WET): Develop Innovative Solutions to Address Professional Workforce Shortages

- #1. Increase CYF clinical staff (e.g., youth support staff, therapists in schools)
- #2. Hire culturally-matched CYF staff (LGBTQ+ staff, staff from marginalized backgrounds)
- #3. Essential Strategies to retain CYF staff: Reduce Staff Turnover, increase pay, provide staff trainings

CYF Recommendations: Prevention & Outreach (38 comments)

(Spans many of the BHSD priorities #1-3)

- #1. Expand families' knowledge of MHSU through increased community helper trainings and outreach
- #2. More Outreach to schools & college campuses
- #3. More mental health & substance use education in schools (e.g., vaping prevention, integrating activities to increase engagement, ethnic specific outreach)

CYF Recommendations: Access to CYF services (29 comments)

BHSD Priority #1 (Timely Access): Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services

- #1: More Non-Call Center Access Options
  - Direct referrals (from agencies, and for unhoused) and more walk-in options
- #2. Increase Youth Awareness of BHSD Services
  - Stakeholders noted that many SCC youth are unaware of BHSD services and the ways that they might benefit.
- #3: Translation/Language Services
  - In-person translation, Spanish, and Vietnamese
- #4. Transportation & Childcare for Parents
  - Youth noted that their parents need BHSD services but are unable to access care without childcare services.

CYF Recommendations: Collaborative & Integrated Care

(20 comments)

BHSD Priority #5 (Integrated Systems/Policy)
Adapt to and Help Shape the Rapidly Shifting State Policy Landscape

#1. Facilitate smooth integrated care between BHSD & other County departments/agencies
Single EHR: SCC Medical Services / Primary Care

#2. Collaborate with Santa Clara County schools to implement **peer referral systems**

CYF Recommendations Housing

(15 comments)

BHSD Priority #2 (Housing)
Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter

#1. Increase housing availability
Housing Generally
Temporary Housing
Permanent Supportive Housing

"especially with the families too… single mom with two kids… you don't call every day and you lost your spot [on the list]"

CYF Recommendations Quality of Care

(7 comments)

#1. Create a more LGBTQ+ affirming environment in temporary/transitional housing

To address anti-LGBTQ+ aggressions in BHSD housing settings

Questions or Comments?

joycepchu@gmail.com

BREAK

30

Q&A

ONLINE FEEDBACK FORM
SCAN QR CODE OR
AVAILABLE AT:
HTTPS://TINYURL.COM/MHSA2025

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MENTAL HEALTH SERVICES ACT

Children, Youth & Family System of Care

- CYF System of Care Overview
- School Linked Services Initiatives Division Updates
- Family & Children Specialty Services Division Updates
- Cross Systems & Intensive Services Updates

COUNTY OF SANTA CLARA
Behavioral Health Services

Children, Youth, & Family System of Care

Our Vision

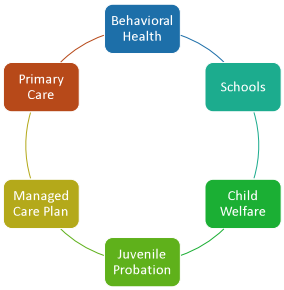
The Children, Youth, and Family System of Care promotes healing, hope, wellbeing, and improved life outcomes for all.

Our Mission

To be alongside children, youth, and families in affirmation of the values of cultural humility, inclusion, hope and equity. Our transformative work is accomplished through coordinated, integrated, growth, recovery and resiliency-oriented approaches.

COUNTY OF SANTA CLARA
Behavioral Health Services

COORDINATED SYSTEM OF CARE



Children's services exist in a complex set of legislation with a variety of stakeholders

COUNTY OF SANTA CLARA
Behavioral Health Services

CHILDREN, YOUTH, TRANSITION AGE YOUTH, AND FAMILY SYSTEM OF CARE

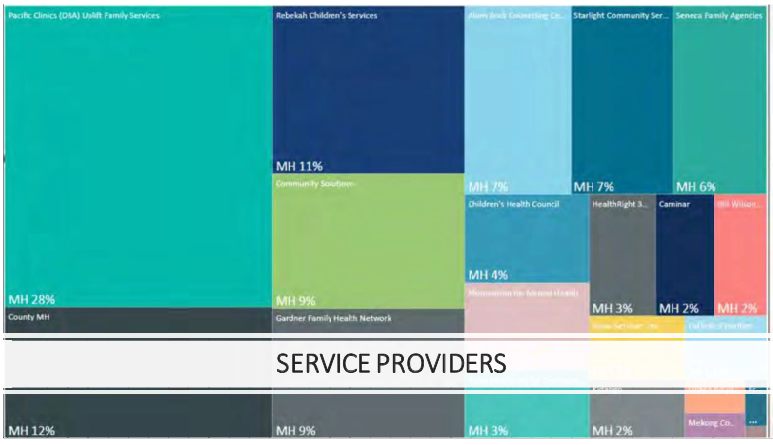
Prevention and Early Intervention	Outpatient	Intensive Outpatient	Intensive Treatment and Supports	Residential
Mental Health Services • School Linked Services (SLS) Family Engagement • Prevention and Early Intervention (PEI) Behavioral Health • Differential Response • SLS Behavioral Health • Nurse Family Partnership (NFP) • Reach out and Read (ROR) • Mentor Parent Program • TAY Drop-in Centers • Raising Early Awareness and Creating Hope (REACH) Clinical High Risk for Psychosis (CHRP) • The Welcoming Center **Co-Occurring Services** • allcove Palo Alto • Downtown Youth Wellness Center **Substance Use Services** • Substance Use Prevention Programs and Services	**Mental Health Services** • Outpatient Continuum Services (Behavioral health services provided by contracted providers and County-operated clinics) **Population-Specific Outpatient Programs:** • Ethnic Outpatient Continuum Services • KidConnections Network (Birth through Five) • Transition Age Youth (TAY) • TAY Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) • Young Adult Transition Team (YATT) • Dually Involved Youth (DIY) **Co-Occurring Services** • Integrated Outpatient Services (Co-Occurring Mental Health and Substance Use • TAY Interdisciplinary Service Team (IST) • Treatment Focused Services (TFS) **Substance Use Services** • Youth Substance Use Outpatient Treatment Services	**Mental Health Services** • Katie A. Services • Eating Disorders Programs • Facility Based Intensive Outpatient Program • Cross-Systems Behavioral Health Clinic (Transformation Team) • Therapeutic Visitation Services **Co-Occurring Services** • Court for Individualized Treatment of Adolescents (CITA) • Probation- Response Intervention Services and Empowerment (RISE) **Substance Use Services** • Youth Substance Use Intensive Outpatient Services	**Mental Health Services** • Full Service Partnership (Child/Transition Age Youth TAY) • Intensive Full Service Partnership (Youth/TAY) • Wraparound (Child Welfare and Juvenile Justice) • Therapeutic Foster Care • Placement Supportive Services (PSS) • Immediate Stabilization Services **Substance Use Services** • Integrated Youth MAT Services In-Patient **Substance Use Services** • In-patient VMC MAT Services	**Mental Health Services** • Eating Disorder Residential Programs • Therapeutic Home Placements **Co-Occurring Services** • Short Term Residential Therapeutic Program (STRTP) **Substance Use Services** • Residential Treatment Programs Juvenile Facilities **Co-Occurring Services** • Juvenile Justice Custody Treatment • Secure Youth Treatment Program • Guadalupe Services • Morgan Hill Services

Therapeutic Behavioral Services (TBS/TBS-ID) can be accessed across the continuum of care, but cannot be received as a standalone service

Crisis Services can be accessed across the continuum of care and offers Mobile Crisis, Community Transition Service (CTS), Crisis Stabilization Unit (CSU)

Child Welfare/Juvenile Justice Referred
Child Welfare Referred
Juvenile Justice Referred

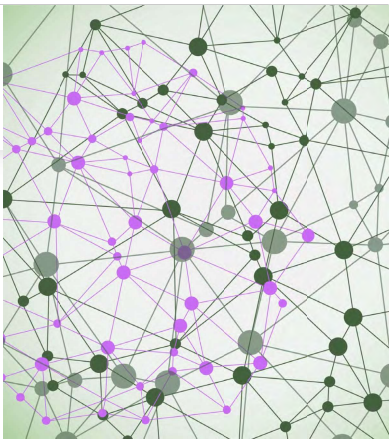
COUNTY OF SANTA CLARA
Behavioral Health Services



SERVICE PROVIDERS

FY24 SYSTEM PRIORITIES

- Access to timely services
- Opioid Crisis: Proactively address the needs of young people
- Expansion of Wellness Services
- Evidence-based approaches to maximize improvements in health
- Trauma-informed and culturally responsive system of care
- Equity for unserved and underserved populations



SCHOOL-LINKED SERVICES PROGRAMS AT-A-GLANCE

- Family Engagement
- PEI Prevention
- PEI Early Intervention
- SLS Behavioral Health

TIER 1
Universal *- Support strategies provided to all. Serves majority of students. (90%-100%)*

TIER 2
Targeted *–Supplemental support to address risk. Small group of students served. (10-25%)*

TIER 3
Selected *- Individual support to remediate significant challenges. Serves less students. (<10%)*

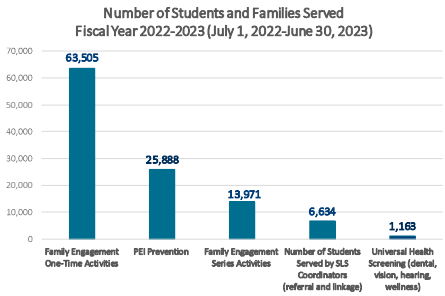
- **Family Engagement** includes activities such as one-time events or series, to welcome students and families on school campuses, increase families' knowledge about available resources and services, provide tools to help improve their child's health and well-being, academic success, and their abilities to advocate for their child.
- **SLS Coordinators,** located on school campuses/school districts, provide access to school-based services and community-based resources through linkage and referrals.
- **Prevention services** include mental health screening, outreach, mental health promotion, psychoeducation, and Classroom-wide SkillStreaming curriculum.
- **Early Intervention** includes parenting workshops such as Strengthening Families and Triple P, student skills groups, behavioral support services, and early intervention therapy – individual, group, family.
- **Intensive services** include individual and group therapy in school settings for students experiencing moderate behavioral and emotional needs.
- **Medication and Crisis Intervention** support
- **Additional services and support staff** by paraprofessionals are provided to students and their families with higher acute needs.

COUNTY OF SANTA CLARA Behavioral Health Services

SLS FY24 RECOMMENDATIONS – STATUS UPDATES

RECOMMENDATIONS FROM MHSA SLC JUNE 2022	STATUS	SUMMARY
Repurpose COVID recovery support for schools 10% increase ($1,484,055) to ongoing budget 1. Expand PEI to provide universal services to all school districts ($890,336) on-going. 2. Convert 10% increase to on-going SLS capacity (52 slots, $593,719)	✓	In FY2024, 10% funding remained in the CCP contracts. 1. Funding for PEI remained in outreach to provide universal supports and strategies. 2. Funding for SLS BH was used to leverage to increase capacity for Medi-Cal clients
Support the implementation of Wellness Centers	↓	• In May 2023, BHSD contracted with Valley Health Foundation to conduct pre-development activities and planning for the wellness center grant program. • In August 2024, $10M was budgeted to support the implementation of new wellness centers, enhance existing wellness centers, and support infrastructure. $5M of the $10M is funded through MHSA PEI. An additional $2M from Juvenile Probation will support this program.
Re-design programs to be fully implemented in FY2025 1. PEI Universal Supports and Services 2. SLS BH OP/IOP programming	✓	1. In FY2024, PEI CCPs and BHSD met monthly to re-design PEI to increase Tier 1 supports and services (i.e. Triple P Level 2 and 3, MH Screenings, etc). 2. In FY2023, SLS BH CCPs and BHSD met monthly to re-design SLS BH to include paraprofessionals, extend the continuity of care to include intensive services, and identify training and supports for direct services staff.

SLS HIGHLIGHTS & DATA: TIER 1 - FAMILY ENGAGEMENT & PREVENTION

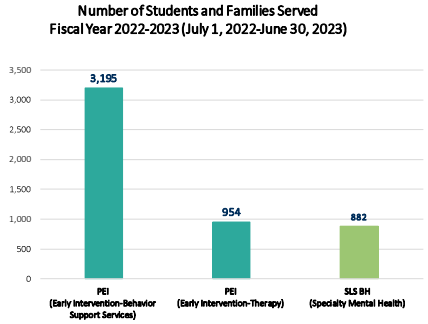


FY 2022-2023 Highlights

1. BHSD executed service agreements with **7 new school districts**. SLS Coordinator at **25 of the 32 school districts (78%).**
2. SLS Coordinators received 8,260 referrals and **80.4% referrals were successfully linked to services.**
3. Since FY 2021-2022, student/family participation in Family Engagement events and in Workshop Series **increased by 48%.**
4. In FY 2022-2023, **88%** of surveyed families reported **feeling more comfortable and welcomed** at school, and **87%** of families **indicated that the events and workshops allowed them to learn about available resources and services in the community.**
5. **80% of teachers** were satisfied with the SkillStreaming lessons provided.
6. **43% of students** screened by HKF for emotional wellness, were **connected to a parent advocate for additional support.**

COUNTY OF SANTA CLARA Behavioral Health Services

SLS HIGHLIGHTS & DATA: TIER 2 – EARLY INTERVENTION AND TIER 3- SLS BH

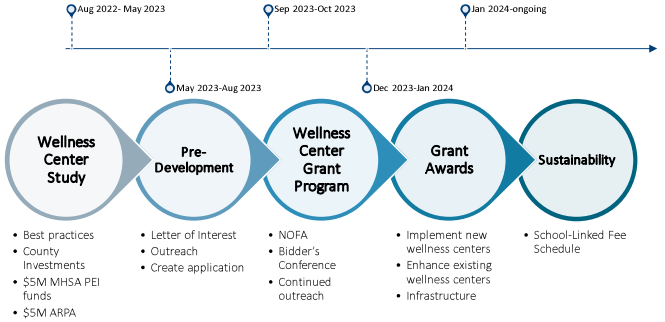


FY 2022-2023 Highlights

1. **83% of students were successfully discharged** from SLS BH and other SBBH programs upon satisfactory levels of improvement and stabilization in their behavioral/emotional well-being.
2. Students receiving therapeutic school-based behavioral health services **showed improvement in behavioral and emotional domain and life functioning domain,** as measured by the Child and Adolescent Needs and Strengths questionnaire.

COUNTY OF SANTA CLARA Behavioral Health Services

WELLNESS CENTER GRANT PROGRAM



COUNTY OF SANTA CLARA Behavioral Health Services

REACH PROGRAM AT-A-GLANCE

Prevention
- Outreach
- Psychoeducation
- Consultation
- Screening

Clinical High Risk for Psychosis (Early Intervention)
- CBTp
- Case Management
- Education and Employment
- Psychiatric assessment
- MFG Groups

First Episode of Psychosis
- First intervention: Medication Support
- CBTp
- Case Management
- Education and Employment
- MFG Groups

REACH HIGHLIGHTS & DATA

Number Served: 129 (includes 17 FEP clients)

76% Successful Discharge

CANS Outcomes:
- LDF -10%
- YBEN -12%
- YRB -30%

Outreach Campaign
- New digital campaign
- New brochures and flyers

Outreach to 989 individuals

Developing a continuum of care from CHR-P to FEP

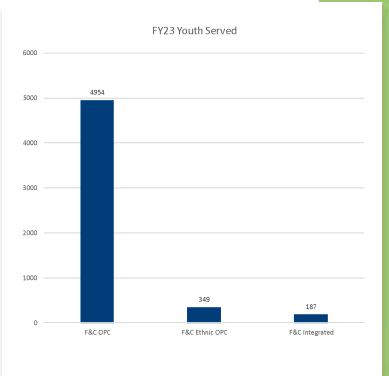
REACH FY24 RECOMMENDATIONS – STATUS UPDATES

RECOMMENDATIONS FROM MHSA SLC JUNE 2022	STATUS	SUMMARY
Create 6 FEP conversion slots (3/agency) through EPI+ program/grant • Reduce total EPI+ capacity from 26 to 8. • Pilot conversion slots, refine programmatic parameters to meet clients with FEP	✓	In mid-year FY2023, CCP contracts were amended to reduce EPI+ capacity to create FEP conversion slots. Currently, there are 17 FEP clients.
Review REACH capacity, budget, and program needs and increase FEP conversion slots for REACH, if needed.	↓	BHSD and CCPs are reviewing FEP capacity, existing clients, and funding needs such as additional Flex Funding to support housing needs.

F&C OUTPATIENT SPECIALTY SERVICES

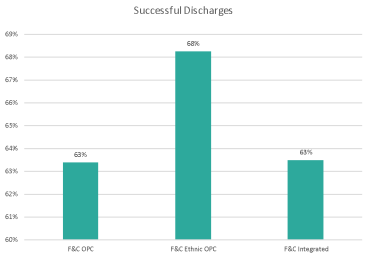
Programs:
- Family & Children Outpatient Continuum (F&C OPC)
- Family & Children Ethnic Outpatient Continuum (F&C Ethnic OPC)
- Family & Children Integrated Outpatient (F&C Integrated OP)
- Transitional Age Youth Outpatient (TAY OP)
- Transitional Age Youth LGBTQ Outpatient (TAY LGBTQ)
- Transitional Age Youth Interdisciplinary Service Team (IST)
- Child Full Service Partnership (Child FSP)
- Youth Intensive Full Service Partnership (Youth IFSP)
- Transitional Age Youth Full Service Partnership (TAY FSP)
- Transitional Age Youth Intensive Full Service Partnership (TAY IFSP)
- Support for Parents
- County Clinical Services

- F&C OUTPATIENT CONTINUUM
- ETHNIC OUTPATIENT CONTINUUM
- INTEGRATED OUTPATIENT



F&C OUTCOMES

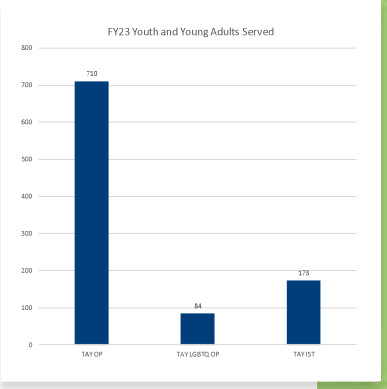
Child and Adolescents Needs and Strength (CANS) Outcomes
- Youth receiving F&C OPC services showed positive improvement in Behavioral Emotional Needs, Risk Behaviors and Life Functioning domains
- Youth receiving F&C Ethnic OPC services showed positive improvement in Behavioral Emotional needs and life functioning domains
- Youth receiving F&C Integrated Services showed positive improvement in Behavioral Emotional Needs, Risk Behavior, and Life Functioning domains.



F&C HIGHLIGHTS

- F&C Outpatient Continuum (OPC) Services began their first full fiscal year of continuum services in FY23. The program now provides the flexibility in level of service to meet the needs of the youth when they need it.
- F&C Ethnic Outpatient was re-designed to a continuum in the middle of the FY23 to provide a similar range of service levels as F&C OPC.
- Services have been smooth for youth with the flexibility to move up and down service levels dependent on their needs at that moment.

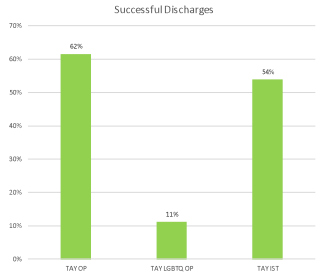
- TAY OUTPATIENT
- TAY LGBTQ OUTPATIENT
- TAY INTERDISCIPLINARY SERVICE TEAM



TAY OUTCOMES

Child and Adolescents Needs and Strength (CANS) Outcomes

- TAY receiving services showed positive improvement in Behavioral Emotional Needs, Risk Behaviors and Life Functioning domains
- TAY receiving IST services showed positive improvement in Behavioral Emotional Needs and Life Functioning domains.

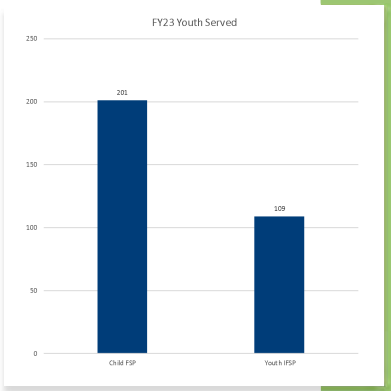


COUNTY OF SANTA CLARA
Behavioral Health Services

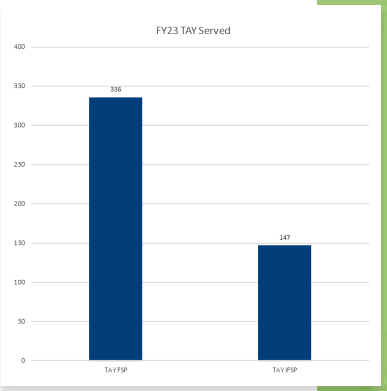
TAY HIGHLIGHTS

- TAY LGBTQ services increased in FY23 to support the needs of the target population
- TAY OP and LGBTQ programs began discussions for redesign to provide a continuum of level of services, similar to F&C OPC and Ethnic OPC

- CHILD FULL SERVICE PARTNERSHIP
- YOUTH INTENSIVE FULL SERVICE PARTNERSHIP

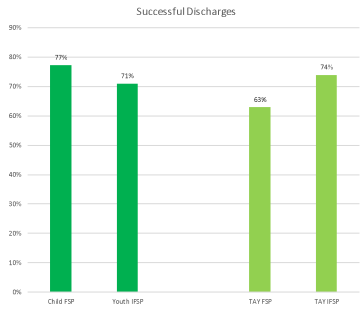


- TAY FULL SERVICE PARTNERSHIP (FSP)
- TAY INTENSIVE FULL SERVICE PARTNERSHIP (IFSP)



FSP OUTCOMES

Child and Adolescents Needs and Strength (CANS) Outcomes
- Child FSP and IFSP services showed positive improvement in Behavioral Emotional Needs, Risk Behaviors and Life Functioning domains
- TAY FSP services showed positive improvement in Behavioral Emotional Needs, Risk Behavior and Life Functioning domains.
- TAY IFSP services showed positive improvement in Behavioral Emotional Needs and Risk Behavior domains



COUNTY OF SANTA CLARA Behavioral Health Services

FSP HIGHLIGHTS

- Both Youth and TAY FSP programs began discussion on program redesign in FY23 to provide a continuum of services that provides both FSP and IFSP service levels under one program
- FSP providers boosted re-engagement efforts to support youth and young adults who disengage while in services to re-engage.

SUPPORT FOR PARENTS HIGHLIGHTS

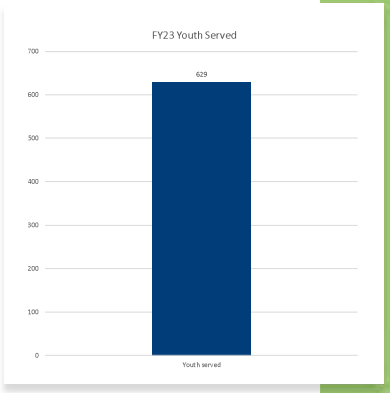
Reach out and Read (ROR)
- FY23 reached 12,940 children, providing books to children and caregiver to promote ROR model supporting attachment and early literacy

Triple P – Positive Parenting Program
- 37 providers trained
- 275 Parents received Triple P services
- Trainings brought in focused on parents with Teens, and workshop style supports targeted to identified behaviors.

Dependency Advocacy Center (DAC) Mentor Parent Program
- 118 parents participated in program
- 21 parents reunified with their children
- Over 681 referrals made/supported to various community resources

COUNTY OF SANTA CLARA Behavioral Health Services

COUNTY CLINICAL SERVICES



COUNTY CLINICAL SERVICES HIGHLIGHTS

Child and Adolescents Needs and Strength (CANS) Outcomes
- County Clinical Services demonstrated a positive change in Behavioral Emotional Needs and Life Functioning Domains

COUNTY OF SANTA CLARA Behavioral Health Services

ADDITIONAL CYF HIGHLIGHTS

Youth Advisory Council – development and planning began in FY23

Integration of Integrated Core Practice Model (ICPM) into additional CYF programs to support collaboration and family voice into decision making

CROSS-SYSTEMS INITIATIVES (CSI)
MHSA PROGRAMS

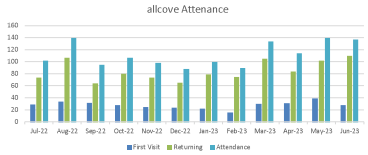
- Downtown Youth Wellness Center (PEI)
- allcove Integrated Health Center (INN)
- Dually Involved Youth (DIY) Advocacy and Support (CSS)
- Cross-Systems Transformation Team (CSS)
- Juvenile Justice Intensive Services (CSS)

Prevention/Early Intervention — Intensive Treatment and Support

Treatment and Support

COUNTY OF SANTA CLARA
Behavioral Health Services

COMMUNITY WELLNESS CENTER FY23 DATA REVIEW AND SUCCESSES*
ALLCOVE PALO ALTO



Highlights

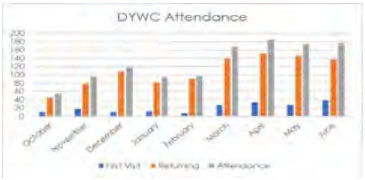
- **83%** of young people visiting the center expressed interest in **mental health service**
- **Continued expansion** of the program and increased community presence
- **Overwhelming satisfaction** from youth with the staff and center, and would recommend the allcove program to a friend

Service Numbers
Unduplicated Youth served: 326
Outreach events: 73
Community tours: 275

Encounters
Behavioral health: 939
Psychiatry: 66
Medical: 31
Peer support: 527
Supportive Education and Employment: 56

COUNTY OF SANTA CLARA
Behavioral Health Services

COMMUNITY WELLNESS CENTER FY23 DATA REVIEW AND SUCCESSES*
DOWNTOWN YOUTH WELLNESS CENTER



Service Numbers (since October 2022)
Unduplicated Youth served: 220
Outreach events: 74
Community tours: 217

Encounters (since January 2023)
Behavioral health: 103
Other counseling/support: 100
Peer support and general center activities: 778

Qualitative Highlights

- Parenting youth are utilizing the center and infant supplies are on-hand to assist/support
- Outside providers have high regard for the program
- Returning youth numbers are high
- Several youth come to the center multiple times a week
- Unhoused youth have successful assistance to become housed
- Youth are reaching out to DYWC for substance use support. One youth called DYWC during an overdose and life-saving help was able to be dispatched to them.

COUNTY OF SANTA CLARA
Behavioral Health Services

CROSS-SYSTEMS SERVICES FY23 DATA REVIEW AND SUCCESSES*

Juvenile Justice includes Guadalupe, Competency and DIY (IOP Level of Care)	641 youth served 75% successful or administrative discharges** Continuity of care, integrated treatment, engagement, and cross systems collaboration
Morgan Hill Services (Intensive Services)	51 youth served Provider change - discharge rates being established Continuity of care / integrated treatment / engagement
Transformation Team (CSEC) (IOP Level of Care)	27 youth served 71% successful or administrative discharges** Access and no-wrong door approach; staff retention rates; coordination across systems

Notes:
*time frame July 1, 2022 – June 30, 2023
**common for program to transition youth to higher level of care

COUNTY OF SANTA CLARA
Behavioral Health Services

CRISIS AND INTENSIVE SERVICES (CIS)
MOBILE RESPONSE AND STABILIZATION (MRSS)

MRSS Activated

- **Stabilized by phone**
- **Mobile Response in field**
  - **Hospital Diversion Safety Plan** (72% of mobile responses)
  - **Hospital Diversion- Crisis Stabilization Unit (CSU)** (28% of mobile responses)
    - **Hospital Diversion from CSU- Safety Planned**
    - **Admitted to Psychiatric Hospital**

Additional Highlights

- Increased capacity/access and community awareness through 988 access and additional teams and expansion to serve up to age 21
- Focused on quality of services through diversion efforts and time to service through launch of Salesforce (to support dispatch and tracking in Spring 2023 (via CCMU grant)

Additional Data

- 86% hospital diversion rate
- Access to same or next day post-crisis stabilization services (PCSS)
- 71% successful engagement for youth referred to PCSS after CSU discharge
- 64% successful discharges from PCSS

COUNTY OF SANTA CLARA
Behavioral Health Services

CRISIS AND INTENSIVE SERVICES (CIS)
EATING DISORDERS CONTINUUM – CHILD, YOUTH AND ADULT

Outpatient (New in FY23)	Intensive Outpatient (Expanded in FY23)	Partial Hospitalization Program (Expanded in FY23)	Residential (Expanded in FY23)
• Youth to Adult • Clinic or virtual • Therapy, nutrition, psychiatry provided weekly or as clinical indicated • Symptoms minimally impact daily life • Length of stay based on clinical need	• Youth to Adult • Daily meal support • Individual, family, and group treatment • Weight and vitals checks • Meal planning • Length of treatment average 21-30 day • **Treatment dosage varies per provider** on average 3-5 hours per day 3-5 days per week	• Youth to Adult • Meal support multiple times a day • Clients able to control symptoms away from program • Clients provide own meals • Length of treatment average 21-30 days • **Treatment dosage varies per provider average** is 6 hours a day 5 days per week	• Youth to Adult • 24/7 supervision in residential treatment setting • 2-4 sessions per week, group, family, individual services provided • Psychiatric, physician and dietician services • Individual requires daily supervision to manage ED behaviors

COUNTY OF SANTA CLARA
Behavioral Health Services

EATING DISORDER SERVICES HIGHLIGHTS FY23

Notable demographics for treatment services

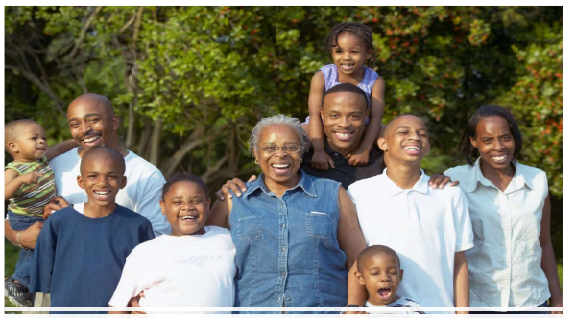
- 9% identify as transgender
- 60% under age 16; 27% 16-25 years; 13% 26 years or older
- 59% receiving treatment identified Spanish as the primary language

Service Expansion in FY23- Full Continuum of Care

- Increased treatment capacity and clinical services through additional locations with two new provider agencies; additional capacity and levels of care (including virtual options)
- Focus on family-inclusive services and communication; eating disorders coordinator support readiness for treatment and engagement and communication with other providers

COUNTY OF SANTA CLARA Behavioral Health Services

68



QUESTIONS

COUNTY OF SANTA CLARA Behavioral Health Services

MHSA FY2025 ANNUAL PLAN UPDATE

COMMUNITY PROGRAM PLANNING PROCESS TIMELINE

70

Public/Stakeholder Meetings/Activities*
To be Conducted Onsite/In-Person

MHSA FY2025 Annual Plan Update

Date	Meeting
October 11, 2023 1-4pm	Children, Youth & Families (CYF) Data Charcot Training Rooms 1 & 2 (2310 N. First Street, Suite 102)
October 18, 2023 1-4pm	Housing + Adult/Older Adult (AOA) data SSA Andrew Hill Training Room (353 W. Julian)
November 1, 2023 1-3pm	Round 1 Program Recommendations: Housing + AOA SSA Auditorium (333 W. Julian St.)
November 16, 2023 1-3pm	Round 1 Program Recommendations: Access & Unplanned, WET, CYF SSA Andrew Hill Training Room (353 W. Julian)
November 29, 2023 1-3pm	Round 2 Program Recommendations: Access & Unplanned, WET, CYF SSA Auditorium (333 W. Julian St.)
December 15, 2023 10am-12pm	Round 2 Program Recommendations Housing + AOA SSA Auditorium (333 W. Julian St.)

*Note: Additional planning /refinement meetings may be scheduled. Please stay connected for schedule info: https://bhsd.sccgov.org/about-us/mental-health-services-act.

CLOSING REMARKS & NEXT STEPS

PLEASE TAKE A FEW MINUTES TO FILL IN THE SURVEY

72

Thank you!

For any questions about MHSA and the FY2025 MHSA Planning Process, please email MHSA@hhs.sccgov.org.

Mental Health Services Act (MHSA)
FY2025 Community Program Planning Process
Housing and Adult & Older Adult System of Care

October 18, 2023, 1:00 PM – 4:00 PM
353 W. Julian St, San Jose, CA 95110
Andrew Hill Training Room

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

MEETING AGENDA – October 18, 2023	TIME
1. Welcome & Background (Roshni Shah) a. Introductions b. Welcoming Remarks & Housekeeping	1:00 PM – 1:10 PM
2. Data Findings from 2023 MHSA Survey & Community Conversations (Dr. Joyce Chu) a. A/OA & Housing Recommendations b. Questions & Answers	1:10 PM- 1:55 PM
3. Break	1:55 PM- 2:00 PM
4. Highlights from the Adult/Older Adult & Housing System of Care (Margaret Obilor & Soo Jung) a. Program Highlights b. Questions & Answers	2:00 PM- 3:55PM
5. Closing Remarks	3:55 PM-4:00PM

COUNTY OF SANTA CLARA
Behavioral Health Services

Q/A sections are included in the schedule to provide an opportunity to ask questions and/or provide comment/input.

Give space, take space.

Meeting Agreements

3

Welcome & Background

- Introductions
- Housekeeping
  - Parking
  - Access to Restrooms
  - Safety Practices

4

Follow along with today's presentation!

https://tinyurl.com/EventsCPP

5

DATA FINDINGS FROM 2023 MHSA SURVEY & COMMUNITY CONVERSATIONS

6

Feedback Forms at your seats

If you prefer to provide comments in an online form, feel free to use this link or QR code:
https://tinyurl.com/MHSA2025

Community Planning Process
to inform the FY25 update

3 Sources of Data
(collected Jan-Mar '23)

- 29 Community Conversation Groups
- SCC Mental Health & Substance Use Survey
  Consumer/Family Feedback
- SCC Mental Health & Substance Use Survey
  Tracking MHSA domains over time

5 BHSD Community-Driven Goals

#1 Timely Access	Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services
#2 Housing	Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter
#3 Emerging Needs	Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations
#4 WET	Develop Innovative Solutions to Address Professional Workforce Shortages
#5 Integrated Systems / Policy	Adapt to and Help Shape the Rapidly Shifting State Policy Landscape

Recruitment Advisory Committee

Catherine Aspiras
LouMeshia Brown
Dinh Chu
Rita Mamarian
Gabby Olivarez
Jennifer Pham
Elania Reis
Juan Troy

Efforts to Boost South County, Unhoused, and Youth Participation

- Hosted multiple Youth-, South County-, and Unhoused-focused community conversations
- Convened a Survey Recruitment Committee which met bi-weekly to brainstorm ways to enhance participation
- Coordinated with SCCOE to facilitate youth participation
- Encouraged survey participation & dissemination from all community conversations participants
- Asked community conversation host agencies to disseminate the surveys within their networks

Unhoused Participants

Unhoused Data

- 5 Unhoused-related Community Conversations
- 26 Unhoused stakeholders in Community Conversations
- 134 stakeholder comments about housing
- On the Survey: 69 individuals who not stably housed
  - 22 were BHSD clients
  - 7 were family members
  - 31 did not answer items to determine if they were consumers/family members

Unhoused Demographics: Consumer/Family Survey Sample (n = 69)

Age
92.6%% Adult / 4.4% Older Adult / 2.9% Youth

Disability
50.9% Yes / 49.1% No

Gender Identity
65.2% cisgender men or boys / 20% cisgender women or girls / 15.2% TGI+

Race / Ethnicity
52.3% Hispanic/Latino/a/e / 39.7% White / 14.3% Black / 14.3% Native American, American Indian, Alaskan Native / 11.1% Asian / 3.2% Middle Eas·ern or North African / 1.6% Pacific Islander

City of Residence
Mostly from San Jose, followed Santa Clara, Morgan Hill, & Mountain View

Sexual Orientation
82.1% Heterosexual / 17.9% LGBQPA2S+

Unhoused sample
Higher proportion of TGI+ & cisgender men / boys

TGI+ individuals make up represent 7.1% of the community sample, but they represent 15.2% of those who are unhoused.

Cisgender men/boys represent 33.8% of the community sample, but they represent 65.2% of those who are unhoused.

Unhoused-Specific Findings

Unhoused related comments
Strengths (9 comments)

- Strong Permanent Supportive Housing investment & services – 4
- Use of housing flex funding to get immediate housing post-release from custody – 1
- Strong case management services – 1
- Whole-person approach incorporating trauma - 1
- Focus on multidisciplinary teams – 1
- Focus on housing and youth / TAY services - 1
- Easy Valley Homeless Clinic - 1

The most important needs of the BHSD system
Responses from unhoused consumers/family members

Disability accommodations need to be improved (n=4)	Services should be helpful (n = 4)
Services should employ more peer support staff (i.e., people with similar experiences) (n = 4)	Service providers should talk to each other and coordinate services with other agencies (n = 4)

Unhoused Recommendation #1/ AOA Rec #11

BHSD Priority #2 (Housing)
Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter

(62 comments)

Unhoused Rec #1 / AOA Rec #11
Increase Housing Availability

- More housing in general
- **Other needs**: LGBTQ+-specific housing, flex funds, South County, wheelchairs, Criminal Justice consumers

Treatment Services

(50 comments)

BHSD Priority #3 (Emerging Needs)
Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations

AOA/Unhoused Recommendation #2
Expand Housing-Related Treatment Services

For those not currently involved in a BHSD-related housing program	• More case management during the housing application process • FSP-like program specific for chronically unhoused individuals • More clinicians to visit the unhoused wherever they can be found
For those currently involved in a BHSD-related housing program	• Additional resources for scattered-site Permanent Supportive Housing • Psychiatry/therapy at all Permanent Supportive Housing sites • MHSU treatment within temporary/transitional housing sites

Unhoused Recommendations
Collaborative & Integrative Care

(22 comments)

BHSD Priority #5 (Integrated Systems/Policy)
Adapt to and Help Shape the Rapidly Shifting State Policy Landscape

Unhoused Rec #3 / AOA Rec #8

Enhance Collaboration Between BHSD/Housing Sites with Inpatient Discharge

Seek ways to improve collaboration between hospital and Permanent Supportive Housing staff when PSH consumers are discharged from BHSD hospitals

Unhoused Rec #4 / AOA Rec #7

Improve AOA's Collaboration With the Office of Supportive Housing

Consider effects on Permanent Supportive staff and programming

WET Recommendation #4
Staff Trainings

(43 comments)

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

Cultural Trainings	Other Trainings
• LGBTQ+ • Diversity, Equity, & Inclusion • Middle Eastern culture • Black & African Ancestry culture	• AB1424 (consideration of family information in involuntary psychiatric treatment) • Trauma-informed care • Harm reduction • Psychiatric emergency services • "Soft skills" (e.g. customer services) • Service access eligibility requirements at access points (e.g., Call Center & Cultural Wellness Center) • Homeless Management Information System (HMIS) training

Unhoused Recommendation #5

(5 comments)

BHSD Priority #3 (Emerging Needs)
Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations

Improve BHSD-CBO Contracts

Improve contract flexibility for permanent supportive housing (PSH) agencies for activities such as burnout prevention, client advocacy, time spent traveling to clients, and MHSU training.

Unhoused Recommendation #6
Workforce, Education, & Training

(20 comments)

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

Consider Innovative Ways to Retain Clinical Staff Who Support Housing Programs

Reduce staff productivity requirements

Reduce burnout with innovative approaches to supporting staff who experience vicarious trauma.

Increased PSH staff pay for their dual skillsets in therapy and housing

Unhoused recommendation #6 / WET #5
Increase Staff Pay

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

- Increase pay for all clinical staff
- Pay Staff based on the cost-of-living
- PSH staff should be compensated for their dual skillsets in therapy & housing
- Increase pay for paraprofessionals, CBO staff, and psychiatrists

Unhoused Access to Care

Overall sample: 29.3% didn't receive treatment in the past year

Unhoused sample: 48.7% didn't receive treatment in the past year

Unhoused Access to Care

- **44.3% of the Unhoused respondents reported it's been hard to access or afford MHSU services**
- It is "mostly true" that they know where to go to access services (2.92) and that it is "mostly true" that they know who to call to access services (3.09).
- The average number of weeks for unhoused consumers to get connected was 3.7 weeks

Unhoused Recommendation #7
Timely Access to Care
(6 comments)

BHSD Priority #1 (Timely Access)
Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services

Only 21.4% of consumers who are unhoused interacted with the Call Center or Access Line in their service connection process

Recommendation:
Consider facilitating direct agency referrals for those who are unhoused

Unhoused Recommendation #8
Quality of Care
(7 comments)

Increase the cultural safety of LGBTQ+ housing programs training for staff at transitional & temporary housing sites

1. LGBTQ+ training for staff at transitional & temporary housing sites to address issues of anti-LGBTQ+ prejudice.
2. Implement and disseminate quality control measures
   Ensure unhoused consumers know avenues of reporting anti-LGBTQ+ discrimination so that BHSD can respond appropriately.

AOA Participants

Adult & Older Adult Services Participants

- 18 Community Conversations
- 310 stakeholders in Community Conversations
- 614 stakeholder comments
- 133 consumers or family members on the survey

List of 18 AOA Community Conversation Groups (n = 310)

Region
1. North County Community
2. South County Older Adults
3. South County Spanish & English Speaking, Some Unhoused

Cultural Communities
4. Spanish Speaking LGBTQ+ Adults
5. Spanish Speaking Adults
   South County Spanish & English Speaking, Some Unhoused
6. African Immigrant Community
7. South Asian (Punjabi) Community
8. African American
9. Vietnamese Community
10. Middle Eastern Community
11. Providers: Refugee Services

Justice-Involved
12. Diversion Community
13. Reentry Community

Unhoused
14. Unhoused
15. Adults in Residential/Transitional Housing (Unhoused)
16. Providers: Supportive Housing
    South County Spanish & English Speaking, Some Unhoused

General / Other
17. Providers: Adult & Older Adult
18. Consumers/Clients, General

Older Adults
South County Older Adults

South County Data

- 2 South County-related Community Conversations
- 45 South County stakeholders in Community Conversations
- 41 stakeholder comments re: South County
- 14 South County consumers or family members on the survey

AOA-Specific Findings

AOA System Strengths

(76 comments)

CBOs/Clinics/Programs
- Goodwill, Evans Lane, AACI, African CCWP, Case management programs, Castle program, East Valley Homeless Clinic, Elmwood, FSP, Gardner's ethnic wellness program, New Haven, Seneca program, Star program

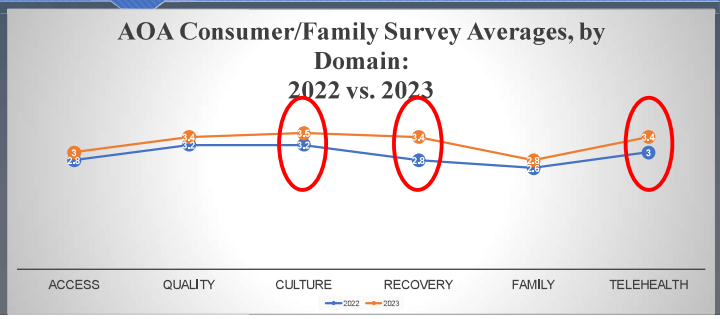
Access Processes
- 988
- Informational Brochures
- Navigator Program
- Valley Homeless Van

Criminal Justice Services
- Goodwill S.T.R.I.V E Program
- Diversion Services
- Mental Health Court

Telehealth Services

Progress on MHSA domains & priorities

Consumer/Family Survey Averages, by Domain: 2022 vs. 2023



Top Stakeholder AOA Needs: Year-by-Year Comparison

2022 Primary AOA Stakeholder-Identified Needs	Number of comments
Treatment Services	209
Workforce Education and Training	188
Access	127
Prevention/Outreach	118
Housing	81
Quality of Care	81
Cultural Considerations	46
Criminal Justice	30

2023 Primary AOA Stakeholder-Identified Needs	Number of comments
Treatment Services	198
Workforce Education and Training	167
Collaborative & Integrative Care	50
Access	49
Housing	35
Outreach & Prevention	24
Quality of Care	17

Top Stakeholder AOA Needs & Corresponding BHSD Goals

2023 Primary AOA Stakeholder-Identified Needs	Number of comments	% Overlap with BHSD Goals
Treatment Services	198	90.4%
Workforce Education and Training	167	80.2%
Collaborative & Integrative Care	50	100%
Access	49	34.7%
Housing	35	100%
Outreach & Prevention	24	0%
Quality of Care	17	0%

76.2% of AOA stakeholder comments mapped directly onto the 5 Main Department Goals

AOA: Most frequently mentioned themes of change

- #1: More Treatment Services (198 comments)
- #2: Workforce, Education & Training (167 comments)
- #3: Collaborative & Integrative Care (50 comments)
- #4: Access (49 comments)
- #5: Housing (35 comments)
- #6: Outreach & Prevention (24 comments)
- #7 Quality of Care (17 comments)

AOA Recommendation #1

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

Keep AOA Outpatient Services Flexible with Expanded Offerings to Meet the Changing Needs of the Community (76 comments)

Most Commonly Requested	Other Outpatient Services
• Services to reduce isolation •Supported Employment •Services in client's homes •Support groups •Step-down treatment services after hospitalization •Longer-term treatment	•COVID-19 related services (COVID-related grief, testing, long-term effects) •In-person while keeping telehealth options •Neurocognitive conditions •Injectable antipsychotic treatment •Individual therapy •Pre-crisis services •Behavioral health treatment for sex workers

Treatment Services

(198 comments)

BHSD Priority #3 (Emerging Needs)
Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations

AOA Recommendation #2
Expand Criminal Justice Services
(31 comments)

Reentry Services
- Reentry Vocational centers, verifying list of felon-friendly employers

Diversion Services
- additional levels of case management, more outpatient care, longer-term treatment

Treatment Over Incarceration

Expand Treatment Within Prisons

Train AOA providers to serve Criminal Justice clients

Treatment Services

(198 comments)

BHSD Priority #3 (Emerging Needs)
Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations

AOA/Unhoused Recommendation #3
Expand Housing-Related Treatment Services
(21 comments)

For those not currently involved in a BHSD-related housing program	• More case management during the housing application process • FSP-like program specific for chronically unhoused individuals • More clinicians to visit the unhoused wherever they can be found
For those currently involved in a BHSD-related housing program	• Additional resources for scattered-site Permanent Supportive Housing • Psychiatry/therapy at all Permanent Supportive Housing sites • MHSU treatment within temporary/transitional housing sites

AOA Recommendations
Additional Treatment Services

BHSD Priority #3 (Emerging Needs)
Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations

AOA Rec #4: Expand AOA Substance Use Treatment Service (SUTS).
(30 comments)
- Dual Diagnosis Treatment
- Harm reduction approaches
- Medical detox capacity
- Residential treatment programs.

AOA Rec #5: Increase AOA Capacity for Residential & Inpatient Beds.
(16 comments)
- Crisis residential beds, inpatient beds, residential beds, Board & Care capacity, and beds for those released from prison/jail

BHSD Priority #3 (Emerging Needs)
Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations

AOA Recommendations
Additional Treatment Services
(198 comments)

AOA Rec #6
Services for Immigrants and Refugees
(16 comments)

- Training and support addressing cultural acculturation challenges for immigrants and refugees
- Services for those without legal status / documentation
- LGBTQ+ education
- Extended services
- Employment support

AOA Recommendations
Workforce, Education, & Education

BHSD Priority #3 (WET)
Develop Innovative Solutions to Address Professional Workforce Shortages

(167 comments)

Note: Refer to the WET subreport for a more detailed set of recommendations that may be relevant for the AOA system of care.

AOA Rec #6: WET. Continue, and ideally enhance, efforts to recruit and retain clinical providers

Specific focus on culturally matched clinical providers

AOA Recommendations
Collaborative & Integrative Care

(50 comments)

BHSD Priority #5 (Integrated Systems/Policy)
Adapt to and Help Shape the Rapidly Shifting State Policy Landscape

AOA Rec #7

Enhance AOA's Collaboration With Other SCC Departments
- SCC medical services
- SCC Office of Supportive Housing

AOA Rec #8

Enhance AOA's Collaboration with BHSD Programs/CBOs
- Diversion services
- Between BHSD programs
- Inpatient & Permanent Supportive Housing staff post-discharge from hospitals

#8. Decrease Barriers to Accessing AOA Services

- Language/translation services (e.g., Spanish, ESL classes, Vietnamese, Dari, Pashtu)
- Increase transportation support

#9. Improve Processes/ Procedures for Accessing AOA Services

- More assistance navigating the BHSD system
- Less paperwork, fewer admission requirements
- improve Call Center screening tool
- Non-Call Center options

AOA Recommendations

Access

(49 comments)

Note: Refer to Access portion of the Access & Unplanned subreport for a more detailed set of recommendations that may be relevant for the AOA system of care.

BHSD Priority #1 (Timely Access)

Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services

Unhoused Recommendation #1/ AOA Rec #11

BHSD Priority #2 (Housing)

Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter

(35 comments)

Unhoused Rec #1 / AOA Rec #11

Increase Housing Availability

More housing in general

Other needs

LGBTQ+-specific housing, flex funds, South County, wheelchairs, Criminal Justice consumers

AOA Recommendations

Outreach & Prevention *(24 comments)*

AOA Rec #12: Improve AOA Outreach/Prevention Efforts

Suggestions for outreach at religious/spiritual venues.

AOA Recommendation #13

Improve Quality of Care *(17 comments)*

Reduce anti-LGBTQ+ discrimination within BHSD housing services

Improve quality of care from AOA providers

(e.g., therapists, psychiatrists, orientation to residential programs, planfulness around the 90 days of initial re-entry services)

BREAK

55

Q&A

ONLINE FEEDBACK FORM
SCAN QR CODE OR
AVAILABLE AT:
HTTPS://TINYURL.COM/MHSA2025

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DATA FINDINGS FROM ADULT/OLDER ADULT& HOUSING SYSTEM OF CARE

PROGRAM UPDATES

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AOA Systems
BHSD Housing

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

BHSD Housing Goals

- Prevent homelessness by providing access to stable and appropriate housing
- Utilize Housing First and harm reduction principles
- Create various levels of housing, from residential care homes to independent housing, to place individuals in housing appropriate for their needs
- Increase bed capacity of Acute and Subacute Care Facilities, MH Community Residential Facilities, and Substance Use Treatment Residential Facilities so that individuals are able to transition from one level of care to another without delay

Housing Strategies

1. Housing Stabilization
   - Established Wellness and Housing Stabilization Program (WHSP), an emergency rental assistance to prevent homelessness and provide housing stabilization for clients in outpatient programs.
2. Transitional (Interim) Housing
   - Use transitional housing to quickly house and stabilize individuals to transition them for permanent housing.
3. Permanent Supportive Housing (PSH)
   - Provide permanent or ongoing housing assistance for individuals in intensive outpatient programs.

Housing Expansion

Behavioral Health Bridge Housing (BHBH) Grant

- Increase shelter beds
- Provide short-term rental assistance, security deposit
- Board and Care Patches
- Incentives for independent housing operators and family members living with individuals receiving BH services
- Increase Master Lease Housing

Community Care Expansion (CCE) Grant

- Provide Capital Improvement support to prevent Licensed Residential Care Facilities from closing
- Provide Patches for Licensed Residential Care Facilities

Facilities

- Continual partnership with the Office of Supportive Housing (OSH) to look for opportunities to increase shelter bed capacity, rapid rehousing, and permanent supportive housing.
- Work with Facilities and Fleets (FAF) to identify potential sites for MH and SUDs treatment facilities
- BHSD contracted with Hallsta, a consultant that provides healthcare construction and facility management to identify sites for BHSD services
- Evaluated 15 county properties as potential sites for the Mental Health Rehabilitation Center (MHRC) and other behavioral health facilities.

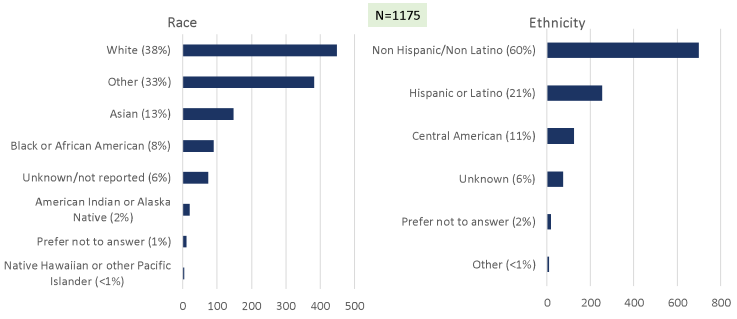
CROSS SYSTEMS INITIATIVES DIVISION

Full Service Partnership

Full Service Partnership - FSP

- Provides intensive, wraparound services to adult (age 26-59) and older adult (age 60 and over) individuals with severe mental illness and/or co-occurring disorders with a low staff to consumer ratio (1:10)
- "Whatever it takes" approach
- Community-based model
- Evidence-based practices
- FSP program aims to
  - Decrease mental health stigma, frequency of hospitalizations and incarcerations, and homelessness.
  - Promote recovery, housing stability, and meaningful improvements in key areas of life
- Total capacity – 802

FSP FY23 Client Demographics



Full Services Partnership

FSP Program Outcomes

- Clients served – Out of 802 contracted capacity, 1175 unduplicated clients were served. Unduplicated clients overserved by 373 or 47%.
- Engagement outcomes – Number of referrals received is 348 and out of which 211 were opened. Admission rate is 61%.
- Access timeliness – Average days to first offered assessment appointment is 8.3 days.
- Successful discharges - Number of discharges is 161 and out of which 78 were successful. Successful discharge rate is 48%.

FSP Program Highlights

- FSP program expanded by 88 new slots from FY22 to FY23, total increased capacity from 714 to 802.
  - Continued to have overserved and performed on target
  - Continued to have delivered services in the community
  - Continued to have used Evidence-Based Practices and modelled "whatever it takes" approach with whole person support
  - Continued to have taken proactive approach and utilized creative interventions to maintain beneficiaries' housing stability
  - Have learned to quickly adapt to CalAIMs expectations and succeeding in the implementation
  - Responded promptly to serve transfers from the BHSD Central Wellness and Benefits Center (CWBC) for individuals with no Medi-Cal, restricted Medi-Cal or out of county Medi-Cal

Some Challenges:
- High number of referrals
- Increased transfers from CWBC for unsponsored clients
- Staff recruitment and retention
- Difficulty in locating referred individuals who have unstable housing or are unsheltered

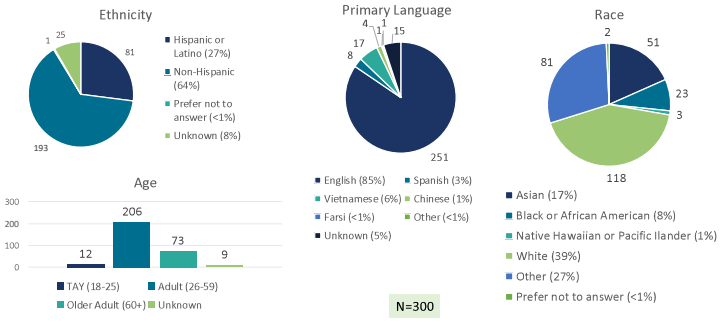
CROSS SYSTEMS INITIATIVES DIVISION

Assertive Community Treatment

Assertive Community Treatment - ACT

- Evidence-based behavioral health program for adults with serious mental illness who are at risk of or would otherwise be served in institutional settings.
- Comprehensive community-based model to prevent frequent and repetitive hospitalizations and/or incarcerations, and homelessness.
- ACT program aims to:
  - Decrease symptoms and reduce experience of crises by assertively providing services to promote recovery, housing stability, and meaningful improvements in key areas of life.
- Current program capacity is 250.

ACT FY23 Client Demographics



N=300

Assertive Community Treatment

ACT Program Outcomes

❖ Clients served: 300

❖ Engagement outcomes -
- 81% referral to admission rate
  - 119 referrals received
  - 96 successfully admitted

❖ Access timeliness –
- Average days to initial service – 21
  - Impacted by IMD discharge timelines

❖ Discharges
- Total 56
- Successful:
  - 23% (non administrative)
  - 50% when administrative discharges without adverse outcomes are included

ACT Program Highlights

❖ACT program expanded by 50 slots, from total capacity of 200 to 250, in January 2023
- Accepted large number of transfers from Partners in Wellness / Pay for Success program due to its closure
- Continued admitting individuals ready for discharge from IMDs
- Continued accepting transfers from other outpatient providers and Call Center referrals

❖ACT Fidelity Reviews by external evaluator
- Key fidelity indicators met by both ACT teams
- Appropriate staffing and staff to client ratios
- Fidelity to team approach
- Services delivered in the community

❖Master Lease
- Onboarded 3 new properties with total of 20 additional beds and continues housing ACT and AOT clients.

Some Challenges:
- High number of referrals
- High housing costs due to significant number of clients needing Licensed Board and Care
- Staff recruitment and retention

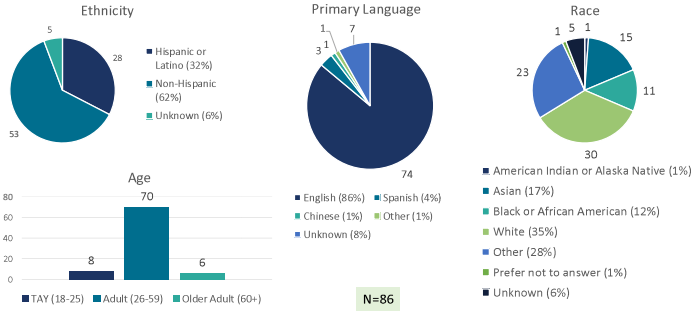
CROSS SYSTEMS INITIATIVES DIVISION

Assisted Outpatient Treatment

Assisted Outpatient Treatment - AOT

- AOT is a less restrictive form of civil commitment for individuals with severe mental illness who are unable or unwilling to receive or adhere to community mental health services voluntarily.
- In Santa Clara County, individuals may be enrolled in AOT services voluntarily and with a court order.
- AOT applies ACT service delivery model.
- AOT program aims to:
  - Interrupt the cycle of repetitive psychiatric crises and resulting hospitalizations, incarcerations, and homelessness for people with the most serious mental health problems who struggle to engage in services.
- Current program capacity is 100.

AOT FY23 Client Demographics



Assisted Outpatient Treatment - AOT

Triage and Referrals

- BHSD Triage team Received and investigated 182 AOT referrals in FY23
  - 71 met AOT criteria and were referred to AOT providers
  - The rest were offered other behavioral health services and resources, as appropriate
  - The Triage team established effective warm handoff process to AOT and other BH providers.

Program Outcomes FY23

- Clients served: 86
- Referrals to AOT providers: 71
- Engagement
  - Consented to treatment : 57 (80%)
- Petitions filed with court: 6
  - Settlement agreements: 3
  - Court orders: 3
- Discharges: 21
  - Successful: 10 (48%)
    - Moved with linkage to services; linkage to other BH services or private insurance plans.
  - Other discharge outcomes: 11
    - Incarcerated; state hospital etc.

AOT Program Highlights

- AOT program expanded by 50 new slots, from initial capacity of 50 to 100, starting January 2023
- Master Lease
  - Onboarded 3 new properties with total of 20 additional beds and continues adjusting to AOT clients' unique needs
- Housing placements and status:
  - Master Lease – 9%
  - B&C – 16%
  - Living with family – 17%
  - Independent living – 5%
  - In other residential/treatment settings – 15%
  - Incarcerated – 12%
  - Unsheltered – 3%
  - Unable to locate 23%
- Preliminary outcomes show overall decrease (though not statistically significant yet) in emergency services use and number of incarcerations.

Some Challenges:

- Fast growth in client number while still learning the best way to serve
- Increasing number of court referrals
- Staff recruitment and retention
- Housing challenges
  - Behavioral barriers
  - Other barriers: lack of id; history of evictions, etc.
- Difficulty locating referred individuals

CROSS SYSTEMS INITIATIVES DIVISION

Independent Living Empowerment Project

Independent Living Empowerment Project – ILEP

Launched in April 2022

In partnership with Community Health Improvement Partners (CHIP).

ILEP Goals:

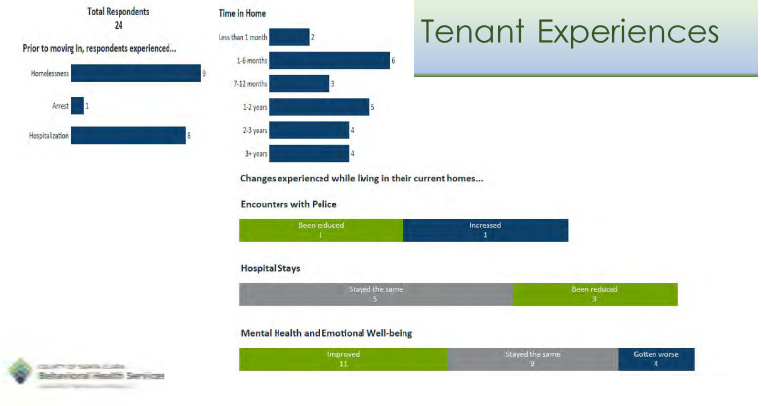
- Improve tenant experiences in independent living homes
- Improve health outcomes and social determinants of health for independent living tenants
- Improve staff/operator skills and relationships with tenants
- Increase the number of independent living homes providing housing to BHSD clients

CIBHS (California Institute for Behavioral Health Solutions) evaluated the program's success in achieving those goals.

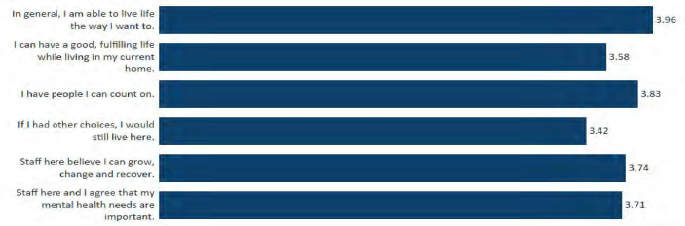
Program Highlights

- Independent Living Association (ILA) of Santa Clara County
  - Quality Standards
  - Peer Review and Accountability
- Current ILA Membership
  - 6 member homes / 57 beds
  - 5 applications in process
  - Ongoing outreach
- Funding obtained for operator incentives
- Operators reported a positive experience with ILA
  - ILEP staff supportive and trustworthy
  - Constructive feedback to address any issues in their home.

Tenant Experiences



Tenant Experiences



Responses were weighted from 1 (strongly disagree) to 5 (strongly agree)

CROSS SYSTEMS INITIATIVES DIVISION

Intimate Partner Violence Prevention Program

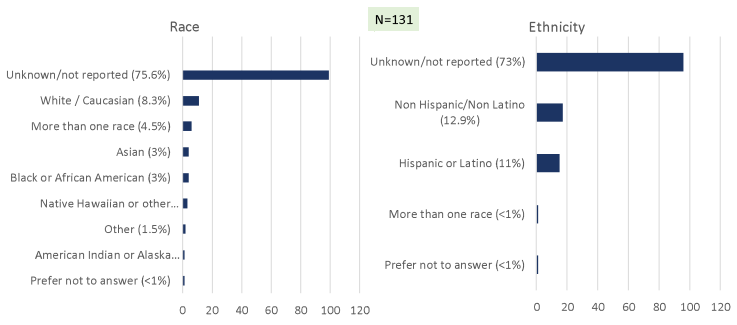
COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Intimate Partner Violence - IPV

- IPV is funded under the Prevention and Early Intervention (PEI) component of MHSA. Program is to serve transitional aged youth (TAY), adult, and older adult individuals
- Focusing on education, trainings, and outreach
- Networking and collaborating with other community resources
- Linking clients to resources
- Referring clients to other programs as needed
- IPV program aims to
  - ❑ Increase ability to identify warning signs of intimate partner violence, unhealthy relationships, and stressors
  - ❑ Increase coping skills to foster healthy relationships
- Total Capacity – up to 300

IPV FY23 Client Demographics

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery



IPV Program Highlights

❖ IPV program launched July 1, 2023. In FY23, IPV served 131 clients.

- ❑ Served Tay youth and began to expand target audience to adult and older adult population
- ❑ Increased networking and collaborating with other IPV/DV community resources
- ❑ Provided outreach and delivered services in the community
- ❑ Increased partnership with community resources to provide more workshops and presentations

Some Challenges:

- Delayed program implementation due to difficulty in staff recruitment in Q1 and Q2
- Capacity deliverables has yet to be met
- Client demographics has yet to be fully reported
- Challenge in reaching out to adults and older adults population

ADULT/OLDER ADULT (AOA)

Our Vision

The Santa Clara County AOA System of Care seeks to provide a Continuum of Care that is successful in supporting individuals experiencing behavioral health symptoms, and ensuring that all residents facing challenges of mental illness, co-occurring or substance use disorder are;

- Physically and emotionally healthy, happy and thriving;
- In safe and permanent living situations;
- Part of a caring and supportive social network;
- Involved in meaningful school, work, and family activities;
- Stable and secure within their environment and not causing harm to self and others.

SYSTEM PRIORITIES

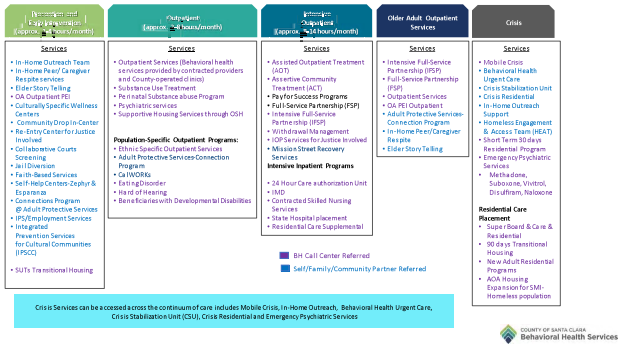
Increase	Increase Outreach, Engagement, and Access to Timely Services
Promote	Promote Wellness and Recovery
Reduce	Reduce Recidivism and Maximize Residential Capacity
Increase	Increase Trauma Informed Care with Culturally Sensitive Services
Integrate	Successfully Integrate into the Community
Increase	Increase Natural Networks of Supportive Relationships

STRATEGIC PLAN

interrupt the cycle of EPS, hospitalization, and incarceration and facilitate connection to care	• Modify contracts and programs to increase flexibility of outreach and engagement services offered to high utilizers of services • Modify Urgent Care & Addiction Medicine services to include walk-in options for individuals with mental health & Co-occurring disorder • Develop Same-Day Access for residential Substance Use Treatment from EPS, Inpatient hospitals & Jail
strengthen the community-based system of care for people with the most intense service needs	• Strengthen existing Intensive Outpatient programs to centralize housing options • Develop a Housing Stabilization program • Expand services for individuals requiring Withdrawal Management services • Expand Adult Residential Treatment options
facilitate access to the appropriate level of care and align capacity to demand	• Timely Access to Care: Expand outpatient capacity • Build processes for county-operated services by re-designing access to care, provision of outpatient service (service activity), Length of stay, staffing etc. • Improve transitions of care to PCBH using CAL-AIMs tools • Expand Outpatient services across AOA system of care

COUNTY OF SANTA CLARA Behavioral Health Services

ADULT AND OLDER ADULT SYSTEM OF CARE



COUNTY OF SANTA CLARA Behavioral Health Services

AOA System Program Highlights

- **Evans Lane obtained State certification** to provide services for justice involved clients with co-occurring MH/SUTS needs the County-operated mental health clinic.
- **Successful implementation of Cal Aim payment reform** as of July 1st, 2023, in the Outpatient programs for County & Contracted agencies
- **Intensive Outpatient Programs (FSP/IFSP) are full merged into one continuum, that ensures appropriate level of care** for clients and addresses **timely access** and **continuity of care.**
- **Distributed 2,494 Narcan Kits** through vending machines in justice settings. **Expanding Narcan training and distribution** in libraries, school settings, and more.
- **Expand SUTS Services** to Improving Timely Access, Increasing Bed Capacity, and Addressing Needs of High Need Individuals.
- **Increased community awareness by increasing the number of Outreach & Stigma Reduction activities** provided in the community and in the Peer run self-help Centers.

Inpatient and Residential Services Division

COUNTY OF SANTA CLARA Behavioral Health Services

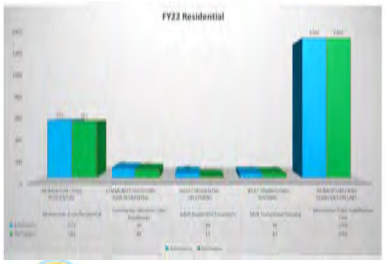
Program Description

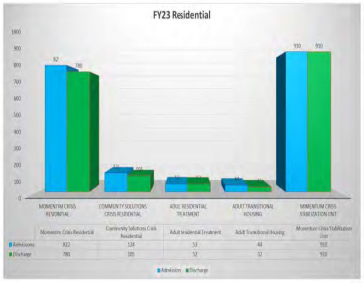
- The BHSD 24 Hour Care Unit is a centralized program that provides clinical assessment and authorization of placements for Santa Clara County adults ages 18 years and older into the following MHSA funded programs: Crisis stabilization unit, short-termed crisis residential treatment, long-term adult residential treatment, and adult transitional housing.

Program Goals

- Reduce the rate of recidivism into inpatient psychiatric and justice settings
- Increase residential care beds for SCC adults with co-occurring disorders
- Decompress the overcrowding issue within the jail and hospital settings

Numbers Served





COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Referral Tracking*

Level of Care	Number of Referrals
Crisis Residential	772
Crisis Extension	280
Shelter	238
SNF	60
IMD	155
RCF	284
Total	1,678

*Note: Referral counts are for a 6 month time frame in FY23.

CLINICAL AND WELLNESS SERVICES DIVISION

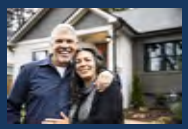
COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

CWS Program, Descriptions, Goals and Outcomes

VISION
The Clinical and Wellness Services Division is committed to ensure that all Adults and Older Adults who reside in Santa Clara County can find hope and support to live a healthy and meaningful life.

MISSION
To assist individuals in our community affected by mental illness, substance use and serious emotional disturbance to achieve their hopes, dreams and quality of life goals.

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery



ADULT AND OLDER ADULT OUTPATIENT SERVICES SUMMARY

Who we Serve
AOA Outpatient Services offers a wide range of behavioral health services to ensure that Adult and Older Adult (18 years+) residents of Santa Clara County, both insured through Medi-Cal and/or Medicare or are uninsured have access to quality behavioral health services.

How to Obtain Services
Santa Clara County residents who call the Behavioral Health Call Center are matched with the appropriate provider for a Mental Health Assessment.

What Services are Offered
Outpatient providers offer a full array of services including Mental Health Assessment, Medication Support Services, Rehabilitation Counseling, Individual and Group Therapy, Crisis Intervention, Community Linkage to resources and wellness services.

How and Where Services are Provided
Services are offered at the outpatient clinics; in-person, via telehealth and access is provided for telehealth space for residents to use hence eliminating the technology barriers to receiving care in their desired setting.

COUNTY OF SANTA CLARA
Behavioral Health Services

Innovation

Stigma and Trauma Reduction

WELLNESS • RECOVERY • RESILIENCE

Ujima Stigma and Discrimination Reduction Program

Increased African American/Ancestry/Black community knowledge of and access to BHSD/SCC/community resources available.

Decreased stigma by pairing community building events alongside mental health and substance use education and resource facilitation.

Reduced isolation and expanded connections for African Parents.

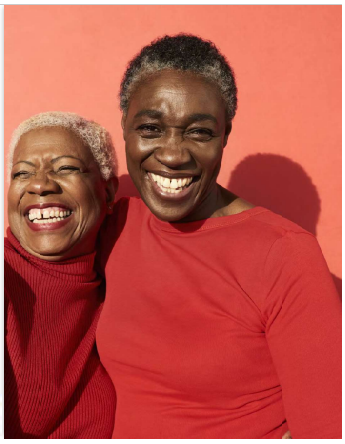
Ubuntu Wellness Center (Collaboration with Ujima and Roots Center)

- 75 Healing Circle Events (806 dup. clients, 453 und. clients)
- 29 Parent Cafes (124 dup. clients, 35 und. clients)
- 22 Tabling Events (1,878 people reached)
- 26 referrals

African/Black outreach is most effective when conducted via relations with the African/Black network. It has increased our participation count, is helping us increase our reach and provided a sense of credibility.

- Working with people in the community, whom the community know & respect
  - Faith Based organizations
  - Medical centers
  - Fraternities & Sororities

Parent cafes are constantly being requested due to the way we executed them in a culturally relevant and healing manner. "I absolutely love the space', 'Really good idea- Definitely needed'



VIVO Program

Decreased stigma by holding community discussions on critical topics and sharing the discussions on radio broadcasts.

- 56 Family Harmony Workshops
- 6 tabling events (570 people reached)
- 488 Referrals
- Outreach to over 4,000 via radio56 workshops-cafes & circles (1,045 dup. clients, 607 und. clients)
- Outreach: Weekly airtime on Vietnamese radio (40,000 est. listeners)

"Thanks to VIVO's deep understanding of the community dynamics including its culture, issues, stigma, and outreach, VIVO has given the name "Family Harmony" to the program, which conveys a positive and nourishing feeling that invites people to respond, participate, and speak up."

Radio. During Y1, VIVO contracted with a local radio station commonly used by the Vietnamese community. They have arranged for weekly airtime in which a staff member (Mr. Tam) revisits the main speaking points from that week's Family Harmony Workshop. It is estimated that each week's radio address reaches an audience of over 40,000.

Prevention and Early Intervention

Ethnic Wellness Centers
Older Adult Prevention & Early Intervention
Older Adult In Home Peer Respite
Older Adult Elder Storytelling
IPSCC
New Refugee
Promotores

PROVIDER	OUTREACH IN COMMUNITY (SELF-REPORTED)
Indian Health Center – American Indian/Alaska Native	8,379
Gardner Family Health Network (Latina/Hispanic)	40,516
Gardner Family Health Network (African Descent)	8,473
Mekong (Asian, Pacific Islanders)	8,379

Ethnic Wellness Center

- Increase access to ethnic and culturally reflective, strength-based behavioral health treatment services, including outreach, education, and preventive counseling.
- Build individual, community, and organizational capacity, knowledge, and skills that contribute to the prevention of behavioral health disorders.

Provider	Clients Served (Unduplicated)
Gardner Family Health Network	65

Older Adult Prevention and Early Intervention

Goals

- Provide assessment, counseling, case management services that focus on early symptoms of mental health in older adults with Peer Support, for up to four months.
- Utilize Evidence Based Practices (EBPs) to stabilize symptoms to prevent further symptoms.

Outcomes

- Program successfully served 65 Older Adult clients
- 100% of clients transitioning from the program successfully met PEI treatment goals.
- Clients were linked to long term outpatient services and/or community resources.

Provider	Clients Served (Unduplicated)
Gardner Family Health Network	47

In Home Peer Respite

Goals

- Mobilize peers to provide respite services, supportive counseling, visitation, and linkage to community resources.
- Provide caregivers on-going time away while simultaneously providing the older adult with companionship and social supports.

Outcomes

- 100% Respite services offered to the caregiver reduced caregiver stress and successful linked them community services.
- 71% of clients and 66% of caregivers reported experiencing a decrease in symptoms of depression
- 76% of clients and 62% of caregivers experienced significant improvement in life functioning at discharge.

Provider	Clients Served (Unduplicated)
Gardner Family Health Network	54
Asian Americans for Community Involvement	58

Elders' Storytelling

Goals

- Serve isolated older adults with mild/moderate depression using culturally proficient techniques of life review (reminiscence therapy).
- Incorporate innovation and creativity to help client's depressive symptoms and restore them to social connectedness with family, friends, caregivers, and community.

Outcomes

- Program served 112 older adult clients.
- 100% successful participant completion rate.
- Clients successfully shared their story as elicited and documented by Peer Specialist and transformed into a storybook (100%).

Provider	Clients Served (unduplicated)
Asian Americans for Community Involvement	201
Gardner Family Health Network	553

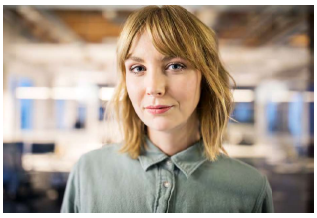
Integrated Prevention Services for Cultural Communities

Goals

- The goal of the program is to improve access for cultural communities to behavioral health services by care coordination and providing them as an integrated part of our primary health centers to improve clients emotional, physical, and overall wellbeing.

Outcomes

- 100% of clients report feeling better as a result of receiving services. 91% reported being satisfied with services and attention received.
- Consumers and the members of their support networks are supported in accessing the services they need to support their recovery and wellness.



Provider	Clients Served (unduplicated)
Asian Americans for Community Involvement	117

New Refugee

Goals

- The goal of the program is to reduce stigma and increase awareness of available mental health services for newly arrived refugees and intervene at the early signs of mental health issues.

Outcomes

- 71% of clients improved in their daily living functioning.
- 61% of clients reported an improvement in their mental health

Provider	Clients Served (Unduplicated)
Gardner Family Health Network	3,058

Promotores

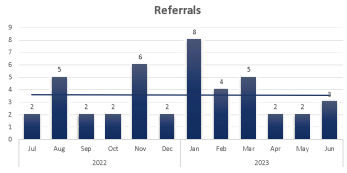
Goals

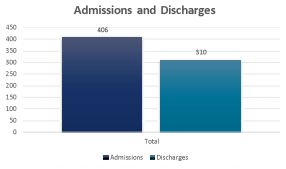
- Outreach and education to increase access to ethnic and culturally reflective, strength-based behavioral health treatment services, including housing, legal healthcare and preventive counseling.

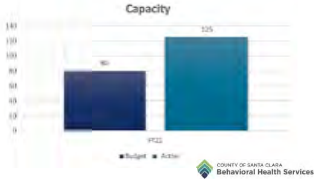
Outcomes

- Build individual, community, and organizational capacity, knowledge, and skills that contribute to the prevention of behavioral health disorders, using the "Promotores" community-based model.

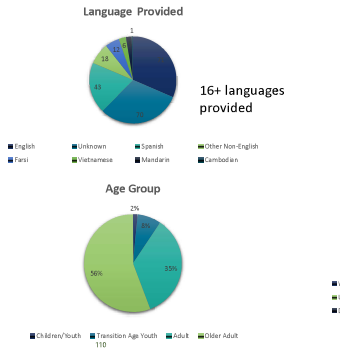
FY22-23 DATA - CWS CONTINUUM OF CARE FOR CCP – PEI PROGRAMS

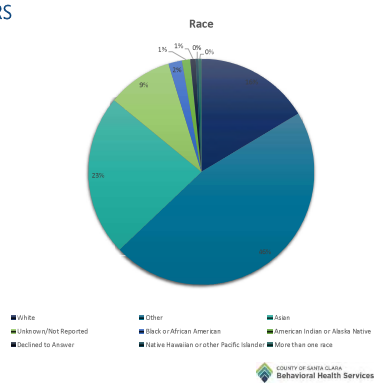






FY23 DEMOGRAPHICS – PEI PROVIDERS





COUNTY OF SANTA CLARA Behavioral Health Services

Community Services & Support (CSS)

Outpatient
Ethnic Outpatient
Deaf & Hard of Hearing
Intellectual and Developmentally Disabled
Employment Services (IPS/SE)
CalWORKs-Health Alliance
County Clinics
Behavioral Health Urgent Care
Connections

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

Adult and Older Adult Outpatient – Contracted Providers

- Outpatient (served 5,994 unduplicated clients)
- Ethnic Outpatient (served 383 unduplicated clients)
- Deaf & Hard of Hearing (served 26 unduplicated clients)
- Intellectual and Developmentally Disabled (served 1,367 unduplicated clients)

Goals
- Clients access Medication & BH support (therapy, rehabilitation, case management, crisis and linkage) to manage symptoms and maintain wellness, & avoid higher care levels
- Clients stabilize and improve integration in the community
- Reduce costs to other areas (ER, EPS, Jail, Residential)

Outcomes
- Program serves approximately 7,770 adults and older adults
- 3,617 new referrals to services, discharged 3,866 clients
- Continued to successfully manage high numbers of referrals and provide services during times of intense need in the County.

Adult and Older Adult Outpatient – County Providers

Central Wellness and Benefits Center (CWBC), Downtown Behavioral Health (DMH) and Vietnamese American Services Center-Behavioral Health (VASC-BH)

CWBC Serves underserved and unserved primarily bilingual Latino/X 32% and Vietnamese 3.1% speaking beneficiaries. Linkage to Vocational Service and IPS. Serves 966 unduplicated clients.

DBH Offers Same Day Access, TAY Transition program and emphasizes serving bilingual speaking beneficiaries. Serves 1,102 unduplicated clients.

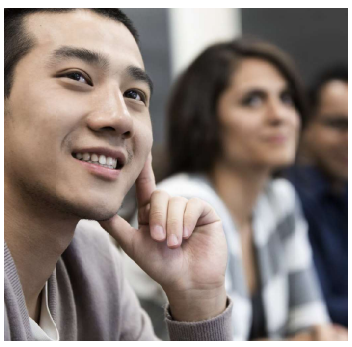
VASC-BH Primarily serves bilingual/bicultural Vietnamese clients, as well as Hispanic clients in a "one-stop shop" location with multi-services from other health, social services and community partners. Served 236 unduplicated clients. Monthly average # of clients served increased threefold, from 45 to 150, compared from first 6 months of FY' 23 to last 6 months of FY '23.

Employment Services IPS/SE

IPS/SE is for people with serious mental illness to work on their individual barriers to employment. Getting and keeping gainful employment is the treatment goal. IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing.

Goals
- IPS/SE is for people with serious mental illness (e.g., schizophrenia spectrum disorder, bipolar, depression) to work on their individual barriers to employment
- Getting and keeping gainful employment is the treatment goal.
- IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing.

Outcomes
- Catholic Charities of Santa Clara County: 54 clients
- Fred Finch: 32 clients
- Momentum for Mental Health served: 77 clients
- 115 clients employed competitively at any one time
- 83 New Job Starts
- 32 successful discharges from the program
- 9 clients enrolled in formal education programs



Outpatient – CalWORKs Health Alliance

Provides behavioral health services to adult clients enrolled in the Welfare-to-Work (WTW) Program who experience mental health and substance abuse issues. Health Alliance is a partnership between County of Santa Clara Social Services Agency, Santa Clara Valley Health and Hospital Systems' Department of Alcohol and Drug Services (DADS), and BHSD.

- Gardner Family Health Network, Catholic Charities of Santa Clara County (CCSCC), Asian Americans for Community Involvement (AACI)

Goals
- To help address issues that prevent people with mental health issues from obtaining and maintaining employment which can help them transcend poverty. The program focuses on the health of the whole person by providing individualized counseling and other services to enhance and support self-sufficiency

Outcomes
- Program served 292 unduplicated clients
- 61% Successful Discharge

Outpatient – *Behavioral Health Urgent Care (BHUC)*

BHUC is a walk-in outpatient clinic for all residents in need of urgent mental health services. Offers immediate relief to people in psychiatric distress by providing time-limited, urgent, therapeutic and psychiatric interventions.

Goals

- To avoid, or reduce, the need for involuntary hospitalization, psychiatric emergency room visits, and incarceration.

Outcomes

- 2,640 client episodes open
- 1,101 EPS/BAP/psychiatric hospital referrals
- 271 involuntary holds
- 94 bridge medication requests
- 470 Same Day Access medication evaluations

Outpatient – Connections

The Connections Program is a collaboration with Social Services -Adult Protective Services (APS) to provide short-term counseling and linkage services to older adults ages 60 and older who are at risk of abuse or neglect and have come to the attention of APS.

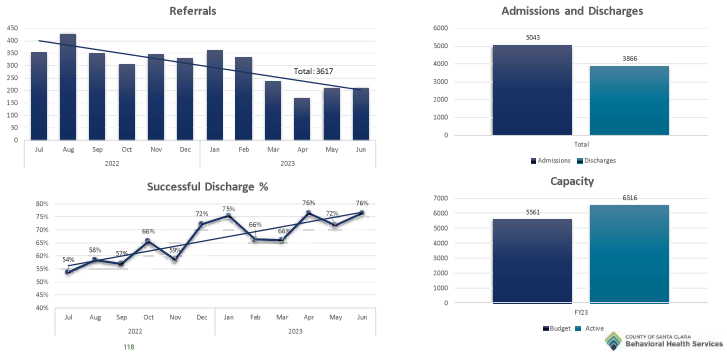
Goals

- BHSD clinician assesses SSA APS older adults and dependents clients referred to the program
- Provide short term mental health services and link to long term services and community resources.

Outcomes

- This program served 98 unduplicated client's therapy and/or linkage services.
- 100% of participants transitioning from the program successfully met goals

FY23 DATA - CWS CONTINUUM OF CARE FOR CCP – OUTPATIENT PROVIDERS



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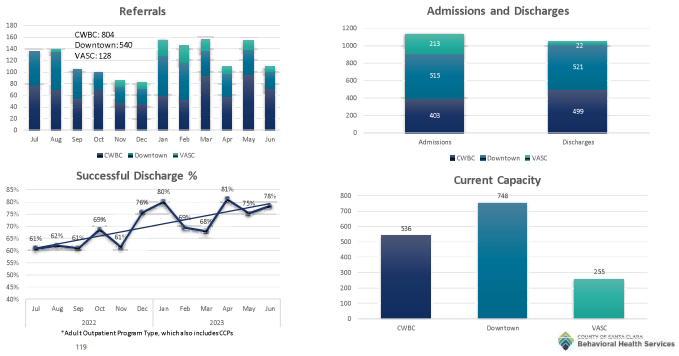
FY23 DATA - CWS CONTINUUM OF CARE FOR CCP – COUNTY PROVIDERS



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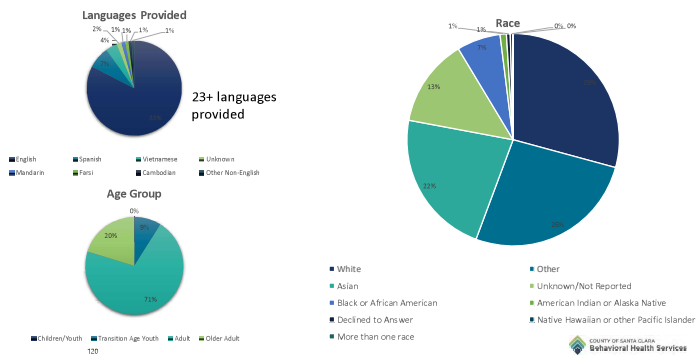
FY23 DEMOGRAPHICS – OUTPATIENT AND COUNTY PROVIDERS



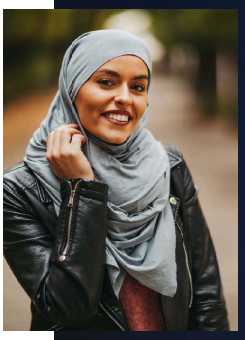
120

Success and Highlights

A client was referred to Catholic Charities and was in a Transition Housing Unit (THU), struggling with alcohol use. The treatment team supported her recovery to the point that she obtained a position of Assistant Manager of the THU and is now mentoring and coaching the residents and helping them manage their ADLs.

A 70-year-old monolingual speaking Korean woman with paranoia and severe depression. Due to her symptoms and cultural stigma of mental illness, she has been isolated and had impaired relationships with her neighbors. Through collaboration, this client has restored family relationships and engage in daily activities such as scheduling medical appointments, handle banking transactions, exercising & healthy eating. She has learned how to communicate more effectively with her neighbors and set boundaries with families.

VASCBH - Monthly workshops / trainings for the community at large on behavioral health topics & healthy family relationships, e.g., Family Conflict Resolution, Seeking Safety, Queer and Asian Support Group. Provides Walk-in and same day service access availability.



Questions and Comments

Forensic Diversion & Reintegration Division

(formerly known as Criminal Justice Services)

CRIMINAL JUSTICE SERVICES DIVISION: PROGRAMS DESCRIPTION & GOALS

Program Name	Description	Goals
CRIMINAL JUSTICE SERVICES (CJS) EVANS LANE OUTPATIENT AND RESIDENTIAL	• Both an Outpatient and a Residential program for justice involved clients • Provides comprehensive outpatient behavioral health services that combine components of recovery-oriented, evidence-based practices, promising practice, and trauma-informed practices • Provides safe and temporary housing for un-housed justice involved adults/older adults.	1. Promote recovery and increase quality of life 2. Decrease negative outcomes such as hospitalization, incarceration, and homelessness 3. Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports
CRIMINAL JUSTICE SERVICES (CJS) FULL SERVICE PARTNERSHIP (FSP) PROGRAM	• Serves justice involved individuals with severe mental illness to provide intensive, wraparound services with a "whatever it takes" approach. • Provides full spectrum of community services necessary to attain the goals identified in each person's Individual Services and Supports Plan (ISSP) • A criminogenic risk and needs assessment is performed on adults enrolled that assist treatment programs address areas such as criminogenic thinking and antisocial behavior.	1. Promote recovery and increase quality of life 2. Decrease negative outcomes such as hospitalization, incarceration, and homelessness 3. Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports

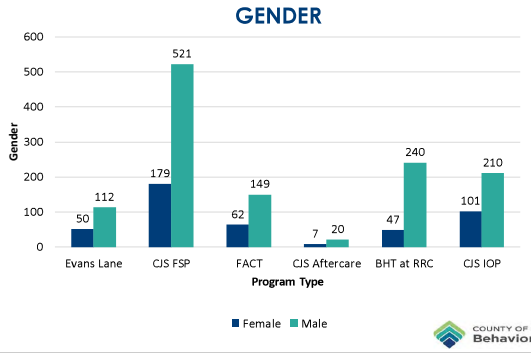
CRIMINAL JUSTICE SERVICES DIVISION: PROGRAMS DESCRIPTION & GOALS

Program Name	Description	Goals
CRIMINAL JUSTICE SERVICES FACT PROGRAM	• Comprehensive community-based model of treatment, support, & rehabilitation for severely mentally adults unwilling or unable to engage in mental health services and frequent repetitive incarcerations, likely to be homeless, may have a co-occurring disorder. • Multidisciplinary team that consists of a low staff to client ratio (1:12) • High frequency and intensity of community-based services with at least four face-to-face contacts per week for a minimum of two hours total per week, where at least 80% of services are provided in the community, not in an office.	1. Promote recovery and increase quality of life 2. Decrease negative outcomes such as incarceration, hospitalization, and homelessness 3. Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports.
CRIMINAL JUSTICE SERVICES (CJS) AFTERCARE	These services provide aftercare support for those nearing graduation or have recently graduated from the justice system but continue to require treatment while they wait to be transitioned to other systems of care. • Provides culturally and linguistically appropriate services including individual, group, and family counseling and education on wellness, recovery, and resiliency. • Offers comprehensive, coordinated services that address a variety of needs, including mental health and co-occurring conditions, situational stressors, family relations, interpersonal relationships, life span issues	1. Increase stability and quality of life 2. Decrease signs and symptoms of mental illness

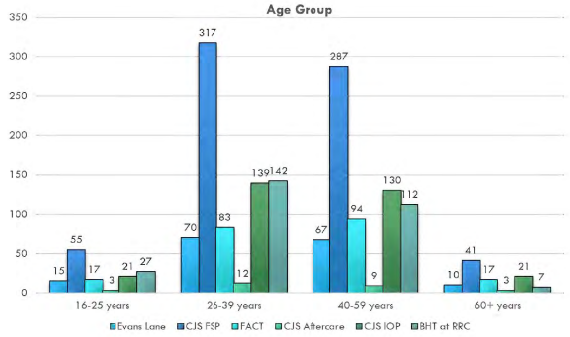
CRIMINAL JUSTICE SERVICES DIVISION: PROGRAMS DESCRIPTION & GOALS

Program Name	Description	Goals
CJS INTENSIVE OUTPATIENT	• Provides justice-involved individuals the skills to manage stress and better cope with emotional and behavioral issues. • Provides comprehensive behavioral health services for clients that combine components of recovery-oriented, evidence-based practices, promising practice, and trauma-informed practices. • Seeks to decrease negative outcomes, such as hospitalizations, isolation, abuse, incarceration, and homelessness. • Works collaboratively with other mental health & substance use agencies, physical health providers, other groups that provide supportive services, and justice partners.	1. Promote recovery and increase quality of life 2. Decrease negative outcomes such as hospitalization, incarceration, and homelessness 3. Increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and psychosocial supports
CJS PREVENTION EARLY INTERVENTION (PE&I) BEHAVIORAL HEALTH SERVICES TEAM LOCATED AT THE RE-ENTRY CENTER	• Walk-in services available (no appointment necessary) to Santa Clara County adult and older adult residents who are justice-involved. • Services include screenings and referrals to Behavioral Health (mental health, substance use and co-occurring programs) specializing in the treatment of justice involved adult clients. • When clients are danger to self or others, or gravely disabled, BH-RRC staff place clients on a Welfare & Institution Code (WIC) 5150 hold. • The BH-RRC program is also state certified as a Substance Use Outpatient treatment program.	1. Collaborate with the justice involved adults and their families to support reentry. 2. Reduce stigma associated with mental health status among those in the Forensic, Diversion and Reintegration (FDR) network of care. 3. Increase service connectedness to mental health resources among justice involved adults and older adults.

FY23 DEMOGRAPHIC INFORMATION

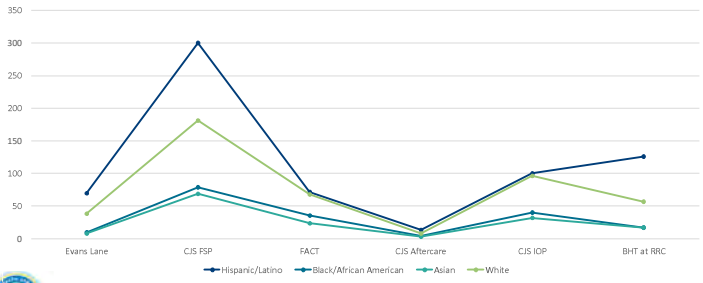


FY23 DEMOGRAPHIC INFORMATION



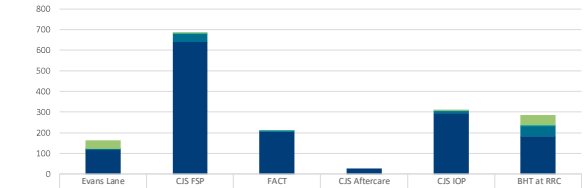
COUNTY OF SANTA CLARA
Behavioral Health Services

FY23 DEMOGRAPHIC INFORMATION
TOP FOUR (4) ETHNIC BACKGROUNDS



COUNTY OF SANTA CLARA
Behavioral Health Services

FY23 DEMOGRAPHIC INFORMATION
TOP FOUR (4) LANGUAGES



	Evans Lane	CJS FSP	FACT	CJS Aftercare	CJS IOP	BHT at RRC
Unknown	39	4	0	0	2	49
Vietnamese	1	6	2	0	2	5
Spanish	5	36	4	0	10	50
English	117	642	205	27	295	182

COUNTY OF SANTA CLARA
Behavioral Health Services

FY23 PROGRAM OUTCOMES

Evans Lane	CJS FSP	FACT	CJS Aftercare	CJS IOP	BHT at RRC
• Unduplicated beneficiaries served in the Outpatient Program was 94. The successful discharge rate was 51%. • The program filled several clinical positions with staff who dedicated to improving the lives of justice-involved individuals. • The program managers also reported new staff members contributed to positive work environment due to desire to improve their clinical skills and achieve professional growth. • Additionally, clinic set its goal of becoming a co-occurring program in FY23 for which the program underwent an arduous process to become certified to provide Substance Use Treatment Services. • At the time of this reporting, the program has submitted required documentation and has been certified by the State. • Finally, the program reported that department hiring freeze has impacted its ability to hire and on-board vacant clinical positions.	• Unduplicated clients overserved by 122 for Community Solutions and 183 for Gardner • Dosage underutilized by 4.73 hours for Community Solutions and 3.18 hours for Gardner • Case management services underdelivered by 31.52% for Community Solutions and on target for Gardner • Mental health services overdelivered by 28.56 % for Community Solutions and on target for Gardner	• Unduplicated clients overserved by 20 for FACT Track I and 7 for FACT Track II • Mental health services overdelivered by 13.49% for Track I and 7.77% for Track II	• Unduplicated beneficiaries served was 25. • The successful discharge rate was 100% for this program. • Due to increase utilization of the Aftercare program, the contracted caseload was increased from 10 to 20 for FY23. • Once individuals complete the Aftercare program, they also successfully transitioned to traditional, non-justice programs. • The program manager also stated that they were able to utilize housing flex funds to provide temporary housing to individuals facing homelessness	• 375 individuals with serious mental illness referred to treatment • 225 individuals followed through on the referral and engaged in treatment • Average 14 intervals between the referral and participants in treatment (defined as participating at least once in the treatment to which referred) and standard deviation • Despite staffing challenges, IOP continues to have solid core of case managers who have been with program since inception. • The IOP program also works hard in connecting individuals with stable housing. The IOP program reports that placement continues to be the biggest barrier for justice-involved individuals as housing can either be extremely expensive or low quality with poor supervision.	• 373 individuals with serious mental illness referred to treatment • 217 individuals who engaged in treatment • Four (4) days average interval between the referral and participants in treatment and standard deviation

COUNTY OF SANTA CLARA
Behavioral Health Services

CLIENT SUCCESS STORIES

Outpatient (~4-7 hours/month)	Intensive Outpatient (~8-14 hours/month)	Full Service Partnership (~4-7 hours/month)
· Adult male under court supervision was referred for psychiatric treatment · Received case management services, therapy, and psychiatry · Obtained independent housing · Found employment · Successfully graduated court	· Adult female referred to treatment for psychotic symptoms and substance use · Lost custody of child as a result of psychiatric hospitalizations · Received intensive case management, therapy and psychiatric medications · Regained custody of child · Obtained employment · Successfully graduated program to a lower level of care	· Adult male with a history of paranoia cycled in and out of incarceration and homelessness · Received weekly rehabilitation groups and regular check-ins with case manager · Consistently met with psychiatrist for medication management · Obtained steady employment · Found stable housing · Successfully graduated from the program due to symptom stability

COUNTY OF SANTA CLARA
Behavioral Health Services

OTHER KEY INFORMATION

FY23 Challenges

- Department hiring freezes impacted the program's ability to hire and on-board vacant clinical positions.
- Group treatment continues to be a challenge due to ongoing fluctuations of COVID-19 transmissions from large gathering.

FY24 Changes

- In the FY24 and FY25 annual plan update, a Division name change will be reflected. The Criminal Justice Services (CJS) Division changed its name to the Forensic, Diversion and Reintegration (FDR) Division. This change was officially announced in the FY23 SLC meetings.

COUNTY OF SANTA CLARA
Behavioral Health Services

Peer Services Division

(formerly known as Office of Consumer Affairs, Office of Family Affairs and Cultural Communities Wellness Program)

Peer Services Division Description & Goals

- Three teams of peer specialists (OCA, OFA, CCWP) providing the following services:
  - Peer Services, 1:1 Peer Support, Variety of Daily Psycho-Educational and Support Groups, Social, Cultural and Educational Activities, Workshops and Trainings
  - Peer provides resources, linkages and referrals to community resources
  - Two walk-in Navigation Sites: Zephyr and Esperanza Self-Help Centers

Peer Services Division Description & Goals continued

Top Priorities for FY 23

Increase:

- Outreach and Engagement
- Culturally Sensitive and Linguistic Services and highlight lived experience to improve beneficiary experience
- Self-help, consumers and family involvement
- Natural networks of supportive relationships

Promote and Improve:

- Wellness and Recovery
- Peer Services integration and access to the Behavioral Health Services (i.e. Inpatient, Outpatient, MAT, Urgent Care, etc.)

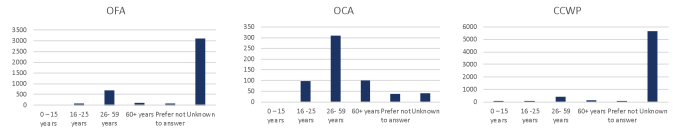
Demographic Info & Numbers Served

Total Served and Cost per Person			
Programs	**FY 22**	**FY 23**	**% Increase**
Office of Consumer Affairs (OCA)	2247	5357	138% increase
Office of Family Affairs (OFA)	3491	5322	52% increase
Cultural Communities Wellness Program (CCWP)	5355	6288	17% increase

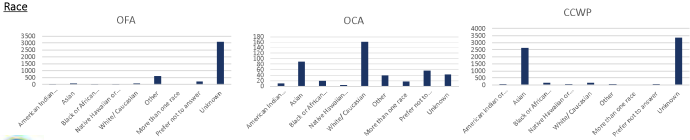
Total: Unduplicated Data: OCA: 5357 OFA: 5322 Duplicated Data: CCWP: 6288

Demographic Info & Numbers Served

Age

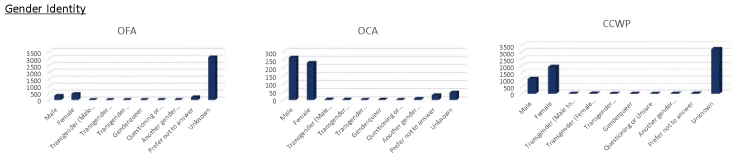


Race

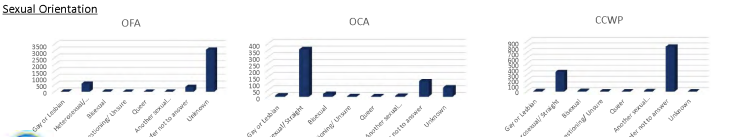


Demographic Info & Numbers Served continued

Gender Identity

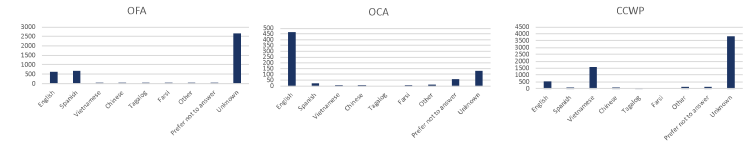


Sexual Orientation



Demographic Info & Numbers Served continued

Language

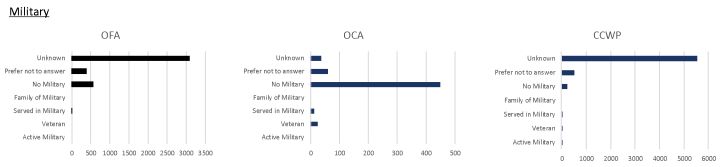


Disability

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Demographic Info & Numbers Served continued.

Military



COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Program Outcomes

- Data showed an increase in services from FY22 to FY23 (138% OCA, 52% OFA, 17% CCWP)
- With the goals to reduce stigma and improve/change in attitude or behaviors toward behavioral health services, data showed less people are:
  - more likely to state they are less ashamed about their own mental health after receiving education services and training
  - less worry telling other people about their mental health
  - less worry telling other people about receiving psychological treatment (Therapy, Medications, etc.)

Program Success

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Program	Services	Peer certification	Staff Hired	Division highlights/success
Office of Consumer Affairs	• 138% increase	• 5	• 4 – 2 bilingual	• Reopened both Self-Help Centers full-time • Expanded training for Navigation services: System of Care, and Peer Certification training
Office of Family Affairs	• 52% increase	• 4	• 3 – 1 bilingual	• Accounted for 1007 calls at the Navigator Program for fiscal year 2023 • Expansion of outreach services to 12+ additional sites
Cultural Communities Wellness Program	• 17% increase	• 10	• 4 – 4 bilingual	• Staff facilitated 410 wellness and education sessions • Increase collaboration with County Providers and Community Partners (Vietnamese Caregiver Conference in collaboration with SCFHV, UC Davis, VASC, etc.)

Challenges

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

- Due to structural budget deficits, unable to hire into the vacant codes. Resulted in a loss of 7 codes
- With an increase of service data for all programs, and frequent need for coverage, there is a need to increase staffing
- Mask Guidelines Mandates & Eat/Drink Prohibition resulted in reduction of large volume of clients at centers
- Virtual setting of training doesn't always allow for effective PEI data collection
- Burnout and staff retention due to code/staff reduction
- Lack of a career ladder and living wage prevent recruitment, advancement and morale

Questions

MHSA FY 2025 ANNUAL PLAN UPDATE

COMMUNITY PROGRAM PLANNING PROCESS TIMELINE

146

CLOSING REMARKS & NEXT STEPS

PLEASE TAKE A FEW MINUTES TO FILL IN THE SURVEY

147

Public/Stakeholder Meetings/Activities*
To be Conducted Onsite/In-Person

MHSA FY2025 Annual Plan Update

Date	Meeting
October 18, 2023 1-4pm	Housing + Adult/Older Adult (AOA) data SSA Andrew Hill Training Room (353 W. Julian)
November 1, 2023 1-3pm	Round 1 Program Recommendations: Housing + AOA SSA Auditorium (333 W. Julian St.)
November 16, 2023 1-3pm	Round 1 Program Recommendations: Access & Unplanned, WET, CYF SSA Andrew Hill Training Room (353 W. Julian)
November 29, 2023 1-3pm	Round 2 Program Recommendations: Access & Unplanned, WET, CYF SSA Auditorium (333 W. Julian St.)
December 15, 2023 10am-12pm	Round 2 Program Recommendations Housing + AOA SSA Auditorium (333 W. Julian St.)

*Note: Additional planning/refinement meetings may be scheduled. Please stay connected for schedule info: https://bhsd.sccgov.org/about-us/mental-health-services-act.

Thank you!

For any questions about MHSA and the FY2025 MHSA Planning Process, please email MHSA@hhs.sccgov.org.

Mental Health Services Act (MHSA)
FY2025 Community Program Planning Process
Housing and Adult & Older Adult Systems of Care
Round 1 Recommendations

November 1, 2023, 1:00 PM – 3:00 PM
353 W. Julian St, San Jose, CA 95110
Pioneer & Mt Pleasant Training Rooms

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

MEETING AGENDA – November 1, 2023	TIME
1. Welcome & Background (Roshni Shah, MHSA Manager/Coordinator) a. Introductions b. Welcoming Remarks & Housekeeping	1:00 PM- 1:05 PM
2. Fiscal Update (Tina Cordero, Chief Fiscal Officer) a. Questions & Answers	1:05 – 1:30 PM
3. System-Wide Preliminary Recommendations a. Adult/Older Adult System of Care (Margaret Obilor, Director of Adult/Older Adult System of Care) b. Housing System of Care (Soo Jung, Director of Housing System of Care)	1:30 – 2:05 PM
4. Break	2:05 – 2:10 PM
5. Breakout Sessions & Discussions	2:10 – 2:45 PM
6. Closing Remarks & Next Steps	2:50 PM- 3:00 PM

Q/A sections are included in the schedule to provide an opportunity to ask questions and/or provide comment/input.

Give space, take space.

Meeting Agreements

3

Welcome & Background

- Introductions
- Housekeeping
  - Parking
  - Access to Restrooms
  - Safety Practices

4

Follow along with today's presentation!

https://tinyurl.com/EventsCPP

5

MHSA FISCAL UPDATES

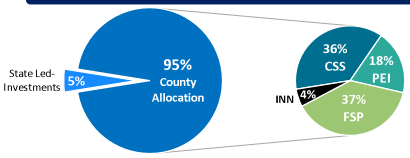
6

IMPACT OF PROPOSED BHSA MODERNIZATION ON SANTA CLARA COUNTY - AUGUST AMENDMENT

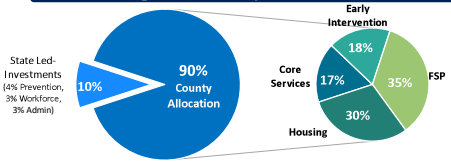
UPDATES FROM SEPT 2023 PRESENTATION

MHSA COMPONENTS VS BHSA CATEGORIES FUNDING ALLOCATIONS

Current MHSA Allocation



August BHSA Proposed Allocation

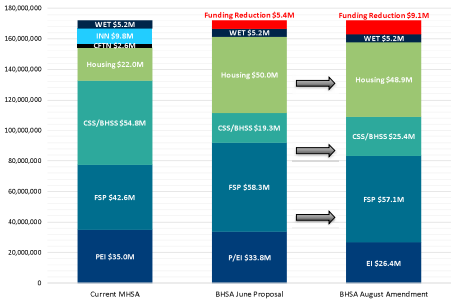


Key Takeaways

- Modernization changes MHSA name to Behavioral Health Services Act (BHSA)
- Loss of funding of 5% total BHSA funding to State-Led Investments
- Reallocating remaining 90% total BHSA funding and revising categories into new areas, notably increasing funding in Housing as standalone category, but reducing core mental health services.

COUNTY OF SANTA CLARA Behavioral Health Services

IMPACT BASED ON $172.1M PLANNED EXPENDITURES



Key Takeaways

- Loss of 5% ($9.1M) of total expenditure budget to state-led investments.
- Loss of funding for core mental health outpatient, crisis, and recovery services by 54%.
- Innovation and Capital Facilities and Technology Needs may be eliminated.
- The BHSA Proposal made in June was revised in August and may undergo further changes.

Footnote: Analysis does not reflect substance use disorders (SUD) requirements and loss of services due to Medi-Cal federal match (FFP)

COUNTY OF SANTA CLARA Behavioral Health Services

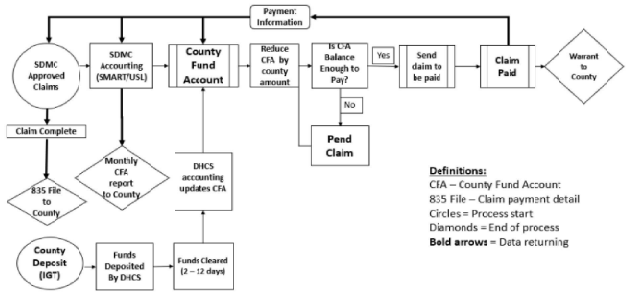
UNDERSTANDING INTERGOVERNMENTAL TRANSFERS (IGT)

Intergovernmental Transfers (IGT) Process Flow

- DHCS will establish an account threshold for each county that will be equal to approximately three months of County Fund payments based on historical claims data
- When payments arrive from county sources that are for a specific county, the DHCS accounting team will add the funds to the CFA for that county to the SDMC accounting system.
- When SDMC approves claims and processes payments, the accounting systems will adjust the CFA balance by the county fund amount of the claims. The transaction that will impact the CFA balance will be at the payment/warrant level (the amount of county fund paid on a warrant).
- If claims are received that exceed a CFA balance, claims will not be paid until the CFA balance is sufficient to pay the county share

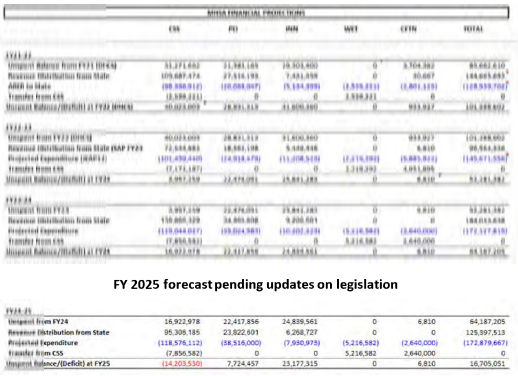
COUNTY OF SANTA CLARA Behavioral Health Services

IGT Process Flow



COUNTY OF SANTA CLARA Behavioral Health Services

MHSA Financial Projections



FY 2025 forecast pending updates on legislation

Unspent from FY24	16,922,978	22,417,856	24,839,561	0	6,810	64,187,205
Revenue Distribution from State	95,306,185	23,822,601	6,268,727	0	0	125,397,513
Projected Expenditure	(118,576,112)	(38,516,000)	(7,930,973)	(5,216,582)	(2,640,000)	(172,879,667)
Transfer from CSS	(7,856,582)	0	0	5,216,582	2,640,000	0
Unspent Balance/(Deficit) at FY25	(14,203,530)	7,724,457	23,177,315	0	6,810	16,705,051

SYSTEM-WIDE RECOMMENDATIONS & UPDATES

13

CONTINUING PROGRAM MODIFICATIONS

These include program modifications that were approved in FY2024 and are being proposed to continue for FY 2025, subject to available funding.

SYSTEM OF CARE: ADULT/OLDER ADULT (A/OA)

CONTINUING PROGRAM MODIFICATIONS

FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	STATUS	FY 2025 NET FISCAL IMPACT
CJS - Forensic Assertive Community Treatment	CSS	FACT program expansion by increasing service capacity by 50 slots to include housing support flex funds, client support flex funds, unsponsored and outreach funding	Ongoing recommendation from FY 2024	712,525
CJS – Forensic Assertive Community Treatment	CSS	Funding to support clothing and personal needs to assist individuals releasing from a custodial setting into community treatment will assist in safeguarding their health and safety as they release into community	Ongoing recommendation from FY 2024	20,000
Individual Placement Services (IPS)	CSS	CCP with the addition of Individual Placement Services (IPS) to increase accessibility to vocational education, training and workforce development to beneficiaries.	Ongoing recommendation from FY 2024	996,135

SYSTEM OF CARE: HOUSING

CONTINUING PROGRAM MODIFICATIONS

FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	ONE-TIME OR ONGOING	FY 2025 NET FISCAL IMPACT
CSI / ACT	CSS	Combining new funding and reallocating funds from Housing and Flex for Assertive Community Treatment (ACT). This additional funding will appropriate funding needs for the existing clients and increase capacity by 60 to accommodate the transfer of clients from Pay For Success (PFS).	Ongoing	1,114,720
Supported Housing Services: Homeless Engagement and Access Team (HEAT)	CSS	Add 2.0 FTE for Abode's contracted homeless outreach team too increase services geographically and increase hours of service	Ongoing	300,000

NEW PROPOSED RECOMMENDATIONS

These include new program modifications that are being proposed for consideration for FY 2025, subject to available funding.

SYSTEM OF CARE: ADULT/OLDER ADULT (A/OA)

NEW PROPOSED RECOMMENDATIONS

PROGRAM MODIFICATIONS FOR CONSIDERATION FOR MHSA FY 2024 MID-YEAR & FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	REASON FOR PROGRAM MODIFICATION & IMPACT ON SERVICES	FY 2025 FISCAL IMPACT
Momentum Adult Residential Treatment (ART) (431 N White Rd)	CSS	Moving program to be ongoing instead of one time from FY23 onwards	Continue funds to ART program located at 431 N. White Road, San Jose, CA due to current increase in admissions and utilization for FY23. This is a 24- hour program that provide services for the SMI population 365 days a year. The goal of the program is to decompress the Emergency Psychiatric (EPS) and other inpatient psychiatric settings.	+$4,437,732
NEW Momentum Adult Residential Treatment (ART) (650 Bascom)	CSS	Moving program to be ongoing instead of one time from FY23 onwards	The goal is to set aside funding to support: • development (financing, construction, rehab, acquisition) of new temp shelter, temp treatment and permanent housing • support efforts around increasing all the new program/work plan/set aside for the Purchase & renovation of Properties • to increase Residential Care Facilities (RCF), Temporary Shelters, Adult Residential Treatment (ART), Crisis Residential program and Master lease shared housing options in a phased approach since these projects require on going funding.	+$4,000,000
			TOTAL ART BUDGET FOR FY2025	$12,229,108

SYSTEM OF CARE: HOUSING

NEW PROPOSED RECOMMENDATIONS

PROGRAM MODIFICATIONS FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION & IMPACT ON SERVICES	FY 2025 NET FISCAL IMPACT
Permanent Supportive Housing (PSH) request to move housing flex budget to 3rd party admin	CSS	Reallocation $3.9M ongoing in FY24 Mid-Year and $7.3 ongoing in FY25 from FSP contracts Flex/Housing to support MHSA CSS PSH initiative	No Net Fiscal Impact FY24 mid-year reallocation: $3,900,000 to PSH FY25 reallocation: $7,300,000 to PSH
Sunsetting Independent Living Empowerment Program (ILEP)	INN	Termination of ILEP implementation after it reaches its term as an Innovation project on 3/31/2024. In alignment with the modernization of California Mental Health Services Act (MHSA), the Department is aiming to optimize the usage of existing housing programs to expand housing resources for individuals in intensive outpatient behavioral health services.	No Net Fiscal Impact Innovation project will end on 3/31/2024
Sunsetting Intimate Partner Violence Prevention Program	PEI	Termination of the IPV contract at the end of the FY24, on 6/30/2024. In alignment with the modernization of California MHSA, the Department is aiming to prioritize care and treatment for individuals with severe mental illness and substance use issues and optimize the usage of existing IPV programs and networking to reduce redundancy in programming.	TBD Fiscal impact includes 1.0 FTE position shift to CSS and reduction in PEI contracts ($450,000)

UPDATES ON FY 2025 PROGRAM MODIFICATIONS

These include program modifications that were originally proposed in the FY2024 – 2026 three-year plan but:

1. **are being proposed to not move forward in FY 2025; or**
2. **are utilizing other funding sources (not MHSA) from FY 2025 onwards**

SYSTEM OF CARE: ADULT/OLDER ADULT (A/OA)

FY2025 PROGRAM MODIFICATIONS NOT MOVING FORWARD

MODIFICATIONS ORIGINALLY PROPOSED IN THE MHSA FY 2024-2026 THREE-YEAR PLAN

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	ONE-TIME OR ONGOING	FY 2025 NET FISCAL IMPACT
24 hour care unit-since program is re-structuring	CSS	Add 1.0 FTE Rehabilitation Counselor to the community placement team to assist with care coordination efforts in order to transition clients from long term psychiatric facilities.	Ongoing	($147,113)
Behavioral Health (BH) Urgent Care	CSS	To support the implementation of the Peer Navigation program an additional 1.0 FTE added to cover the gaps in coverage. This will increase capacity for Same Day Access.	Ongoing	($177,527)
Cultural Communities Wellness Program	PEI	Add 1.0 FTE for the Cultural Communities Wellness Program to increase support for the Latino Community	Ongoing	($104,901)

SYSTEM OF CARE: HOUSING

UPDATES ON FY2025 PROGRAM MODIFICATIONS

ORIGINALLY PROPOSED IN THE FY2024-2026 THREE-YEAR PLAN

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	ONE-TIME OR ONGOING	FY 2025 NET FISCAL IM PACT
Cross Systems Initiatives (CSI)	CSS	AOT Master Lease Housing Expansion – to serve additional fifty (50) clients	Ongoing*	($1,960,000)
Supportive Services	CSS	Supportive Services for No Place Like Home (NPLH) Supportive Housing units Note: This program was proposed to utilize MHSA starting FY24, but the program continued utilizing a different funding source.	Ongoing	($2,893,000)

*Note: The modification was originally proposed in the MHSA FY 2024-2026 three-year plan but will be utilizing other funding sources (not MHSA) from FY 2025 onwards.

MHSA FY 2025 ANNUAL PLAN UPDATE

COMMUNITY PROGRAM PLANNING PROCESS TIMELINE

24

Public/Stakeholder Meetings/Activities*

To be Conducted Onsite/In-Person

MHSA FY2025 Annual Plan Update

November 16, 2023
- **Round 1 Program Recommendations: Access & Unplanned, WET, CYF**
- *SSA Andrew Hill Training Room (353 W. Julian)*
- 1:00 PM- 3:00 PM

November 29, 2023
- **Round 2 Program Recommendations: Access & Unplanned, WET, CYF**
- *SSA Auditorium (333 W. Julian St.)*
- 1:00 PM- 3:00 PM

December 15, 2023
- **Round 2 Program Recommendations Housing + AOA**
- *SSA Auditorium (333 W. Julian St.)*
- 10:00 AM - 12:00 PM

*Note: Additional planning /refinement meetings may be scheduled. Please stay connected for schedule info: https://bhsd.sccgov.org/about-us/mental-health-services-act

PLEASE TAKE A MOMENT & PROVIDE YOUR FEEDBACK ON TODAY'S MEETING!

https://tinyurl.com/MHSA2025

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Thank you!

For any questions about MHSA and the FY2025 MHSA Planning Process, please email MHSA@hhs.sccgov.org.

Mental Health Services Act (MHSA)
FY2025 Community Program Planning Process
Access & Unplanned, WET, CYF System of Care
Round 1 Recommendations

November 16, 2023, 1:00 PM – 3:30 PM
353 W. Julian St, San Jose, CA 95110
Oak Grove & Gunderson Training Rooms

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

MEETING AGENDA – November 16, 2023	TIME
1. Welcome & Background a. Introductions (Roshni Shah) b. Welcoming Remarks & Meeting Goals (Darren Tan)	1:00 PM- 1:05 PM
2. Fiscal Update (Katelyn Lu) a. Questions & Answers	1:05 – 1:30 PM
3. System-Wide Preliminary Recommendations a. Access & Unplanned Services (Bruce Copley) b. Children, Youth & Families (Zelia Faria Costa) c. Workforce, Education & Training (Darren Tan) d. Other BHSD Divisions (Darren Tan)	1:30 – 2:30 PM
4. Break	2:30 – 2:35 PM
5. Breakout Sessions & Discussions	2:35 – 3:15 PM
6. Breakout Session Report Back & Closing Remarks	3:15 - 3:30 PM

Meeting Agreements

Q/A sections are included in the schedule to provide an opportunity to ask questions and/or provide comment/input.

Give space, take space.

Follow along with today's presentation!

https://tinyurl.com/EventsCPP

Goals for Today's Meeting

- Focus for today's meeting will be to:
  - Hear BHSD's suggested programmatic recommendations for FY 2025 given budget constraints
  - Provide feedback on BHSD's FY 2025 recommendations in breakout groups
- Separate meeting will be held to address the impacts of BHSA on BHSD programming on November 29, 2023
- BHSD would like to host a working session on December 15, 2023 with stakeholders to:
  - discuss stakeholder priorities
  - engage in an active dialogue on BHSD's recommended changes to address the impacts of BHSA

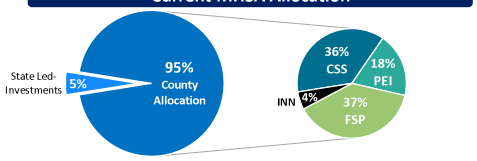
MHSA FISCAL UPDATES

IMPACT OF PROPOSED BHSA MODERNIZATION ON SANTA CLARA COUNTY - AUGUST AMENDMENT

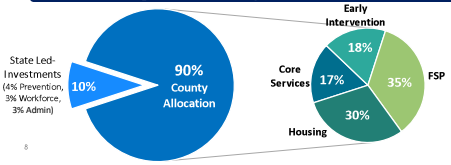
UPDATES FROM SEPT 2023

MHSA COMPONENTS VS BHSA CATEGORIES FUNDING ALLOCATIONS

Current MHSA Allocation



August BHSA Proposed Allocation

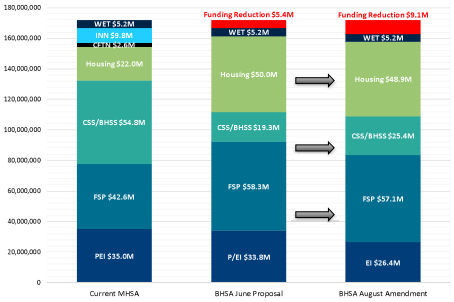


Key Takeaways

- Modernization changes MHSA name to Behavioral Health Services Act (BHSA)
- Loss of funding of 5% total BHSA funding to State-Led Investments
- Reallocating remaining 90% total BHSA funding and revising categories into new areas, notably increasing funding in Housing as standalone category, but reducing core mental health services.

COUNTY OF SANTA CLARA Behavioral Health Services

IMPACT BASED ON $172.1M PLANNED EXPENDITURES



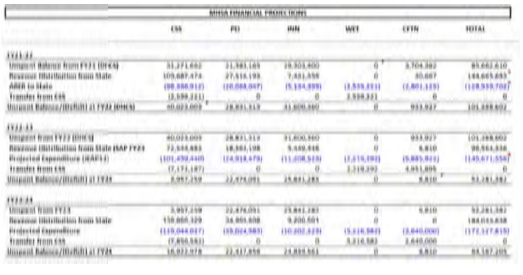
Footnote: Analysis does not reflect substance use disorders (SUD) requirements and loss of services due to Medi-Cal federal match (FFP)

Key Takeaways

- Loss of 5% ($9.1M) of total expenditure budget to state-led investments.
- Loss of funding for core mental health outpatient, crisis, and recovery services by 54%.
- Innovation and Capital Facilities and Technology Needs may be eliminated.
- The BHSA Proposal made in June was revised in August and may undergo further changes.

COUNTY OF SANTA CLARA Behavioral Health Services

MHSA Financial Projections



FY 2025 forecast pending updates on legislation

	CSS	PEI	INN	WET	CFTN	TOTAL
FY24-25						
Unspent Balance from FY24 (Unaud)	16,922,978	22,417,856	24,839,561	0	6,810	64,187,205
Revenue Distribution from State	95,306,195	23,822,601	6,268,727	0	0	125,397,513
Projected Expenditure	(118,576,112)	(38,516,000)	(7,930,973)	(5,216,582)	(2,640,000)	(172,879,667)
Transfer from CSS	(7,856,582)	0	0	5,216,582	2,640,000	0
Unspent Balance/(Deficit) at FY25	(14,203,530)	7,724,457	23,177,315	0	6,810	16,705,051

SYSTEM-WIDE PRELIMINARY RECOMMENDATIONS

Access & Unplanned Services

CONTINUING PROGRAM MODIFICATIONS

These include program modifications that were approved in FY 2024 and are being proposed to continue for FY 2025, subject to available funding.

SYSTEM OF CARE: ACCESS & UNPLANNED SERVICES

CONTINUING PROGRAM MODIFICATIONS
FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	STATUS	FY 2025 NET FISCAL IMPACT
LGBTQIA + Wellness	PEI	Add additional funding for operating costs that to support outreach and engagement program activities	Ongoing	$30,000
LGBTQIA + Wellness	PEI	Additional funding for Caminar LGBTQ Wellness contract to reflect department-wide rate adjustment for CCPs aligning with current staffing costs	Ongoing	$98,842
Suicide Prevention	PEI	Dedicated Management Analyst to enhance data collection, analysis and reporting capabilities, helping to inform effective outreach efforts and education campaigns; enhancing the program's ability to develop and validate culturally-tailored strategies for Suicide Prevention	Ongoing	$170,796
Suicide Prevention	PEI	Support ongoing 988/1-number communications	Ongoing	$100,000

NEW PROPOSED RECOMMENDATIONS

At this time, the Access & Unplanned Services system of care is not proposing any new recommendations for consideration for FY 2025.

UPDATES ON FY 2025 PROGRAM MODIFICATIONS

These include program modifications were originally proposed in the FY 2024 – 2026 three-year plan but:

1. **are being proposed to not move forward in FY 2025;**
2. **are currently on pause for FY 2025; or**
3. **are utilizing other funding sources (not MHSA) from FY 2025 onwards**

SYSTEM OF CARE: ACCESS & UNPLANNED SERVICES

FY2025 PROGRAM MODIFICATIONS NOT MOVING FORWARD
MODIFICATIONS ORIGINALLY PROPOSED IN THE MHSA FY 2024-2026 THREE-YEAR PLAN

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	ONE-TIME OR ONGOING	FY 2025 NET FISCAL IMPACT
BH Navigator	PEI	Add 1.0 FTE - LPHA will provide direct, dedicated support to Peer Staff when clinically complex or urgent cases present	Ongoing	($165,464)
LEL's		Adding funds to complete the remaining 10 Interactive Video Simulation Training (IVST) videos using a professional talent agency/actors will allow for the LEL's to continue to present IVST to law enforcement and community agencies and groups using new and more relevant examples of the work law enforcement and staff encounter via the use of videos	One-time	($35,000)

SYSTEM OF CARE: ACCESS & UNPLANNED SERVICES

FY2025 PROGRAM MODIFICATIONS – CURRENTLY ON PAUSE
MODIFICATIONS ORIGINALLY PROPOSED IN THE MHSA FY 2024-2026 THREE-YEAR PLAN

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	ONE-TIME OR ONGOING	FY 2025 NET FISCAL IMPACT
LGBTQIA + Wellness	PEI	Add 7.0 FTE to align program staffing to meet urgent County need for LGBTQIA+ Wellness Services	Ongoing	($1,018,796)

Children, Youth & Families

CONTINUING PROGRAM MODIFICATIONS

These include program modifications that were approved in FY 2024 and are being proposed to continue for FY 2025, subject to available funding.

SYSTEM OF CARE: CHILDREN, YOUTH & FAMILIES

CONTINUING PROGRAM MODIFICATIONS
FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	STATUS	FY 2025 NET FISCAL IMPACT
Eating Disorders	CSS	Expand the Eating Disorder Continuum	Ongoing	$1,200,000
Mobile Response Stabilization Services (MRSS)	CSS	Expand mobile response services by two teams to all geographical regions in the County Assess utilization in FY 23 to increase in mobile response and decrease response time	Ongoing	$588,000
MRSS	CSS	One-time 10% increase to MRSS was added in FY22 and this recommendation is to continue the funds in the MRSS program	Ongoing	$283,199
allcove Palo Alto	PEI	Addition of allcove Palo Alto which focuses on TAY services through an integrated model (e.g., physical health, behavioral health, peer support, education, and employment)	Ongoing	$4,250,000
School Linked Services	PEI	Repurpose COVID recovery funding support for schools to expand PEI universal services to all school districts and increase SLS BH capacity	Ongoing	$1,484,055

NEW PROPOSED RECOMMENDATIONS

At this time, the Children, Youth & Families system of care is not proposing any new recommendations for consideration for FY 2025.

UPDATES ON FY 2025 PROGRAM MODIFICATIONS

These include program modifications were originally proposed in the FY 2024 – 2026 three-year plan but:

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SYSTEM OF CARE: CHILDREN, YOUTH & FAMILIES

FY2025 PROGRAM MODIFICATIONS NOT MOVING FORWARD
MODIFICATIONS ORIGINALLY PROPOSED IN THE MHSA FY 2024-2026 THREE-YEAR PLAN

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	ONE-TIME OR ONGOING	FY 2025 NET FISCAL IMPACT
School Linked Services	PEI	Re-design PEI Universal Supports and Services to increase outreach, prevention supports and services, and access to Santa Clara County school districts	Ongoing	($500,000)
School Linked Services	PEI	Re-design SLS BH OP/IOP programming to increases access to intensive services and allows for flexibility to serve your continuously based on need	Ongoing	($653,091)
F&C Services	CSS	Redesign and expand Ethnic programming to support a range in services from Wellness through Intensive	Ongoing	($189,540)
TAY Services	CSS	Redesign and expand TAY OP programming to support a range in services from Wellness through Intensive	Ongoing	($506,915)
Full Service Partnership (FSP)	CSS	Redesign and expand TAY and Child FSP programming to provide the range of FSP and IFSP services	Ongoing	($697,899)

SYSTEM OF CARE: CHILDREN, YOUTH & FAMILIES

UPDATES ON FY2025 PROGRAM MODIFICATIONS
ORIGINALLY PROPOSED IN THE FY2024-2026 THREE-YEAR PLAN

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	ONE-TIME OR ONGOING	FY 2025 NET FISCAL IMPACT
F&C SVCS	CSS	Increase F&C Outpatient continuum services focused on LGBTQ community that is age specific**	Ongoing Will be revisited in FY 26	1,111,826
F&C SVCS	CSS	Sunset the integrated services program as Co-Occurring capabilities are being built into outpatient programs	Sunset Will be revisited in FY 26	(1,111,826)

**Note: This will be considered during the Response for Statement of Qualifications (RFSQ) process.

Workforce Education and Training

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

CONTINUING PROGRAM MODIFICATIONS

These include program modifications that were approved in FY 2024 and are being proposed to continue for FY 2025, subject to available funding.

WORKFORCE EDUCATION AND TRAINING

CONTINUING PROGRAM MODIFICATIONS
FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	STATUS	FY 2025 NET FISCAL IMPACT
WET 3 Career Pathways & Development	CSS	Continue funding eighteen (18) Student Intern Stipend Spots for BHSD	On-going	$268,164
WET 3 Career Pathways & Development	CSS	Continue funding four (4) Peer Intern Stipend Spots for BHSD	On-going	$133,600
WET 3 Career Pathways & Development	CSS	Continue funding forty-eight (48) Student Intern Stipend Spots for County Contract Providers (CCP)	On-going	$715,104

WORKFORCE EDUCATION AND TRAINING

CONTINUING PROGRAM MODIFICATIONS
FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	STATUS	FY 2025 NET FISCAL IMPACT
WET 3 Career Pathways & Development	CSS	Continue funding twenty-four (24) Peer Intern Stipend Spots for County Contract Providers (CCP)	On-going	$312,600
WET 3 Career Pathways & Development	CSS	Continuing funding scholarship for students pursuing a Bachelor's level education in Behavioral Health related field - Social Work, Counseling...	On-going	$322,000
WET 2 Training	CSS	Continue funding for 2 Student Intern III -521 to support the training efforts.	On-going	$74,001

NEW PROPOSED RECOMMENDATIONS

At this time, Workforce Education & Training (WET) is not proposing any new recommendations for consideration for FY 2025.

UPDATES ON FY 2025 PROGRAM MODIFICATIONS

These program modifications were originally proposed in the FY 2024 – 2026 three-year plan but are currently on pause for FY 2025.

WORKFORCE EDUCATION AND TRAINING

FY2025 PROGRAM MODIFICATIONS - CURRENTLY ON PAUSE

MODIFICATIONS ORIGINALLY PROPOSED IN THE MHSA FY 2024-2026 THREE-YEAR PLAN

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	ONE-TIME OR ONGOING	FY 2025 NET FISCAL IMPACT
WET 2 Training	CSS	Pause the development of a new training team to provide internal trainer for the Learning Partnership that supports both County and CCP workforce. Proposing adding the following FTE's: 2.0 FTE Program Manager II and 2.0 FTE Training and Staff Development Specialists	On-going	($704,772)
WET 3 Career Pathways & Development	CSS	Pause the development of a new peer mentoring program for High School (HS) and Community College (CC) Students. This new program was to introduce students to the benefits and rewards of entering the BH system of care's workforce. Proposing adding the following FTE: 1.0 FTE Program Manager II, 8 Student Interns I -521 and 16 Student Interns II -521	On-going	($313,021)

WORKFORCE EDUCATION AND TRAINING

FY2025 PROGRAM MODIFICATIONS - CURRENTLY ON PAUSE

MODIFICATIONS ORIGINALLY PROPOSED IN THE MHSA FY 2024-2026 THREE-YEAR PLAN

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	ONE-TIME OR ONGOING	FY 2025 NET FISCAL IMPACT
WET 3 Career Pathways & Development	CSS	Pause restoring 1.0 FTE Management Analyst that was deleted for FY 24 budget deficit reductions. This position supported the Intern Programs, coordinated the Career Summer Institute and supported the training for psychiatrists so that they are able to receive their Continuing Medical Education (CME) credits required to maintain their licensure.	On-going	($183,673)

Miscellaneous Behavioral Health Services Divisions

COUNTY OF SANTA CLARA
Behavioral Health Services

CONTINUING PROGRAM MODIFICATIONS

These include program modifications that were approved in FY 2024 and are being proposed to continue for FY 2025, subject to available funding.

MISCELLANEOUS BEHAVIORAL HEALTH SERVICES DIVISIONS

CONTINUING PROGRAM MODIFICATIONS

FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	STATUS	FY 2025 NET FISCAL IMPACT
Quality Management	PEI	Review quality of services being provided by TransPerfect	Ongoing recommendation	$20,000

NEW PROPOSED RECOMMENDATIONS

These include new program modifications that are being proposed for consideration for FY 2025, subject to available funding.

MISCELLANEOUS BEHAVIORAL HEALTH SERVICES DIVISIONS

NEW PROPOSED RECOMMENDATIONS

PROGRAM MODIFICATIONS OR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION & IMPACT ON SERVICES	FY 2025 NET FISCAL IMPACT
Various	CSS	Release MHSA funding for 31 positions due to BHSD reorganization. Positions will utilize a different funding source. No impact on service delivery.	FY mid-year: ($3,019,754) FY 2025: ($6,403,695)

UPDATES ON FY 2025 PROGRAM MODIFICATIONS

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MISCELLANEOUS BEHAVIORAL HEALTH SERVICES DIVISIONS

FY2025 PROGRAM MODIFICATIONS NOT MOVING FORWARD

MODIFICATIONS ORIGINALLY PROPOSED IN THE MHSA FY 2024-2026 THREE-YEAR PLAN

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION	ONE-TIME OR ONGOING	FY 2025 NET FISCAL IMPACT
System Initiatives, Planning and Communication	CSS	Expand the BHSD - MHSA team to support the growth of MHSA activities: stakeholder planning activities, evaluation, outreach, required outcomes reporting, program review, coordination, and technical assistance.	Ongoing	($179,732)

MHSA FY 2025 ANNUAL PLAN UPDATE

COMMUNITY PROGRAM PLANNING PROCESS TIMELINE

42

Public/Stakeholder Meetings/Activities*
To be Conducted Onsite/In-Person

MHSA FY 2025 Annual Plan Update

November 29, 2023

- **Program Recommendations to address impacts of BHSA**
- *Pioneer & Mt Pleasant Training rooms (353 W. Julian St.)*
- 1:00 PM - 3:30 PM

December 15, 2023

- **BHSA Prioritization: Working Session**
- *SSA Auditorium (333 W. Julian St.)*
- *10:00 AM – 12:00PM*

*Note: Additional planning /refinement meetings may be scheduled. Please stay connected for schedule info: https://bhsd.sccgov.org/about-us/mental-health-services-act.

PLEASE TAKE A MOMENT & PROVIDE YOUR FEEDBACK ON TODAY'S MEETING!

https://tinyurl.com/MHSA2025

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Thank you!

For any questions about MHSA and the FY2024-2026 MHSA Planning Process, please email MHSA@hhs.sccgov.org.

Mental Health Services Act (MHSA)
FY2025 Community Program Planning Process
BHSA Impacts on BHSD MHSA Funded Programs

December 15, 2023, 10AM – 12PM
333 W. Julian St, San Jose, CA, 95110
First floor Auditorium

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Follow along with today's presentation!

https://tinyurl.com/EventsCPP

2

MEETING AGENDA – December 15, 2023	TIME
1. Welcome & Background (Roshni Shah) a. Introductions b. Welcoming Remarks & Housekeeping	10:00 AM - 10:05 AM
2. Meeting Overview (Darren Tan & Roshni Shah) a. Meeting Goals (Darren Tan) b. Review of BHSD Priorities (Darren Tan) c. BHSA 101: Overview of Proposed Changes (Roshni Shah)	10:05 AM – 10:20 AM
3. Fiscal Impacts of the BHSA (Katelyn Lu)	10:20 AM – 10:40 AM
4. BHSD System of Care Impacts of BHSA a. A/OA (Margaret Obilor & Soo Jung) b. Children, Youth & Family (Zelia Faria Costa) c. Access & Unplanned Services (Bruce Copley) d. Administration & Learning Partnership (WET) / Analytics & Reporting / Quality Management (Darren Tan)	10:40 AM – 11:15 AM
5. Overall County Budget Forecast (Darren Tan & Tina Cordero)	11:15 AM – 11:35 AM
6. Questions & Answers	11:35 AM – 11:55 AM
7. Closing Remarks	11:55 AM – 12 PM

Q/A sections are included in the schedule to provide an opportunity to ask questions and/or provide comment/input.

Give space, take space.

Meeting Agreements

Goals for Today's Meeting

- Focus for today's meeting will be to:
  - Address the impacts of the Behavioral Health Services Act (BHSA) on BHSD programming
- BHSD would like to host a working session on January 9, 2024 with stakeholders to:
  - discuss stakeholder priorities
  - engage in an active dialogue on BHSD's presentation to address the impacts of BHSA

Review of BHSD Priorities

- Ensure Medi-Cal Beneficiaries are Provided Timely Access to High Quality Mental Health and Substance Use Treatment Services
- Increase the Availability of Treatment beds, Permanent Housing, and Temporary Shelter
- Proactively Address Ongoing and Emerging Needs for Specific High-Need Populations
- Develop Innovative Solutions to Address Professional Workforce Shortages
- Adapt to and Help Shape the Rapidly Shifting State Policy Landscape

BHSA 101: Overview of Proposed Changes

High-level Summary

- Name change to **Behavioral Health Services Act (BHSA)**
- Transition from current 5 funding components to 3 funding categories
- Expands eligible services to include substance use disorder (SUD) treatment services
- Doubles the state's allocation of the tax from 5 to 10%
- 30% set aside to fund housing with housing first requirements
- Overhauls the adult and children's system of care statutes
- Eliminates county-based prevention funding priority
- New structure for planning, data gathering, reporting and accountability across all county behavioral health funding streams
- Establishes new benefit requirements (e.g., ACT/FACT)
- Requires counties to engage commercial plans and MCPs for contracting

10% State allocation

- Creates new state-wide, state-led investments
  - **4% Population-based Prevention** Focus on mental health and SUD stigma reduction and suicide prevention; will target the entire population of the state, a county or specific community. For example, in school-linked settings, this prevention funding must focus on school-wide or classroom-based mental health and substance use disorder programs, not individual services.
    - 51% of Prevention funds must serve youth 25 years and younger
  - **3% BH Workforce** Investments to develop a culturally-competent and diverse behavioral health workforce to address statewide need and leverage these dollars to draw down additional federal funding that will benefit the entire state system with a $2.4 billion investment over 5 years.
  - **3% State Administration** used to develop statewide outcomes, conduct oversight of county outcomes, train and provide technical assistance, research and evaluate, and administer programs.

30% Housing category

- For children and families, youth, adults and older adults living with serious mental illness/serious emotional disturbance (SMI/SED) and/or SUD who are experiencing homelessness or are at risk of homelessness
- Eligible interventions include (Housing First model):
  - Rental subsidies, operating subsidies, shared housing, family housing for children/youth who meet criteria, and the non-federal share for certain transitional rent
- 50% of these funds (15%) must be used for "chronically homeless"
- Up to 25% of funds may be used for capital development (including affordable housing)
- Housing interventions for FSP consumers **shall be funded** under this category
- Prohibits use of these funds for mental health or SUD treatment services

35% Full Service Partnership category

- Full-Service Partnership (FSP) programs are the most effective model of comprehensive and intensive care for people at any age with the most complex needs.
- Funds will be used to expand the number of FSP slots available across the state and are key to CARE Court being successfully implemented.
- Requires evidence-based practices, including ACT/FACT, IPS Supported Employment and Wraparound all to fidelity
- Requires assertive field-based initiation for SUD treatment services
- Includes outpatient and engagement services for "persons enrolled"

35% Behavioral Health Services & Supports (BHSS) category

- Behavioral Health Services & Supports funds:
  - Adult and Children's System of Care activities
  - Early intervention (EI) programs
  - Outreach and engagement
  - Workforce education and training (WET)
  - Capital facilities and technological needs (CFTN)
  - Innovation pilots and projects across all funding categories
- At least 51% of these funds must be used for Early Intervention (EI)
  - At least 51% of EI funds dedicated to youth 25 years and younger

BHSA Funding Considerations

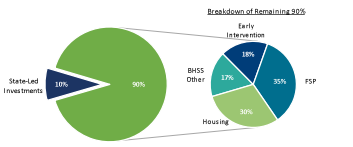
- Allows counties to move funds from one category to another with approval and CPP process
  - Flexibility aligns with the transition to implementation and is on-going
    - Can shift **7%** from any one category to another; **14%** max – 2026/27 through 2028/29
    - Can shift **6%** from any one category to another; **12%** max – 2029/30 through 2031/32
    - Can shift **5%** from any one category to another; **10%** max – 2032 forward
  - Funding changes can be made during the 3-year plan cycle and annually **with DHCS approval**
  - Counties will need to justify shifts (data, local priorities, community input)
- No dedicated local funding for prevention activities or programs
- Counties required to reassess their prudent reserve accounts every 3 years
  - Current cap reduced from 33% to 20% for large counties; transfers to prudent reserve can come from **all** new funding categories

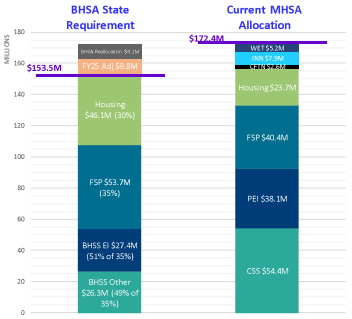
BHSA is Focused on

Outcomes	Accountability	Equity
• County Integrated Plan for Behavioral Health Services and Outcomes • Integrated 3-year plan for **ALL** BH funding sources	• County Behavioral Health Outcomes, Accountability and Transparency Report (to replace ARER) • DHCS role enhanced	• Connects the BH system statewide to increase parity between commercial and Medi-Cal MH/SUD benefits • Expands required stakeholder list

FISCAL IMPACTS of the BHSA

BHSA (STATE) PROPOSED ALLOCATION

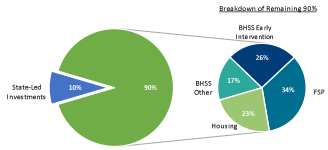


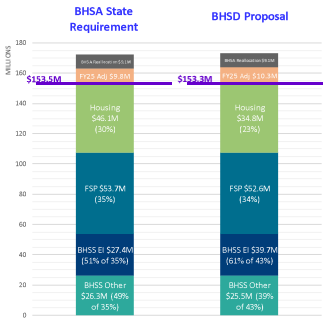


Key Takeaways:

Note: BHSS Other includes adult and children's system of care activities, outreach and engagement, workforce education and training (WET), capital facilities and technological needs (CFTN), and innovation pilots and projects across all funding categories. Currently active Innovation projects are included in this analysis.

BHSD PROPOSED ALLOCATION



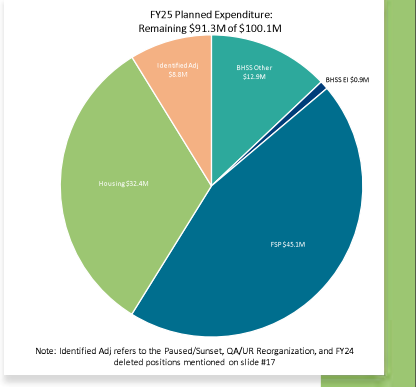


Key Takeaways:

Note: BHSS Other includes adult and children's system of care activities, outreach and engagement, workforce education and training (WET), capital facilities and technological needs (CFTN), and innovation pilots and projects across all funding categories. Currently active Innovation projects are included in this analysis.

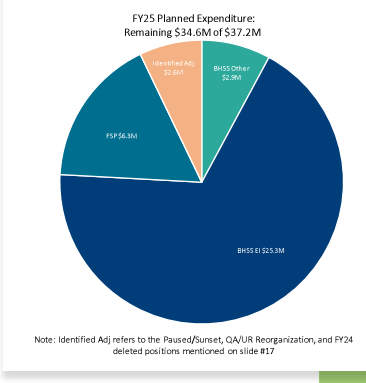
BHSD System of Care Impacts of BHSA

SYSTEM OF CARE: ADULT & OLDER ADULT



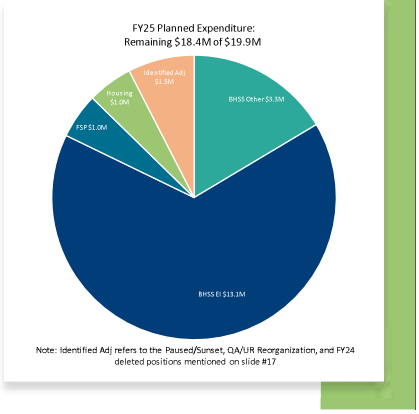
Note: Identified Adj refers to the Paused/Sunset, QA/UR Reorganization, and FY24 deleted positions mentioned on slide #17

SYSTEM OF CARE: CHILDREN, YOUTH, AND FAMILIES



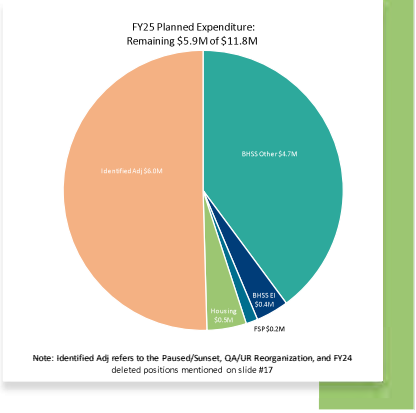
Note: Identified Adj refers to the Paused/Sunset, QA/UR Reorganization, and FY24 deleted positions mentioned on slide #17

SYSTEM OF CARE: ACCESS AND UNPLANNED SERVICES



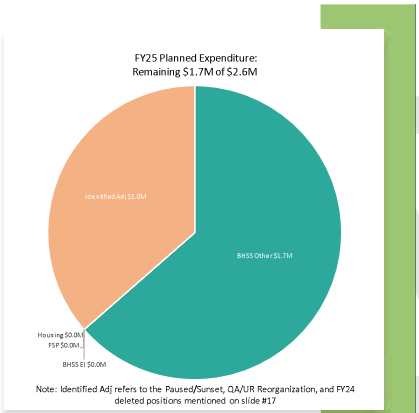
Note: Identified Adj refers to the Paused/Sunset, QA/UR Reorganization, and FY24 deleted positions mentioned on slide #17

SYSTEM OF CARE: ADMINISTRATION & LEARNING PARTNERSHIP (WET)



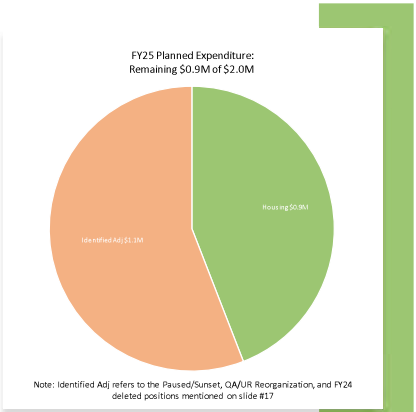
Note: Identified Adj refers to the Paused/Sunset, QA/UR Reorganization, and FY24 deleted positions mentioned on slide #17

SYSTEM OF CARE: ANALYTICS & REPORTING



Note: Identified Adj refers to the Paused/Sunset, QA/UR Reorganization, and FY24 deleted positions mentioned on slide #17

SYSTEM OF CARE: QUALITY MANAGEMENT



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OVERALL COUNTY BUDGET FORECAST

MHSA Projections

MHSA FINANCIAL PROJECTIONS

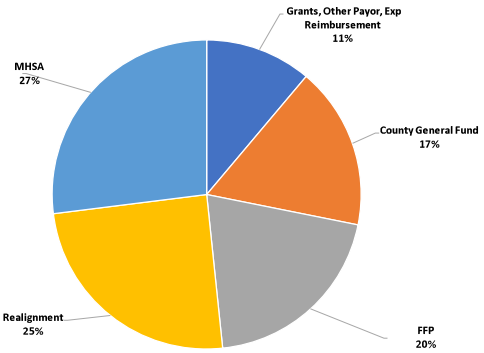
FY21-22	CSS	PEI	INN	WET	CFTN	TOTAL
Unspent Balance from FY21 (EHCS)	31,271,462	21,385,165	29,303,400	0	3,704,382	85,662,610
Revenue Distribution from State	109,687,474	27,516,193	7,431,359	0	30,667	144,665,693
ARCR to State	(98,396,512)	(20,068,047)	(5,134,399)	(2,539,221)	(2,801,123)	(128,939,702)
Transfer from CSS	(2,539,221)	0	0	2,539,221	0	0
Unspent Balance/(Deficit) at FY22 (DHCS)	40,023,003	28,833,313	31,600,360	0	933,927	101,388,602
FY22-23						
Unspent from FY22 (DHCS)	40,023,003	28,833,313	31,600,360	0	933,927	101,388,602
Revenue Distribution from State (SAP FY23	72,544,883	18,563,198	5,449,466	0	6,810	96,564,356
Projected Expenditure (IEAP13)	(101,439,440)	(24,918,476)	(11,208,923)	(2,219,292)	(5,885,822)	(145,671,556)
Transfer from CSS	(7,171,187)	0	0	2,219,292	4,951,895	0
Unspent Balance/(Deficit) at FY23	3,957,259	22,478,031	25,841,283	0	6,810	52,211,582
FY23-24						
Unspent from FY23	3,957,259	22,478,031	25,841,283	0	6,810	52,211,582
Revenue Distribution from State	139,886,329	34,988,808	9,200,351	0	0	184,013,638
Projected Expenditure	(112,677,390)	(40,983,190)	(10,202,223)	(4,098,480)	(1,773,390)	(169,734,679)
Transfer from CSS	(5,871,670)	0	0	4,098,480	1,773,390	0
Unspent Balance/(Deficit) at FY24	25,274,321	16,459,649	24,839,351	0	6,810	66,510,341
FY24-25						
Unspent from FY24	25,274,321	16,459,649	24,839,351	0	6,810	66,510,341
Revenue Distribution from State	95,306,165	25,822,601	6,268,727	0	0	125,397,513
Projected Expenditure	(104,023,407)	(35,118,535)	(7,930,971)	(3,960,392)	(1,678,093)	(152,711,399)
Transfer from CSS	(5,638,485)	0	0	3,960,392	1,678,093	0
Unspent Balance/(Deficit) at FY25	10,918,615	5,163,715	23,177,316	0	6,810	39,196,454

FY 2025 forecast pending updates on legislation

FY25-26						
Unspent from FY25	10,918,615	5,163,715	23,177,316	0	6,810	39,266,454
Revenue Distribution from State	131,902,859	25,471,448	8,702,667	0	0	134,076,713
Projected Expenditure	(103,316,227)	(35,829,773)	(7,346,593)	(4,087,694)	(1,678,093)	(150,559,852)
Transfer from CSS	(5,765,787)	0	0	4,087,694	1,678,093	0
Unspent Balance/(Deficit) at FY26	3,739,260	(5,194,613)	23,533,390	0	6,810	22,783,315

as of 12.22.2023

BHSD Funding Sources



*Note: AB 109 is included in Grants, Other Payor, Exp Reimbursement

QUESTIONS & ANSWERS

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MHSA FY 2025 ANNUAL PLAN UPDATE

COMMUNITY PROGRAM PLANNING PROCESS TIMELINE

Public/Stakeholder Meetings/Activities*
To be Conducted Onsite/In-Person

January 9, 2023

- BHSA Prioritization: Working Session
- SSA Auditorium (353 W. Julian St.)
- 1PM – 3:30PM

*Note: Additional planning /refinement meetings may be scheduled. Please stay connected for schedule info: https://bhsd.sccgov.org/about-us/mental-health-services-act.

PLEASE TAKE A MOMENT & PROVIDE YOUR FEEDBACK ON TODAY'S MEETING!

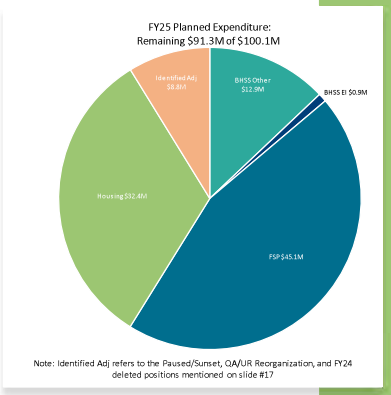
https://tinyurl.com/MHSA2025

Thank you!

For any questions about MHSA and the FY2024-2026 MHSA Planning Process, please email MHSA@hhs.sccgov.org.

SUPPLEMENTAL INFORMATION:
Detailed BHSD System of Care Impacts of BHSA

SYSTEM OF CARE: ADULT & OLDER ADULT



ADULT/OLDER ADULT: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 # of CLIENTS SERVED
Adult Residential Treatment	CSS	Housing	Aligns with new housing definitions and includes providing placement for individuals discharging from (EPS) and other inpatient psychiatric settings.	164
CalWORKs Community Health Alliance	CSS	BHSS Other	Aligns with BHSS definition of adult system initiatives	292
Crisis Stabilization Unit and Crisis Residential Treatment	CSS	Housing	Aligns with new housing definitions and includes individuals who are or at risk of becoming homeless, incarcerated, institutionalized & conserved.	1,628
Hope Services: Integrated Mental Health and Autism Services	CSS	BHSS Other	Aligns with BHSS definition of adult system initiatives	1,367

*Note: Proposed BHSA category and justification for change is based on the latest August 2023 amendment, as shared by the California Behavioral Health Directors Association (CBHDA) and is tentative based on legislative changes and the outcome of the proposition.
^unduplicated

ADULT/OLDER ADULT: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 # of CLIENTS SERVED
Individualized Supported Services (Employment)	CSS	FSP	Aligns with new FSP definitions and includes evidence Based Practices, Supported Employment and provides high-fidelity wraparound	163
Criminal Justice Residential and Outpatient Treatment Programs	CSS	FSP Housing	Aligns with new housing definitions and includes individuals who are or at risk of becoming homeless, incarcerated, institutionalized & conserved. Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan both clinical and nonclinical services including support to maintain housing	142
Connections Program	CSS	FSP	Aligns with new FSP definitions and includes outpatient & engagement	98
Outpatient Services for Older Adults	CSS	FSP	Aligns with new FSP definitions and includes outpatient & engagement	1,337
Intensive Outpatient Program (IOP)	CSS	FSP	Aligns with new FSP definitions and includes evidence Based Practices, Supported Employment and provides high-fidelity wraparound	311

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ADULT/OLDER ADULT: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 # of CLIENTS SERVED
Outpatient Services for Adults	CSS	FSP	Aligns with new FSP definitions and includes outpatient & engagement services including access to medication & BH support (therapy, rehabilitation, case management, crisis and linkage)	4,414
Specialty Outpatient Services	CSS	FSP	Aligns with new FSP definitions and includes outpatient services for ongoing evaluation and stabilization	429
County Clinics	CSS	FSP	Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan both clinical and nonclinical services including support to maintain housing	2,277
Criminal Justice Outpatient Services	CSS	FSP	Aligns with new FSP definitions and includes outpatient services for ongoing evaluation and stabilization	27

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^unduplicated

ADULT/OLDER ADULT: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 # of CLIENTS SERVED
Criminal Justice FSP	FSP	FSP Housing	Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan both clinical and nonclinical services including support to maintain housing Aligns with new housing definitions and includes individuals who are or at risk of becoming homeless, incarcerated, institutionalized & conserved.	700
Criminal Justice Residential and Outpatient Treatment Programs	FSP	FSP Housing	Aligns with new housing definitions and includes individuals who are or at risk of becoming homeless, incarcerated, institutionalized & conserved Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan both clinical and nonclinical services including support to maintain housing	142

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ADULT/OLDER ADULT: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 # of CLIENTS SERVED
Forensic Assertive Community Treatment	FSP	FSP Housing	Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan both clinical and nonclinical services including support to maintain housing Aligns with new housing definitions and includes individuals who are or at risk of becoming homeless, incarcerated, institutionalized & conserved	211
New Refugees Program	PEI	BHSS Other	Aligns with BHSS definition of adult system of care initiatives	213
Re-Entry Services Team	PEI	BHSS Other	Aligns with BHSS definition of adult system of care initiatives	287
Office of Consumer Affairs	PEI	BHSS Other	Aligns with BHSS definition of adult system of care initiatives	582
Office of Family Affairs	PEI	BHSS Other	Aligns with BHSS definition of adult system of care initiatives	4037

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ADULT/OLDER ADULT: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 CLIENTS # SERVED
Elders' Storytelling Program	PEI	BHSS EI	Aligns with new BHSS EI definitions and includes strategies targeting Mental Health & Substance Use Disorder Needs of Older Adults	112
Older Adult In-Home Peer Respite Program	PEI	BHSS EI	Aligns with new BHSS EI definitions and includes strategies targeting Mental Health & Substance Use Disorder Needs of Older Adults	47
INN 16 - Addressing MH & Trauma in Diverse Communities Project	INN	BHSS Other	Aligns with BHSS definition of adult system of care initiatives	1,095
Cultural Communities Wellness Program (CCWP)	PEI	BHSS Other	Aligns with new BHSS definitions and includes culturally Competent & Linguistically Appropriate Interventions Strategies to Advance Equity and Reduce Disparities Strategies Addressing Needs of Individuals at High Risk of Crisis	6,288

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ADULT/OLDER ADULT: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 CLIENTS SERVED
Integrated Prevention Services for Cultural Communities (IPSCC)	PEI	BHSS Other	Aligns with BHSS definition of adult system of care initiatives	754
Older Adult PEI Services	PEI	BHSS Other	Aligns with BHSS definition of adult system of care initiatives and includes outreach & engagement	65
Promotores	PEI	BHSS Other	Aligns with BHSS definition of adult system of care initiatives and includes outreach & engagement	3,058
Culture-Specific Wellness Centers	PEI	BHSS Other	Aligns with BHSS definition of adult system of care initiatives and includes outreach & engagement	57,565

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ADULT/OLDER ADULT: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 # of CLIENTS SERVED
Adult Full Service Partnership	FSP	FSP Housing	Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan both clinical and nonclinical services including support to maintain housing Aligns with new housing definitions and includes individuals who are or at risk of becoming homeless, incarcerated, institutionalized & conserved	1,400
Assertive Community Treatment	FSP	FSP Housing	Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan both clinical and nonclinical services including support to maintain housing Aligns with new housing definitions and includes individuals who are or at risk of becoming homeless, incarcerated, institutionalized & conserved	251
Violence Prevention Program & Intimate Partner Violence Prevention	PEI	N/A	Sunset discussed at SLC FY25 Housing & Adult/Older Adult System of Care recommendations meeting on 11-01-2023	131
Independent Living Empowerment Program	INN	N/A	Sunset discussed at SLC FY25 Housing & Adult/Older Adult System of Care recommendations meeting on 11-01-2023	24

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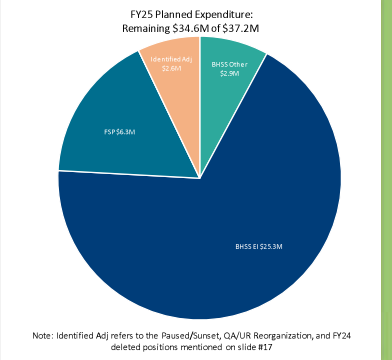
ADULT/OLDER ADULT: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 # of CLIENTS SERVED
Older Adult Full Service Partnership	FSP	FSP Housing	Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan both clinical and nonclinical services including support to maintain housing Aligns with new housing definitions and includes individuals who are or at risk of becoming homeless, incarcerated, institutionalized & conserved.	43
Behavioral Health Urgent Care (aka Mental Health Urgent Care)	CSS	FSP	Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan both clinical and nonclinical services including support to maintain housing	2,640
Permanent Supportive Housing (includes HEAT, Wellness & Housing Support Program, and OSH programs)	FSP	FSP Housing	Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan both clinical and nonclinical services including support to maintain housing Aligns with new housing definitions and includes individuals who are or at risk of becoming homeless, incarcerated, institutionalized & conserved.	1,053
Assisted Outpatient Treatment (AOT)	CSS	FSP Housing	Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan both clinical and nonclinical services including support to maintain housing Aligns with new housing definitions and includes individuals who are or at risk of becoming homeless, incarcerated, institutionalized & conserved.	81

*Note: Proposed BHSA category and justification for change is based on the latest August 2023 amendment, as shared by the California Behavioral Health Directors Association (CBHDA) and is tentative based on legislative changes and the outcome of the proposition.

SYSTEM OF CARE: CHILDREN, YOUTH, AND FAMILIES



Note: Identified Adj refers to the Paused/Sunset, QA/UR Reorganization, and FY24 deleted positions mentioned on slide #17

CHILDREN, YOUTH & FAMILY: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 CLIENTS SERVED
Family & Children Outpatient Continuum	CSS	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	4,954
CSEC Program	CSS	FSP	Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan	56
Family & Children Ethnic Outpatient Continuum	CSS	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	349
Services for Juvenile Justice Involved Youth	CSS	BHSS OTHER	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth.	692
Specialty Services - Integrated MH/SUD	CSS	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	187

*Note: Proposed BHSA category and justification for change is based on the latest August 2023 amendment, as shared by the California Behavioral Health Directors Association (CBHDA) and is tentative based on legislative changes and the outcome of the proposition.

CHILDREN, YOUTH & FAMILY: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 CLIENTS SERVED
Transitional Age Youth FSP	FSP	FSP	Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan	483
School Linked Services (SLS) Initiative	PEI	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	6,922
Services for Children 0-5 (access and linkage)	PEI	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	1,340
Support for Parents – Reach Out and Read	PEI	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	12,976
Support for Parents – Positive Parenting Program (Triple P)	PEI	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	275
Support for Parents Dependency Advocacy Center Mentor Parent Program	PEI	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	118

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CHILDREN, YOUTH & FAMILY: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 CLIENTS SERVED
TAY Crisis and Drop In Center	CSS	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	165
TAY Interdisciplinary Service Teams	CSS	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	173
TAY Outpatient Services	CSS	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	710
TAY LGBTQ Outpatient Continuum	CSS	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	84
Child Full-Service Partnership	FSP	FSP	Aligns with new FSP definitions and includes ongoing engagement services to maintain enrolled individuals in treatment plan	310

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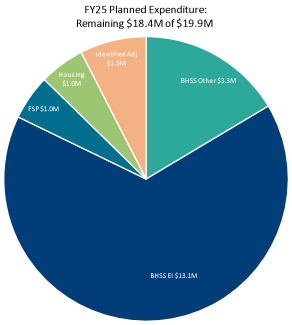
CHILDREN, YOUTH & FAMILY: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 # of CLIENTS SERVED
allcove	PEI	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	477
REACH	PEI	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	129
Downtown Youth Wellness Center	PEI	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	220
Eating Disorders Services	CSS	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement, and services for youth aged 25 and under.	45

*Note: Proposed BHSA category and justification for change is based on the latest August 2023 amendment, as shared by the California Behavioral Health Directors Association (CBHDA) and is tentative based on legislative changes and the outcome of the proposition.

III SYSTEM OF CARE: ACCESS AND UNPLANNED SERVICES



Note: Identified Adj refers to the Paused/Sunset, QA/UR Reorganization, and FY24 deleted positions mentioned on slide #17

ACCESS & UNPLANNED SERVICES: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 # of CLIENTS SERVED
In-Home Outreach Teams	CSS	FSP Housing	Aligns with new FSP definitions and includes outpatient services for ongoing evaluation and stabilization	373
Mobile Crisis Stabilization Services (MRSS)	CSS	BHSS OTHER	Aligns with new BHSS definitions and includes outreach and engagement	1,141*
CMR Community Mobile Response Project (TRUST)	INN	BHSS EI	Aligns with new BHSS definitions and includes early intervention, outreach and engagement	N/A
Suicide Prevention Strategic Plan	PEI	BHSS EI	Aligns with new BHSS definitions and includes outreach and engagement	1,191,200* (duplicated)
LGBTQ+ Access & Linkage	PEI	BHSS EI	Aligns with new BHSS definitions and includes outreach and engagement	20028
Behavioral Health Navigator Program	PEI	BHSS EI	Aligns with new BHSS definitions and includes outreach and engagement	7,750
Law Enforcement Training and Mobile De-Escalation Response	PEI	BHSS OTHER	Aligns with new BHSS definitions and includes outreach and engagement	1,167

*- Represents duplicated numbers.

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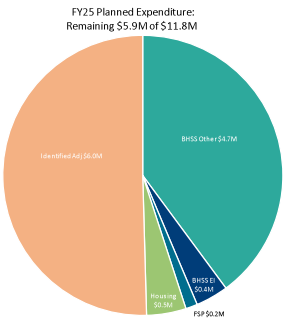
SYSTEM OF CARE: ADMINISTRATION & LEARNING PARTNERSHIP (WET)



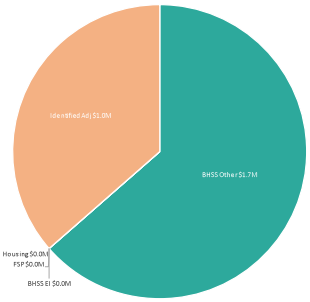
Note: Identified Adj refers to the Paused/Sunset, QA/UR Reorganization, and FY24 deleted positions mentioned on slide #17

ADMINISTRATION & LEARNING PARTNERSHIP: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 # of CLIENTS SERVED
Learning Partnership	CSS	BHSS OTHER	Aligns with new BHSS definitions and includes WET	N/A (does not fund direct services)
WET Coordination	CSS WET	BHSS OTHER	Aligns with new BHSS definitions and includes WET	N/A (does not fund direct services)
WET Training	CSS WET	BHSS OTHER	Aligns with new BHSS definitions and includes WET	6,471 Training Participants (Duplicated)
WET Career Pathways and Development	CSS WET	BHSS OTHER	Aligns with new BHSS definitions and includes WET	30 Interns (County & CCP) 150 Loan Repayment & Stipend Program Participants 3 SJSU Scholarship Participants

*Note: Proposed BHSA category and justification for change is based on the latest August 2023 amendment, as shared by the California Behavioral Health Directors Association (CBHDA) and is tentative based on legislative changes and the outcome of the proposition.

SYSTEM OF CARE: ANALYTICS & REPORTING



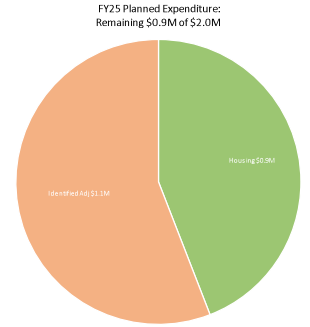
Note: Identified Adj refers to the Paused/Sunset, QA/UR Reorganization, and FY24 deleted positions mentioned on slide #17

ANALYTICS & REPORTING: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 # OF CLIENTS SERVED
CFTN Support Staff	CSS CFTN	BHSS OTHER	Aligns with new BHSS definitions and includes CF/TN	N/A (does not fund direct services)

*Note: Proposed BHSA category and justification for change is based on the latest August 2023 amendment, as shared by the California Behavioral Health Directors Association (CBHDA) and is tentative based on legislative changes and the outcome of the proposition.

SYSTEM OF CARE: QUALITY MANAGEMENT



Note: Identified Adj refers to the Paused/Sunset, QA/UR Reorganization, and FY24 deleted positions mentioned on slide #17

QUALITY MANAGEMENT: PROPOSED PROGRAM CHANGES

PROGRAM NAME	CURRENT MHSA COMPONENT	PROPOSED BHSA CATEGORY	JUSTIFICATION FOR PROPOSED RECOMMENDATION*	FY23 # of CLIENTS SERVED
Community Placement Team Services and IMD Alternative Program	CSS	Housing	Aligns with new housing definitions and includes housing support	298

*Note: Proposed BHSA category and justification for change is based on the latest August 2023 amendment, as shared by the California Behavioral Health Directors Association (CBHDA) and is tentative based on legislative changes and the outcome of the proposition.

Mental Health Services Act (MHSA)
FY2025 Community Program Planning Process
BHSA Prioritization Working Session

January 9, 2024, 1:00 PM – 2:30 PM
353 W. Julian St
San Jose, CA 95110
Oak Grove Training Room

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Follow along with today's presentation!

https://tinyurl.com/EventsCPP

MEETING AGENDA – January 9, 2024	TIME
1. Welcome & Background (Roshni Shah) a. Introductions b. Welcoming Remarks & Housekeeping	1:00 PM – 1:10 PM
2. Meeting Overview (Darren Tan) a. Meeting Goals	1:10 PM – 1:15 PM
3. Additional FY 24 Mid-Year Adjustment & 25 Recommendations (Bruce Copley, Zelia Faria Costa, Margaret Obilor & Soo Jung)	1:15 PM – 1:25 PM
4. Fiscal Updates (Katelyn Lu & Tina Cordero)	1:25 PM – 1:40 PM
5. Discussion on Stakeholder Priorities	1:40 PM – 2:20 PM
6. Closing Remarks & Next Steps	2:20 PM – 2:30 PM

COUNTY OF SANTA CLARA Behavioral Health Ser

Meeting Agreements

Q/A sections are included in the schedule to provide an opportunity to ask questions and/or provide comment/input.

Give space, take space.

Goals for Today's Meeting

- Focus for today's meeting will be to:
  - Share additional FY 24 mid-year adjustments & FY 25 MHSA recommendations
  - Provide pending responses to fiscal questions
  - Engage in an active dialogue on BHSD's presentation to address the impacts of BHSA (presented on December 15th) & discuss stakeholder priorities

ADDITIONAL MHSA RECOMMENDATIONS

NEW PROPOSED RECOMMENDATIONS

PROGRAM MODIFICATIONS FOR CONSIDERATION FOR MHSA FY 2024 MID-YEAR ADJUSTMENTS

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION & IMPACT ON SERVICES	FY 2024 MID-YEAR ADJUSTMENT NET FISCAL IMPACT
Momentum Adult Residential Treatment (ART) (431 N White Rd)	CSS	Continue funds to ART program located at 431 N. White Road, San Jose, CA due to current increase in admissions and utilization for FY23. This is a 24- hour program that provide services for the SMI population 365 days a year. The goal of the program is to decompress the Emergency Psychiatric (EPS) and other inpatient psychiatric settings.	$709, 415
NEW Momentum Adult Residential Treatment (ART) (650 Bascom)	CSS	The goal is to set aside funding to support: • development (financing, construction, rehab, acquisition) of new temp shelter, temp treatment and permanent housing • support efforts around increasing all the new program/work plan/set aside for the Purchase & renovation of Properties • to increase Residential Care Facilities (RCF), Temporary Shelters, Adult Residential Treatment (ART), Crisis Residential program and Master lease shared housing options in a phased approach since these projects require on going funding.	$2,163,968
Psychiatric Emergency Response Team (PERT)	PEI	Shift funding for one (1) Psychiatric Social Worker II from MHSA PEI PERT program to MOU with Campbell from FY 2024 onwards	($171,960)

NEW PROPOSED RECOMMENDATIONS

PROGRAM MODIFICATIONS FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION & IMPACT ON SERVICES	FY 2025 NET FISCAL IMPACT
Mobile Response & Stabilization Services (MRSS)	CSS	Separate Post-Crisis Stabilization Services (PCSS) into another program to track independently. This program has been embedded in the exhibit A for MRSS and is a separate program from Mobile Response with separate funding. The recommendation is to separate PCSS and MRSS for MHSA reporting.	No net fiscal impact
Assisted Outpatient Treatment (AOT)	CSS	Redirect unused AOT operating cost funds to fund the Division Director position that oversees AOT and other intensive outpatient programs	No net fiscal impact to AOT budget Redirection of $260,956

FISCAL UPDATES

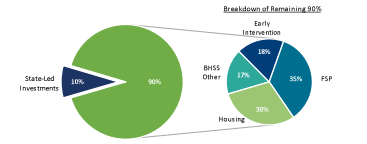
Fiscal Updates from the December 15 Presentation

Is outpatient budget changing as a whole?	• For FY24, no changes have been proposed
Where are realignment dollars coming from?	• Realignment received for BHSD is from the 1991 and 2011 state realignment
Is the County meeting their County General Fund obligation?	• Yes, Santa Clara County meets the required Maintenance of Effort (MOE) to receive 1991 realignment from the state.

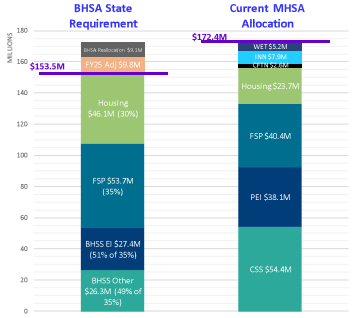
BHSD Funding Sources Trend Data

Funding Source	FY 2021 (%)	FY 2022 (%)	FY 2023 (%)
Grants, Other Payor, Expense Reimbursement	12%	11%	8%
County General Fund	18%	20%	10%
MHSA	22%	21%	21%
Realignment	23%	23%	26%
Federal Financial Participation (FFP)	25%	25%	35%
Total	100%	100%	100%

BHSA (STATE) PROPOSED ALLOCATION

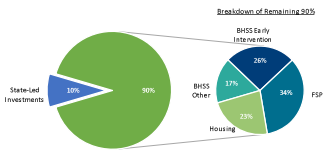


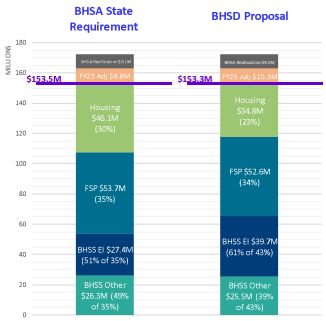
Key Takeaways:



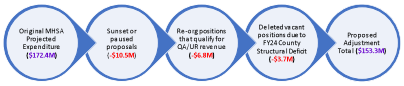
Note: BHSS Other includes adult and children's system of care activities, outreach and engagement, workforce education and training (WET), capital facilities and technological needs (CFTN), and innovation pilots and projects across all funding categories. Currently active innovation projects are included in this analysis.

BHSD PROPOSED ALLOCATION





Key Takeaways:



Note: BHSS Other includes adult and children's system of care activities, outreach and engagement, workforce education and training (WET), capital facilities and technological needs (CFTN), and Innovation pilots and projects across all funding categories. Currently active Innovation projects are included in this analysis.

DISCUSSION ON STAKEHOLDER PRIORITIES

14

MHSA FY 2025 ANNUAL PLAN UPDATE

COMMUNITY PROGRAM PLANNING PROCESS TIMELINE

Public/Stakeholder Meetings/Activities*
To be Conducted Onsite/In-Person

MHSA FY2025 Annual Plan Update

January 2024

- Informational Meeting in advance of 30-day public comment period
- Date & time will be shared soon

*Note: Additional planning /refinement meetings may be scheduled. Please stay connected for schedule info: https://bhsd.sccgov.org/about-us/mental-health-services-act.

PLEASE TAKE A MOMENT & PROVIDE YOUR FEEDBACK ON TODAY'S MEETING!

https://tinyurl.com/MHSA2025

Thank you!

For any questions about MHSA and the FY2024-2026 MHSA Planning Process, please email MHSA@hhs.sccgov.org.

SUPPLEMENTAL INFORMATION

AOA Systems BHSD Housing

BHSD HOUSING GOALS

Focus on unsheltered and/or unstably housed individuals in the BHSD system

Prevent homelessness by providing access to stable and appropriate housing

Utilize Housing First and harm reduction principles

Create various levels of housing, from residential care homes to independent housing, to place individuals in housing appropriate for their needs

Increase bed capacity of Acute and Subacute Care Facilities, MH Community Residential Facilities, and Substance Use Treatment Residential Facilities so that individuals can transition from one level of care to another without delay

WELLNESS • RECOVERY • RESILIENCE

HOUSING STRATEGIES

Homeless Prevention
- Established Wellness and Housing Stabilization Program (WHSP), an emergency rental assistance to prevent homelessness and provide housing stabilization for clients in outpatient programs.
- Will add individuals in SUTs programs in FY25

Transitional (Interim) Housing
- Use transitional housing to quickly house and stabilize individuals to transition them for permanent housing.
- Expand Master Lease Housing

Permanent Supportive Housing (PSH)
- Provide permanent or ongoing housing assistance for individuals in intensive outpatient programs.
- Additional support for family members living with individuals in the BHSD system

HOUSING EXPANSION

Behavioral Health Bridge Housing (BHBH) Grant

- Increase shelter beds
- Provide short-term rental assistance, security deposit
- Board and Care Patches
- Incentives for independent housing operators and family members living with individuals receiving BH services
- Increase Master Lease Housing

Community Care Expansion (CCE) Grant

- Provide Capital Improvement support to prevent Licensed Residential Care Facilities from closing
- Provide Patches for Licensed Residential Care Facilities

FACILITIES

- Continual partnership with the Office of Supportive Housing (OSH) to look for opportunities to increase shelter bed capacity, rapid rehousing, and permanent supportive housing.
- Work with Facilities and Fleets (FAF) to identify potential sites for MH and SUDs treatment facilities

- BHSD contracted with Hallsta, a consultant that provides healthcare construction and facility management to identify sites for BHSD services
- Evaluated 15 county properties as potential sites for the Mental Health Rehabilitation Center (MHRC) and other behavioral health facilities.
- Plans to create Rapid Rehousing for justice-involved individuals

Mental Health Services Act (MHSA)
FY2025 Community Program Planning Process
Innovation and Recommendation Updates

February 5, 2024, 9AM – 10AM
Virtual meeting via Zoom

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

MEETING AGENDA – February 5, 2024	TIME
1. Welcome & Background (Roshni Shah) a. Introductions b. Welcoming Remarks & Housekeeping	9:00 AM - 9:05 AM
2. Meeting Overview (Darren Tan)	9:05 AM – 9:10 AM
3. Innovation Updates (Juan Miguel Munoz-Morris) a. Project Updates b. Prop 1 Impact on Innovation c. Questions & Answers	9:10 AM – 9:25 AM
4. Additional FY25 Recommendations (Bruce Copley, Zelia Faria Costa, Soo Jung, Margaret Obilor, Darren Tan) a. Questions & Answers	9:25 AM – 9:45 AM
5. Next Steps in FY25 Annual Plan Update (Roshni Shah) a. 30-Day Public Comment Period	9:45 AM – 9:55 AM
6. Closing Remarks	9:55 AM – 10:00 AM

Follow along with today's presentation!

https://tinyurl.com/EventsCPP

Meeting Agreements

- Q/A sections are included in the schedule to provide an opportunity to ask questions and/or provide comment/input.
- Give space, take space.

PLEASE TAKE A MOMENT & PROVIDE YOUR FEEDBACK ON TODAY'S MEETING!

https://tinyurl.com/MHSA2025

Goals for Today's Meeting

- Focus for today's meeting will be to:
  - Provide updates on current Innovation projects
  - Present additional FY 2024 mid-year and FY 2025 annual update program recommendations
  - Share information on next steps in the community program planning process, including 30-day public comment period

INNOVATION UPDATES

Over the Last Year

- INN 12 alcove: Ended Jan 2024
- INN 13 Psychiatric Emergency Response Team (PERT): Ended June 2023
- INN 14 Independent Living Empowerment Program (ILEP): Project to end March 2024
- INN 15 TRUST: Went live Nov 2023
- INN 16 Addressing Stigma & Trauma among Vietnamese and African American/Ancestry Communities: Completed year 1 of 3
- INN 17 Transgender, Non-Binary, and Gender Expansive (TGE) Center: Approved July 2023

INN 15: TRUST

BOS Referral asking to make 10-digit Call Center TRUST line available to the public

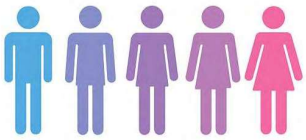
- Call Center Staff to be increased by 3.85 FTEs to cover peak demand call times
- Additional cost to establish the phone line

In addition to the above BOS request:

- Increase evaluator budget to right-size their agreement and expanded scope
  - Evaluator costs can be as high as 10% of a project's budget

INN 17: TGE Center

- Approved by State in July 2023
- Per INN regulations, we have up to 3 years to launch project
- Project was put on hold in August 2022 as BHSD studied the potential impacts of budget reductions.



BHSA Impacts on Innovation

- INN under BHSA
  - No standalone INN category/component
  - "Innovative Practices" across all funding categories
  - Unused INN funds
- Current Active/Approved projects
  - Will continue as planned with no risk of cancellation
  - Possible continuation beyond INN would be determined in the future
- New INN Project Plans
  - BHSD has no plan INN drafts to be submitted to the State
  - No impact in this area at this time

ADDITIONAL FY25 RECOMMENDATIONS

These include new program modifications that are being proposed for consideration for FY 2025, subject to available funding.

SYSTEM OF CARE: ACCESS AND UNPLANNED SERVICES

NEW PROPOSED RECOMMENDATIONS

PROGRAM MODIFICATIONS FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION & IMPACT ON SERVICES	FY 2025 NET FISCAL IMPACT
Trusted Response Urgent Support Team (TRUST)	INN	In response to the BOS referral, TRUST will make the 10-digit phone number for the call center public. The call center will add 3.85 FTEs ($510,000) to cover extra demand and cover the costs of establishing the line ($10,000). Additionally, the budget for evaluation services will be expanded ($140,000) to cover the cost of analyzing and reporting on the project. Unspent INN funds that are at risk for reversion will be utilized.	$650,500
TRUST	INN	TRUST will generate new Medi-Cal revenue. This revenue will offset current MHSA expenditures.	($363,058)
Mobile Response and Stabilization Services (MRSS)	CSS	MRSS will generate new Medi-Cal revenue. This revenue will offset current MHSA expenditures.	($504,248)

SYSTEM OF CARE: ADULTS AND OLDER ADULTS

NEW PROPOSED RECOMMENDATIONS

PROGRAM MODIFICATIONS FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION & IMPACT ON SERVICES	FY 2025 NET FISCAL IMPACT
Criminal Justice System (CJS) Full Service Partnership (FSP)	CSS	Reallocation of funds to make CJS FSP program fully MHSA funded.	$293,679
Crisis Residential	CSS	Reallocation of funds to make Crisis Residential program fully MHSA funded.	$1,036,682
Residential Care Facilities	CSS	Reallocation of funds to make RCF program fully MHSA funded. Program will provide supplemental services in the form of specialized individualized rates/patches to assist individuals with severe mental health behavior issues and medical condition transition from institutional settings back into the community and prevent re-hospitalization.	$2,411,112
Assisted Outpatient Treatment (AOT)	CSS	With the implementation of SB 43, broadening the definition of "gravely disabled," BHSD anticipates a rise in number of referrals to AOT. This recommendation reallocates existing MHSA AOT appropriations to fund SB 43 AOT reserve.	$2,675,200 increase to AOT reserve
Adult Residential Treatment (ART)	CSS	Continue and expand ART services at 431 N White Rd and 650 S Bascom. Includes reallocation of funds to make ART program fully MHSA funded.	$5,982,545

SYSTEM OF CARE: ADULTS AND OLDER ADULTS

NEW PROPOSED RECOMMENDATIONS

PROGRAM MODIFICATIONS FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION & IMPACT ON SERVICES	FY 2025 NET FISCAL IMPACT
Criminal Justice System (CJS) Transitional Housing Units (THU)	CSS	Reallocation of funds to make CJS THU program fully MHSA funded.	$825,978
County Clinics	CSS	Reduction of 3.0 FTEs due to AOA System of Care evaluating its services to optimize resources. Changes will have no impact on services or service delivery.	($415,546)
Momentum Program Closures (Various programs)	CSS	Reduction of funds due to multiple Momentum program closures. Services will be provided by other providers.	($507,843)
Central Wellness Benefits	CSS	New legislation may result in new Medi-Cal revenues. BHSD is evaluating and will provide details in the future.	MHSA reduction amount TBD
Integrated Prevention Services for Cultural Communities (IPSCC)	PEI	Reduction in service agreements to right size utilization. No impact on service delivery.	($850,000)

SYSTEM OF CARE: CHILDREN, YOUTH AND FAMILIES

NEW PROPOSED RECOMMENDATIONS

PROGRAM MODIFICATIONS FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION & IMPACT ON SERVICES	FY 2025 NET FISCAL IMPACT
Services for Children 0 - 5: KidsConnection Network (KCN)	PEI	Recommendation to utilize MHSA funding to support the continuation of KCN services to children birth through five and their family in Santa Clara County due to reduction in First 5 funds.	$937,469
TAY Outpatient (Family and Children Drop-in Center)	CSS	Reallocation of funds to make TAY Outpatient program fully MHSA funded.	$75,363
Eating Disorders	CSS	Eating Disorder will generate new Medi-Cal revenue. This revenue will offset current MHSA expenditures.	($1,720,251)
CYF Cross Systems Programs: Commercially Sexually Exploited Children (CSEC)	CSS	Reduction in MHSA funds due to CYF System of Care evaluating its services to optimize resources. No impact on service delivery.	($412,080)

SYSTEM OF CARE: BHSD ADMINISTRATION

NEW PROPOSED RECOMMENDATIONS

PROGRAM MODIFICATIONS FOR CONSIDERATION FOR MHSA FY 2025 ANNUAL PLAN UPDATE

PROGRAM NAME	MHSA COMPONENT	RECOMMENDED PROGRAM MODIFICATION & IMPACT ON SERVICES	FY 2025 NET FISCAL IMPACT
Workforce, Education and Training (WET)	CSS	Reduce number of CCP student Intern spots from 48 to 23 - due to low number of CCP student interns participating in the WET Stipend program	One-time reduction ($372,420)

NEXT STEPS: FY25 ANNUAL PLAN UPDATE

Timeline for the MHSA FY2025 Annual Plan Update Community Planning Process

Data Collection, Analysis & Review	Planning Process	Local Review Process & Alignment with County Budget Process
Jan 1 – Mid-March 2023 Survey data collection Community conversations **Mid-March to May 2023** Data compilation & analysis **May to June 2023** BHSD reviews initial data findings	**September – January 2024** *September – October 2023* BHSD System of Care data findings & program updates *November – January 2024* Presentation & discussion of BHSD program recommendations	**February 2024:** 30-day public comment period* **April 2024:** BHSD budget proposals shared with Health & Hospital Committee (HHC) **May 2024:** Countywide budget workshops **May 2024:** BHB hearing* **June 2024:** BOS hearing*

*Required by Cal. Code Regs. Tit. 9, § 3315

How to Give Feedback during the 30-day Public Comment Period (Tentative start week of Feb. 5th)

Survey
- Link will be posted on the MHSA website and in the plan document – coming soon!

Email
- MHSA@hhs.sccgov.org
- Please include the plan page #s with your comments

PLEASE TAKE A MOMENT & PROVIDE YOUR FEEDBACK ON TODAY'S MEETING!

https://tinyurl.com/MHSA2025

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Thank you!

For any questions about MHSA and the FY2025 MHSA Planning Process, please email MHSA@hhs.sccgov.org.

Comments and Breakout Group Feedback

Note: The following are comments collected at the nine SLC meetings during the FY 2025 Annual Update community planning process. Two meetings (November 1 and November 16, 2023) specifically collected breakout group feedback.

Stakeholder Leadership Committee Meeting #1, September 13, 2023

Top Comments/Feedback

- Everyone should be able to be in one room instead of split into two rooms. The sound
- was not great.
- Budget Planning
- How will the state holding 5% more impact funding?
- How do you manage service increase with budget reduction?
- Please have meeting virtual option for non-executive leadership on the invite in lieu of in-person as the 2nd room option watching via TEAMS was not helpful. Sound quality was difficult to hear and materials difficult to see from a distance. Secondary request that if in-person is required; to secure a large enough room to reduce sound/ visual issues.

Stakeholder Leadership Committee Meeting #2, October 4, 2023

Any feedback about what should stay the same from the material presented today?

- “Great information- appreciate the opportunity to review it in advance.”
- “Appreciate Dr. Chu”
- “Liked all the updates by different presenters- some presentations could have been shorter.”
- Information is great however it is a lot of information to listen to
- “Comprehensive”
- “Too much information in too little time”
- “Structure was good.”
- “It was well done.”

Any feedback about what should be changed or added from the material presented today?

- “That was a flood of information-3 hours is a bit tad long to review so much data.”
- “Maybe have us look at the slides before presentation so we can hone in on particular issues”
- “Perhaps provide PPT's before our meeting and allow for small group discussion. Retaining this information and knowing what to do next will be discussed in the groups.”
- “A break in between- 3 hours is a long time.”
- “WET materials should be more like ACCESS structure-overview, data, strength, challenges, success stories.”
- “Have a break in between sessions.”
- “Breaks would be very much desired.”

Any other comments?

- “Public Wi-Fi had no internet access so hard to load slides to follow along.”

- "Separate shorter meetings or Hybrid to have an online option- 3 hours is hard to schedule. "
- "How about a snack at last water, or coffee"
- "Kind of a long time without water- these meetings"
- "Also, a break would be nice."
- "Thank you to all of the presenters and information."

Stakeholder Leadership Committee Meeting #3, October 11, 2023

Any feedback about what should stay the same from the material presented today?

- "These meetings should be billed as a system primer & powerpoint review. Not a good use of my time. TOO much repetition on survey process and system data."
- "Need to look at PEI outreach and presence of major changes since the pandemic, like electronic device addition leading to depression and substance use. Treatment programs are good but prevention is best"
- "order of information was great and information presented was helpful."
- "All programs…1, 2, 3, 4, 5 should stay the same. All school programs specifically on mental health screening and substance abuse should stay."
- "well done!"
- "well prepared. I love the highlights – lots of great impacts"

Any feedback about what should be changed or added from the material presented today?

- "Sorry to be so negative, hope that meetings that advance knowledge or planning are coming. And that we will have a meeting that is responsive to requests and questions raised at prior meetings."
- "How do you know you have a valid sample…outreach doesn't seem to go to the isolated youth we observe in informational gatherings. Do you do outreach for recommendations from teachers or youth workers?"
- "more information/data around young children (0-5) and pregnant persons."
- "more training/awareness for parents/family, youth."

Any other comments?

- "There's a reason so few SLS members attend. I think the meetings need to be substantive if you want busy people & system partners to attend."
- "Cultural factors staff doesn't match youth population, LGBTQ candidate with lived experience may not qualify on first round interviews. How do you reach out to youth, LGBTQ and immigrant groups? Youth who are isolated?. "
- "Expand and increase access to all the services to underserved youth such as African/African American youth; more family education specifically schools, university, college about social media awareness; more peers support to go out there and do outreach for youth (distressed youth) in the community; culturally-specific programs that can help youth; new refugee programs and create or invite expert on new refugees; Allow time for discussion and questions."

Stakeholder Leadership Committee Meeting #4, October 18, 2023

Any feedback about what should stay the same from the material presented today?

- "Initial data"
- "I appreciate the response to the community findings in each presentation. Joyce went a bit too quickly. I understand why but if you want us to really gather the info needed break the AOA up into 2"
- "Dr. Joyce is an awesome table setter – I appreciate the priming for what we will discuss throughout the meeting/s."
- "The continual collaboration and goal to end homelessness"
- "Like hearing about survey results, peoples' comments and feedback, also having the different presenters is good"

Any feedback about what should be changed or added from the material presented today?

- "Some slides had too much text + repeat data; some acronyms not initially defined"
- "There are a lot of programs, not much energy for questions/discussion. It was warm in this small room"
- "I want to hear the asks – or angles – from each presenting group. What is our impact on them?"
- "Is it possible to see how presenting programs rank compared to others on/across efficiency, efficacy, meeting MOU quotients etc. (rather than just against themselves – capacity vs patient served)?
- "I think 3 hours is a long time for these meetings – maybe 2.5 hours. Also, maybe a bigger room – the room felt small today"

Any other comments?

- "Thank you for sharing the slides beforehand. It was nice to review. Please offer virtual option. It is hard to miss the presentation and be informed. The material is very dense."
- "I would like to know interactions – if any – one program has to another. For example, if an ACT program is reporting successes in the area of "psychiatry' services, how much did that relieve work flow for one program or even make it worse for another? That is, are other programs that are not invited here responsible for successes that are being presented to us – that therefore influence $$$ decision making? What are the mediating factors/agencies?"
- "Maybe have coffee and or snacks for us"

Stakeholder Leadership Committee Meeting #5, November 1, 2023

Summary of key takeaways/comments from stakeholders (including feedback from breakout sessions)

- SLC members not feeling like a part of the process; Tends to happen when budget comes up
- Financial explanation feels insufficient
- Even beyond MHSA, the BHSD funds in general (other sources including medical, etc.) more transparency and explanation
- More info about how making these decisions about staffing
- Wanting more information about the plan/process – what is BHSD doing?

- For FSP – how will BHSD respond? Opportunities to shift around?
- BOS – what are they doing about this? Where do they get their information?
- Are they aware of these issues? Should they be more involved considering they declared a state of emergency
- More clarify about people who need services (city, by school district)
- Do we have info about licensed boarding facilities? --> Stakeholders requesting more information
- Can we increase marketing about training for peer support?
- How will the county support BH clients in the future?

Breakout Group #1

- The SLC wasn't truly part of the process of budget / program decision making
- The finance presentation was insufficient
- There is a need for BHSD leadership to provide more detail about how they are planning to respond to the potential major shift in MHSA funding
- What is the Board of Supervisors doing about this budget problem?
-

Breakout Group #2

- The presentation was straightforward and got to the point.
- The presenters were responsive to questions and discussions ++
- It was a little hard to know what to do with the proposed funding information when the funding bill hasn't been decided yet.
- BHSD needs more clarity about the number of people who need services (and their ethnicity, what city or school district they're in) - this would help determine how many peer support individuals (and ethnicities) are needed in programs. [This was in response to the discussion on no longer requesting staff for a community wellness program that supports Latino communities; stakeholder was concerned about not meeting needs of the community.]
- There should be a database (one was proposed in 2020?) of licensed board and care facilities - how many are there and how many people do they serve with mental health conditions? BHSD should also determine what the need is in the community (how many people need board and care) to see what the gap is.
- A couple stakeholders expressed concern about what happened with the ILEP

Stakeholder Leadership Committee Meeting #6, November 16, 2023

Summary of key takeaways/comments from stakeholders (including feedback from breakout sessions)

- Brought concerns around prevention (from the PEI component): How will BHSA impact the Department's overall programs and funding?
- Confusion around the 30% housing category: What can those funds be used for - support services or just housing? Will services be lost because of this?
- Want to understand the thinking behind the Department's [BHSD] proposed cuts/recommendations to address the budget shortfall and BHSA impact.

- Request for more transparency from the Department and "humanizing" of the process, especially the decision-making process. What is the impact on the community? What are the county's priorities?
- SLC members and providers want to participate in the process and want a sense of hope in the process: How can we work together to come up with creative solutions?
- When stakeholders/attendees were asked, "In your opinion, what should be prioritized given the proposed BHSA changes?" here are some of the responses:
- Alternative crisis response service in relation to TRUST
- Bring back allcove San Jose
- Transparency from the Department
- Coordination and integration of services and care within school systems
- Support and education for families of adults with mental health conditions
- Support for cultural and faith communities
- Need clarity on housing funds in order to make recommendations

Breakout Room #1

- In future meetings, please provide more detail about the impact on budgets, and the thinking behind how to weather the potential impacts of BHSA within the department.
- Prevention work is so important – please address what will happen to prevention funding
- There's a need for hope in this process (stakeholders seem to be looking for this with more transparency in detail about their thinking / plans to deal with the BHSA budget changes). Can this hope and answers come if BHSD were to engage the community in a participatory process?

Breakout Room #2

- There are a lot of good existing programs – we want to protect this
- Request for more transparency and "humanizing" of the process

Stakeholder Leadership Committee Meeting #7, December 15, 2023

Summary of key takeaways/comments from stakeholders

- Strong appreciation for BHSD staff and this meeting overall
  - Appreciated the department's responsiveness to stakeholder input
  - Felt BHSD was very transparent during this meeting and commended BHSD team on time and effort put into preparing this presentation
  - Continue having leadership presence
- Stakeholders requesting more detailed information on
  - SUTS programs
  - Program actuals along with current MHSA component and proposed BHSA category
  - Housing: collaboration and management to ensure funds are supporting mental health

Any feedback about what should stay the same from the material presented today?

- "I liked the additional slides with details. Open discussion was good, supplemental slides and info. Big room"
- "Overall, well done. More detailed information on which programs will be affected most."

- “More breakdown of impact, alternative plans.”
- “Continue transparency; many questions answered very directly.”
- “Format and detail of information.”
- “So much detail- thanks!”
- “Keep having county leaders present; it is helpful.”

Any feedback about what should be changed or added from the material presented today?

- “More details. Programs’ movement”
- “Still need more granular info.”
- “Please include SUTS program into budget report- spotlight SUTS a bit more, please.”
- “More actual numbers. Spelling out acronyms for new members.”
- “When the county spoke about where program funding would come from with the new buckets, it wasn’t on the slides. It would be helpful to have that on the slides- for example: IHOP is not under housing bucket”

Any other comments?

- “Thank you”
- “Thank you for your ongoing thoughtful and focused work on this challenging subject! Your ability to respond to feedback in a positive and productive way shined today.”
- “Great presentation.”
- “Thank you for always hosting a welcoming and informative session.”
- “Excellent presentation and discussion.”
- “Very hard to hear, microphone was not working well.”
- “Seemed like the microphone wasn’t functioning correctly- difficult to understand or hear what people were saying at times.”

Stakeholder Leadership Committee Meeting #8, January 9, 2024

Any feedback about what should stay the same from the material presented today?

- “Direct answering of questions built into the presentation, appears clear and useful”
- “Highlight of changes rather than repeat of all materials previously covered.”
- “Good bipartisanship: Prop 1 may or may not pass.”
- “Maybe breakout groups could have yielded more discussion.”

Any feedback about what should be changed or added from the material presented today?

- “More info on Prop 1”
- “Guided questions for future discussions? (e.g. fixed response)”

Any other comments?

- “Rome is the people: Thank you for honoring however much or little input we have, handling any or no comments with grace and respect.”

Stakeholder Leadership Committee Meeting #9, February 5, 2024

Meeting questions and comments:

- How do we maximize unused funds? We should strategize and be intentional to make sure we can keep these funds in our county e.g. allcove SJ
- Innovation program updates
    - You mentioned that any innovation that has already started would be able to go through completion regardless of prop 1. Can you please clarify if that includes Inn 17.
    - Request for BHSD Finance team to do some forecasting of INN funds
- Is CSEC funding being reduced due to evaluation of the current services utilization?
- Is TAY for a contracted drop-in center?
- Why isn't there a spirituality component to community presentations?

PUBLIC COMMENTS AND RESPONSE

{Information for this section will be entered after this meeting occurs}

PUBLIC HEARING PRESENTATION AND MINUTES

{Information for this section will be entered after this meeting occurs}